

## Concerns

"Section 1", "Missing definitions of administer, incompetence, incapacity, misconduct, facility and local community."

"Section 1", "I have a general concern with the format of the question. The question you ask with respect to all of the provisions of the Regulations Discussion Document (the RDD") is "do I agree with the intent of the section", but you haven't clearly stated what the intent of each provision is and in a number of cases I have to guess what that might be. I have sought advice so I believe I understand some of the effects and likely results of the various sections, but I really can't comment on their "intent". For example: is the "intent" of section 33 to outlaw International Prescription Service (IPS) pharmacy, or is it (as I mentioned in my comments on the 1" Regulations Discussion Document merely a farcical attempt to outlaw the IPS industry in the guise of a mechanism to allow it? A cynic might believe the latter must be the case, as even the MPhA now concedes that the proposed mechanism (reciprocal agreements with the various US States) cannot work, for various legal and practical reasons. I note that the Government of Alberta has recently rejected a similarly-drafted series of provisions in the legislation that the ACP was promoting: indeed, I understand that all of the provisions in the new Alberta legislation relating to mail order pharmacy were suspended. I would like to see the definition of "authorized practitioner" changed to include US-licensed doctors. I understand that the Manitoba Government has expressed a desire to have such an amendment made (consistent with their expressed desire to keep the IPS industry in Manitoba), which would allow Manitoba IPS pharmacies to fill directly US scripts received from their customers, without the need to engage Canadian doctors ( a practice which neither side to the IPS debate are particularly fond of."

"Section 1", "None"

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"Section 1", "Yes"

"Section 1", "Missing definitions of Administer, Incompetence, Incapacity, Misconduct, Facility, and "Local Community"."

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"Section 1", "Missing definitions of Administer, Incompetence, Incapacity, Misconduct, Facility and Local Community."

"Section 1", "A definition for the term "practice directions"."

"Section 1", "There is a need to define terms better (eg: remote, practice guidelines)."

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"Section 1", "Administer, incompetence, incapacity, misconduct facility and local community."

"Section 1", "Missing definitions of misconduct and local community."

"Section 1", "Missing definitions of Administer, Incompetence, Incapacity, Misconduct, Facility and Local community."

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"Section 1", "Missing definitions of Administer, Incompetence, Incapacity, Misconduct, Facility and Local community"

"Section 1", "Please specify the "other health care professional" which is not restricted to a medical doctor."

"Section 2(4)", "I am concerned about the confidentiality of the profile and about erroneous info being entered in the profile."

"Section 2(4)", "This should be phoned in not available on web."

"Section 2(4)", "Privacy Issues."

"Section 2(4)", "None"

"Section 2(4)", "Providing date of death or retirement to general public. As stated by MSP legal counsel, this could provide opportunity for identity theft."

"Section 2(4)", "Yes"

"Section 2(4)", "Not very relevant but if government insists, then OK."

"Section 2(4)", "I agree. A members address should never be made available to public by any one but BY the member."

"Section 2(4)", "I agree with not having our home address."

"Section 2(4)", "Sated that the public information would not include the home address of the pharmacist - should not include home phone number, cell numbers or E-mail address please. "

"Section C3", "No meaningful changes have been made. The repeated usage of discretionary language such as "satisfy the board", "to the satisfaction of the board", etc. should be removed from this section, and any section of the Regulations, and be replaced with objective language. The criteria for registration should be clear and objective, not subjective. This language needs to be replaced.

"

"Section C4", "No meaningful changes have been made. The repeated usage of discretionary language should be removed from this section, and any section of the Regulations, and be replaced with objective language. Discretionary language should be removed from this and all sections of the Regulations in favor of objective standards."

"Section C5", "No meaningful changes have been made. The repeated usage of discretionary language should be removed from this section, and any section of the Regulations, and be replaced with objective language. Discretionary language should be removed from this and all sections of the Regulations in favor of objective standards."

"Section 6(2)", " However, we need to be clearer in stating "unless a temporary registration" -- is what? Is granted?? Seems like an unfinished sentence"

"Section 6(2)", "None"

"Section 6(2)", "Same concerns as expressed on first response document as to how does someone 'satisfy' the board about their mental and physical well-being."

"Section 6(2)", "g) under what circumstances could this person become a manager?"

"Section 7(2)", "I am concerned with all the documentation involved with the practice and with the fact that liability coverage insurance may not be accessible at a reasonable rate."

"Section 7(2)", "None"

"Section 8(1)", "What if an applicant is physically challenged? Does this not contravene human right?"

"Section 8(1)", "Satisfactory to the registrar wordking is too general. It should be to a certain standard. It should say to the satisfaction of TESOL/TESL or some other recognized standard. This would be a standard which is upheld in all cases and could be substantiated."

"Section 8(1)", "8(I)(J) says that an applicant for registration as a student must satisfy the registrar that the applicant is fluent in one of the official languages of Canada. If the applicant has been accepted into the faculty and passed all required exams. This should not be an issue."

"Section 8(1)", "None"

"Section 8(1)", "Fluent in one of the official languages should not be an issue if applicant is a student."

"Section 8(1)", "Language fluency is paramount in public safety."

"Section 8(1)", "Mention is made less & other parts re: "physical" limitations., is this legal?"

"Section 8(1)", "8(I)(J) sats that an applicant for registration as a student must "satisfy the registrar that the applicant is fluent in one of the official languages of Canada". If the applicant has been accepted into the Faculty and passed all required examination, this should not be an issue."

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"Section 8(1)", "Why is 8(1) h included in the registration of students and nowhere else? How would this be determined?"

"Section 8(1)", "How does a person satisfy conditions (e) and (f)."

"Section 8(1)", "Does not have an addiction to alcohol."

"Section 8(1)", "Satisfy the Registrar that the applicant is fluent in one of the official languages of Canada. "

"Section 8(1)", "8(1)(j) Says that an applicant for registration as a student must "satisfy the Registrar that the applicant is fluent in one of the official languages of Canada". If the applicant has been accepted into the Faculty and passed all the required examinations, this should not be an issue."

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languages of Canada". If the applicant has been accepted into the Faculty and passed all required examinations, this should not be an issue."

"Section 9(1)", "Satisfactory to the registrar would be amended to a standard that is quantifiable. i.e. recognized CEU units, or written verification of internship completed, or letter from prior licensing board showing good standing, etc."

"Section 9(1)", "Is the internship period after graduation still going to be 9 weeks? I wonder if since the experiential program has increased over the last few years is the 9 week internship necessary? I believe that this change will provide comfort to pharmacists who precept students knowing that the Act considers the students interns."

"Section 9(1)", "Would the expected internship following graduation still be maintained @ 9 weeks??"

"Section 9(1)", "None"

"Section 9(1)", "The repeated usage of discretionary language such as "satisfy the Registrar" should be removed from this section, and any section of the Regulations, and be replaced with objective language."

"

"Section 9(1)", "same as 8(1)"

"

"Section 11(2)", " I would like to see what the definition for mental or physical condition as set out by the council - need more information exactly how this is going to be done. "

"Section 11(2)", "If a pharmacist qualifies for a section 12 license that should cover everything required for a section 13 licence."

"Section 11(2)", "This should not be changed from current status."

"Section 11(2)", "Also, Sec 13(3) restricts functions of Sec 13 Pharm-Pharm Managers in hospitals need to be able to do duties described in Sec 50 eg) take an order from an MD or fill/refill Rx's  
There are a small # of hospital managers that do have an administrative role but their decisions (eg. Med Safety/P&T etc) have a direct impact on pts.  
Separating them out from a Sec 12 pharmacists does not save the public & complicates licensure."

"Section 11(2)", "I agree with the intent, but I wonder about the logistics of carrying this out - is it too complicated. Also would someone needing a 12 & 13 license need to pay double?"

"Section 11(2)", "Need clarification as to which situations would require a member to hold both categories of license."

"Section 11(2)", "I would only suggest that the bylaws for those who need/want both section 12 & 13 licenses that there is only one main fee and then selected "categories" would be marked on registration & licensing each year."

"Section 11(2)", "Why do we want to restrict a sec 13 pharmacist's ability to use sec 12 towards application for a sec 12 license?"

"Section 11(2)", "Again, language is too subjective. How exactly do we ""satisfy the registrar"" re our mental/physical condition."

"Section 11(2)", "Definitely agree that a pharmacist should be able to hold and practice both a Section 12 and 13 license."

"Section 11(2)", "Need clarification as to which situation requires a member holds both licenses."

"Section 11(2)", "No need to apply for both types - yes keep section 13 for that for those that qualify"

"Section 11(2)", "At a glance, the title of these licenses does not immediately indicate the nature of a member's practice. A more descriptive nomenclature would be better."

"Section 11(2)", "I thought it was fine the way it was."

"Section 11(2)", "How can you have both section 12 & 13 licenses if you must surrender one when converting to another?"

"Section 11(2)", "Need clarification as to which situation(s) would require a member to hold both categories of license"

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"Section 11(2)", "Need clarification as to which situation(s) would require a member to hold both categories of license."

"Section 11(2)", "Delete category 13."

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"Section 11(2)", "I don't believe there should be two categories of pharmacist licenses. Other provinces have not found a need to differentiate between pharmacists who practice in different capacities. A pharmacist is a drug expert despite who they are in contact with whether it is direct patient care or in a teaching capacity. A pharmacist is a pharmacist and if this requires a change to the definition of the practice of pharmacy so be it."

"Section 11(2)", "Need clarification as to which situation(s) requires a member to hold both categories of license."

"Section 11(2)", "If there is no non-practicing license, what will be the schedule for a member to remain registered? Non-practicing may just mean the member is in retirement."

"Section 11(2)", "Why do we want to restrict a section 13 pharmacist's ability to use section 12 hours towards application for a section 12 license?"

"Section 11(2)", "Need clarification as to which situation(s) would require a member to hold both categories of license."

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"Section 11(2)", "Should be 1 license type."

"Section 12(1)", "Clarify 400 hours in what time span? Does this apply to pharmacists applying for Section 12 on an annual basis?"

"Section 12(1)", "I disagree with the wording of 11(1)(b). Wording using satisfy the registrar should be specific and not general. It should list conditions which must be disclosed. The wording Satisfy the registrar that the applicant does not have... puts the onus on the applicant to defend his or her health and leads to a person (registrar) without diagnostic responsibility to have control of licensing due to health. Out of scope of practice of the registrar. 11(1)(c) wording of Satisfy the Registrar that the applicant does not have ... is inappropriate and should be changed. 11(1)(c) wording is inappropriate and should be specific to conditions of types of activities that would lead danger to the public ie must disclose if has been convicted of a drug diversion offence."

"Section 12(1)", "The requirement of a facility licensed is concerning."

"Section 12(1)", "We need further discussions specifically on this Sec 12 & 13 issue before any final decisions are made."

Does Sec 12 mean all pharmacists (inc Managers) in a hospital & Sec 13 means any setting outside a "health care" setting - I just don't understand it."

"Section 12(1)", "The term facility needs to be defined."

"Section 12(1)", "A pharmacist can hold both a sec 12 and sec 13 license and practice in both settings on an ongoing basis. I am uncertain if the present wording allows this even though one may apply for and hold both licences."

"Section 12(1)", "It may be hard to find pharmacists willing to work as a section 13 pharmacist, because it will be very hard to convert to a section 12 if they needed to."

"Section 12(1)", "The tem facility needs to be defined."

"Section 12(1)", "The term "facility" needs to be defined."

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"Section 12(1)", "What issue of patient safety is regulated by this section? The MPHA appears to be regulating pharmacy business instead of pharmacy practice."

"Section 12(1)", "The term "facility" needs to be defined."

"Section 12(1)", "What about an extended practice pharmacists etc. Based on this statement would they be limited to practicing within a type of pharmacy - facility licensed under the act?"

"Section 12(1)", "See above."

Is there any evidence that supports the need for two types of pharmacist licenses. Has there been documented proof of a danger to public safety in the past where a pharmacist has moved from a non-patient care setting to a patient care setting. If not, what has prompted the need for two types of licenses?"

"Section 12(1)", "If you are a supervisor/manager in a health care facility, would you be licensed under a section 12? Despite perhaps of minimal direct patient contact?"

"Section 12(1)", "The term facility needs to be defined."

"Section 12(1)", "A pharmacist can hold both a section 12 and section 13 license and practice in both settings on an ongoing basis. I am uncertain if the

present wording allows this even though one may apply for and hold both licenses."

"Section 12(1)", "The term "facility" needs to be defined."

"Section 12(1)", "I couldn't find the information about a facility licensed under the act. For 12(2)(a) did you intend to change from health care setting to health care "practice"? I believe that persons directly supervising section 12 pharmacists should also be included in section 12 for operational logistics. Pharmacists who are working at more of a distance (i.e. away from day-to-day operations) would be section 13."

"Section 12(1)", "The term "facility" needs to be defined."

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"Section C13", "No meaningful changes have been made. What issue of patient safety is regulated by this section? The MPHA appears to be regulating business instead of pharmacy practice. This section is unnecessary and should be removed."

"Section C14", "No meaningful changes have been made. The repeated usage of discretionary language such as "satisfy the Registrar" should be removed from this section, and any section of the Regulations, and be replaced with objective language. The MPHA appears to be regulating pharmacy business and not pharmacy practice. A Regulations Impact Statement needs to be developed before this section can be included. If not, it should be removed. As well, discretionary language should be removed from this and all sections of the Regulations in favor of objective standards."

"Section 14(1)", "Why is the internship in 15(2) as determined "by the board" but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer internship requirements to be determined by the board of examiners for both circumstances."

"Section c14(1)", "The process of converting to a section 12 license is an important issue and one that is likely to come up a great deal. It is akin to the process of returning to active practice after a period greater than 2 years. In the latter case it is the Board of Examiners that deals with the process of entering back into practice. I propose that the decision of internship time for converting to Section 12 status should be left to the same Board rather than the registrar alone. In addition, while it is recognized that it would not be appropriate to place the exact amount of time of additional internship that would be required to move from 13 to 12 within the Regulations, I suggest that there, could be guidance placed on this process within the Bylaws or Standards of Practice. As such, could section 14(1)(b) be rewritten to say: register as an intern for educational purposes in a health care practice for a period of time determined by the board of examiners and to the satisfaction of a Section

12 member acting as a supervisor as guided by the applicable bylaws/stds of practice."

"Section C14(1)", "Converting to a section 12 practicing license - As a CSHP member I understand that this section was addressed in their response to the Second Regulations Discussion document. I do not agree that switching from a section 13 to a section 12 practicing license is always akin to the returning to active practice after a period of 2 years as was mentioned in the CSHP response. The circumstances and practice of the section 13 pharmacist may be quite varied. A section 13 pharmacist may be required to maintain a high level of knowledge and updating in their work and the conversion to a section 12 may be a simple one. In contrast there may be those that require significant updating prior to returning to a section 12 license. Standards and guidelines set by a board may not apply to the many different facets of section 13 licensing. Standards and guidelines can quickly become rules. We must be very careful that the conversion to a section 12 license is not made to be a bureaucratic and laborious process if it is not necessary. Of course, we must balance that with protecting the safety of the clients we serve. I would support leaving the decision of internship timing with the Registrar. "

"Section C14(1)", "Why is the internship in 15(2) ad determined ""by the board"", but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer internship requirements to be determined by the board of examiners for both circumstances."

"Section 15(1)", "13 months was too short, but 24 is too long. Would be easy to lose competency with a 24 month abcense from practice."

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"Section 15(1)", "none"

"Section 15(1)", "Too subjective-also vague as to 'conditions' specified by registrar."

"Section 15(1)", "If pharmacist had 400 hours in practice in the previous year the pharmacist should still be licensed. The registrar should not have to consider."

"Section 15(1)", "13 months was too short, but 24 is too long. Would be easy to lose competency with a 24 month abcense from practice."

"Section 15(1)", "The repeated usage of discretionary language should be removed from this section, and any section of the Regulations, and be replaced with objective language."

"Section 15(1)", "It may be advisable to maintain some sort of minimum requirement regarding professional development. Two years is a long time to be away from practice since new developments happen constantly within practice. What criteria would the Registrar go by if not by documented CEU activities?"

"Section 15(1)", "Better now that longer time allowed!"

"Section 15(1)", "13 months was too short, but 24 is too long. Would be easy to lose competency with a 24 month absence from practice."

"Section 15(2)", "Why is the internship in 15(2) as determined "by the board", but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer intership requirements to be determined by the board of examiners in both circumstances.."

"Section 15(2)", "Move into required on what is appropriate evidence for maintaining license. Specify requirement for maintaining license. Specify requirements by board."

"Section 15(2)", "Criteria too vague."

"Section 15(2)", "Why is the internship in 15(2) as determined "by the board", but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer internship requirements to be determined by the board of examiners in both circumstances."

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"Section 15(2)", "What are any other requirements in part C(not clear)."

"Section 15(2)", "none"

"Section 15(2)", "Too vague and subjective"

"Section 15(2)", ""C" is too vague."

"Section 15(2)", "Why is the internship in 15(2) as determined "by the board", but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer intership requirements to be determined by the board of examiners in both circumstances.."

"Section 15(2)", "The repeated usage of discretionary language should be removed from this section, and any section of the Regulations, and be replaced with objective language."

"Section 15(2)", "Why is the internship in 15(2) as determined "by the board", but internship in 14(1) as determined by the Registrar? These should be consistent. I prefer internship requirements to be determined by the board of examiners in both circumstances."

"Section 15(2)", "My concern is what to do with pharmacists who are attending post graduate education."

"Section C16", "No meaningful changes have been made. The repeated usage of discretionary language should be removed from this section, and any section of the Regulations, and be replaced with objective language. Discretionary language should be removed from this and all sections of the Regulations in favor of objective standards."

"Section 16(1)", "The guideline is not defined."

"Section C19", "No meaningful changes have been made. I am concerned about information about me being available on the internet and the invasion of privacy that this may bring about. This section should be removed until a Regulations Impact Statement can be developed."

"Section 20(1)", "Strike place of work on the profile (this is a breach of confidentiality). While I have no problem having the public know where I work, I feel that some members will not want this information released."

"Section 20(3)", "The start date should be the start date of the new regulations. It is possible that an action prior to this date might not constitute an offence under the new regulations"

"Section 20(3)", "I am concerned with erroneous info being included on profile."

"Section 20(3)", "This date chosen is not fair."

"Section 20(3)", "none"

"Section 20(3)", "I do not agree with pharmacist profiles being available to the general public on the MPhA website. However, if we have no choice in the matter, then I think that all that should be included is the member's name and the fact that they are licensed. The general public does not need to know where they work, when they graduated or any disciplinary action. Investigations may take months to resolve and this would be on their profile even though the general public would not know or even understand what exactly was being investigated. This could be damaging to someone's reputation."

"Section 20(3)", "This may constitute an invasion of privacy. If a person is convicted of a crime that has nothing to do with their pharmacy practice or a disciplinary action against them; this information is inappropriate for the profile."

"Section 20(3)", "I don't understand the intent of this section."

"Section 20(3)", "The start date should be the start date of the new regulations. It is possible that an action prior to this date might not constitute an offence under the new regulations."

"Section 20(3)", "I don't understand the basis for this."

"Section C22", "There is an explanation box in the second discussion document that clarifies that "section 22 only pertains to a general description of the profiles and profile categories and does not include council providing an explanation of any member's specific record". This statement should be included in the regulation."

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"Section 24(4)", "Too vague as to information provided to the REGISTRAR"

"Section 24(4)", "I feel the 10 year duration on one's file is too long. It would continue to remain on public view long after any suspension, or condition may have expired. I do not see the relevance of information re a malpractice suit remaining on public view for up to 10 years after settlement of an event. I have concerns that any one person can make a determination of what information might be accessible to the public for up to 10 years"

"Section 24(4)", "I have a concern regarding confidentiality of profile and erroneous info being printed."

"Section 24(4)", "The source of the information should be made available to the applicant if the information is not given to the registrar by the applicant but received from a third party who is deemed a reliable source by the registrar."

"Section 24(4)", "The information should be defined."

"Section 24(4)", "Need clarification in respect to source and what steps the registrar is obligated to take to ensure that the info is accurate"

"Section 24(4)", "none"

"Section 24(4)", "How can the registrar know better than a member what should be on his/her profile? This states that if the registrar 'reasonably believes' some secondhand information about a member is accurate, that he can change it. This is completely unacceptable-standards must be higher than 'reasonably believable' "

"Section 24(4)", "Ensuring information is accurate"

"Section 24(4)", "I would like to see clarification in respect to source and what steps the registrar is obligated to take to ensure that the information is accurate."

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"Section 24(4)", "Improvement - if pharmacist knows 60 days prior to changes, this gives them time to prove/disprove."

"Section 24(4)", "I feel the 10 year duration on one's file is too long. It would continue to remain on public view long after any suspension, or condition may have expired. I do not see the relevance of information re a malpractice suit remaining on public view for up to 10 years after settlement of an event. I have concerns that any one person can make a determination of what information might be accessible to the public for up to 10 years."

"Section 24(4)", "I would like to see clarification in respect to service and what steps the Registrar to like to answer that the information is accurate."

"Section 24(4)", "If someone other than the member is providing the information, would/should the member be able to view it before it becomes public. (Sorry Section 25(1) and 25(2) covers this)."

"Section 24(4)", "More clarification in respect to source to ensure that the information is accurate."

"Section 24(4)", "Council should also be involved."

"Section 24(4)", "I would like to see clarification in respect to source and what steps the Registrar is obligated to take to ensure that the information is accurate."

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"Section 24(4)", "If information re: a member comes from another source.. it should be made in writing and not by a phone call. I believe this section can allow gossip about other members which is not good. I believe the Registrar should have factual evidence on another member before posting possibly damaging inaccurate information about a member. Also, if Registrar posts information regarding another member which proves to be wrong, I believe the Registrar should post an apology to that member on the public website and provide the correct information. Errors WILL happen ... we are all human."

"Section C25", "Every member should receive a copy of their profile that is to be posted at least 60 days prior to it being posted. This should not be "on request" but a given."

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"Section C25", "Every member should receive a copy of their profile that is to be posted at least 60 days prior to it being posted. This should not be "on request", but a given."

"Section 25(2)", "Due to the damage that can be done to ones professional reputation due to erroneous information being published even in if error I feel all steps need to be taken that the information is correct. I feel therefore every member should receive a copy of his or her profile 30 -60 days prior publication.

I also feel there needs to be an appeal mechanism in place as council is not independent and may not protect the rights of the member.

"

"Section 25(2)", "I feel the notification to the member should be by registered mail in the event a member is on vacation or otherwise may not be informed and actually have 60 days to respond."

"Section 25(2)", "The information in question should not be posted until correct."

"Section 25(2)", "Concern with the fact that the onus is on the member for proving that the info is factually accurate rather than having the opportunity to dispute the info prior to it being posted. The onus should be on the Registrar of proving that the info is factually accurate prior to posting."

"Section 25(2)", "none"

"Section 25(2)", "My concern is that the onus is on the member to prove some aspect of his profile is inaccurate."

"Section 25(2)", "Onus is on the member to prove inaccuracy rather than having an opportunity to dispute it prior to being posted."

"Section 25(2)", "Although I had no issue with the initial 30 day term. If 60 days is what members feel is appropriate I am ok with it."

"Section 25(2)", "If it is inaccurate it should not be entered. Will the council review it if pharmacist disagrees?"

"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus should be on the registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus should be on the registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the 8(1)(J) says that an applicant for registration as a student must "satisfy the registrar that the applicant is fluent in one of the official languages of Canada". If the applicant has been accepted into the Faculty and passed all required examinations, this should not be an issue."

"Section 25(2)", "8(1)(J) says that an applicant for registration as a student must "satisfy the registrar that the applicant is fluent in one of the official languages of Canada". If the applicant has been accepted into the Faculty and passed all required examinations, this should not be an issue."

"Section 25(2)", "What about a pharmacist's right to privacy?  
I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus should be on the registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "What about a pharmacist's right to privacy?  
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"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus should be on the registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "Erroneous information may be published on a pharmacist's profile and cause irrevocable damage."

"Section 25(2)", "I have a concern with the fact that the onus is on the member for providing that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus

should be on the registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "Improvement in time given to deal with issue."

"Section 25(2)", "I feel the notification to the member should be by registered mail in the event a member is on vacation or otherwise may not be informed and actually have 60 days to respond."

"Section 25(2)", "The onus of proving that the information is factually inaccurate is on the member. You are GUILTY until you prove your innocence."

"Section 25(2)", "I have concern with the fact that the onus is on the member for proving that the info is factually inaccurate, rather than having the opportunity to dispute the info prior to it being posted. The onus should be on the Registrar of proving that the info is factually accurate prior to posting."

"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to its being posted. The onus should be on the Registrar of proving that the information IS factually accurate prior to posting."

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"Section 25(2)", "I have a concern with the fact that the onus is on the member for proving that the information is factually inaccurate, rather than having the opportunity to dispute the information prior to it being posted. The onus should be on the Registrar of proving that the information IS factually accurate prior to posting."

"Section 25(2)", "Anyone should know that publicly posting possibly inaccurate information on a website is a cause for concern. The statement of proving the facts are inaccurate is on the member is frankly stating ... any information

the Registrar receives from ANYONE the Registrar is going to accept as true, is quite disturbing since anyone who really has an issue with a member should either do so in writing or better yet go down to the Registrar's office in person to show the validity of the claim. The Registrar trusts pharmacists to keep a record of their own cells; it's unfortunate that they feel that pharmacists are guilty until proven innocent.

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"Section 28(3)", "There are no definitions of a satellite pharmacy"

"Section C29", "No meaningful changes have been made. The MPHA appears to be regulating pharmacy business instead of regulating pharmacy practice. Section 29(1)(e) appears to target IPS pharmacy and is not relevant to the protection of the public. Currently, IPS is a separate type of licenser and this is not addressed by this section. This section should be removed until a Regulation Impact Statement can be developed.

"

"Section c29(1)", "I would like to see some mention of evidence of appropriate staffing levels. I think some standards on workload need to be developed. Such issues as number or prescriptions a pharmacist should be handling on a day to day basis. How many shifts in a row is legally acceptable. How many technicians per pharmacists per shift is ideal. All pharmacists must have a technician available while on shift. I don't think this should all fall on the pharmacy managers shoulders all the time. This is a major patient safety issue which I don't think is being addressed. If a pharmacist had issues with staffing levels there must be some forum to address their concerns. Leaving for another job is an option but doesn't address a potential dangerous situation that may exist."

"Section 29(3)", "Is there a definition somewhere on the components?"

"Section 29(3)", "A number of the points in this section seem to focus on the business of pharmacy rather than the regulation w.r.t. patient safety. Having to disclose all business relationships seem to be irrelevant to practice of pharmacy. What does this have to do with MPHA mandate to protect patient safety.

Business insurance is something the owner needs to assess based on risk - it is a business decision not a MPHA decision. This would also put IPS pharmacy out of business. Should there not be a category for IPS as this seems a better place for IPS than separate licensure as present.

The different category and components of licensing seems to be unnecessarily complicated - why do we need all these components and what are the costs associated with these. Surely a pharmacy can have all these components without having to have a special license.

"

"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components on to an existing shop license? Will addition of a component require a re-inspection of the facility?"

"Section 29(3)", "none"

"Section 29(3)", "Regulations seem to be getting overly complicated-does a pharmacy have to pay a separate license fee for every component of their operation?"

"Section 29(3)", "Will addition of a component require re-inspection."

"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components on to an existing shop license? Will addition of a component require a re-inspection of the facility?"

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"Section 29(3)", "The MPHA appears to be regulating pharmacy business instead of regulating pharmacy practice. Section 29 (1)(e) appears to target IPS pharmacy and is not relevant to the protection of the public. Currently IPS is a separate type of licenser and this is not addressed by this section. "

"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components onto an existing shop license? Will addition of a component require a re-inspection of the facility?"

"Section 29(3)", "I do not support telepharmacy and we need more study done on central fill and international satellite pharmacy."

"Section 29(3)", "I do not support telepharmacy and we need more studies done on central fill and international satellite pharmacy."

"Section 29(3)", "I don't believe additional fees of licenser should be added for each component. "

"Section 29(3)", "Do you list home office and storage on the license? 29(7)"

"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components on to an existing shop license? Will addition of a component require a re-inspection of the facility?"

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"Section 29(3)", "Is the intent for (e) community pharmacy?"

"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components on to an existing shop license? Will addition of a component require re-inspection of the facility?"

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"Section 29(3)", "What costs will be associated with the layering of components? How easily will a member be able to layer the components onto an existing shop license? Will addition of a component require a re-inspection of the facility?"

"Section 29(3)", "Need to explain why further additional components are needed."

"Section C31", "No meaningful changes have been made. The MPHA appears to be regulating pharmacy business instead of regulating pharmacy practice. This section appears to have nothing to do with MPHA's mandate which is protection of the public. This section should be removed until a Regulation Impact Statement can be developed."

"Section 32(2)", "non pharmacists should have access to the pharmacy for the purpose of construction, hard ware up grades, after hours as long as as the owner/manager takes steps to ensure the info/stock in the pharmacy is protected ( ie hire a security guard ). Also non pharmacist staff should be able to re-order and stock the shelves for the schedule 3 drugs when the dispensary is closed. Also i still don't agree that a pharmacist should have to be on call for more hours then the dispensary is open ie 37.5 hrs vs 25 hrs, leave it up to the owners/mgrs"

"Section 32(2)", "Technicians according to this section would not be able to work in a lock and leave situation."

"Section 32(2)", "32(2)(c)(ii) and 52(4)(h) are contradictory"

"Section 32(2)", "Contingency should be allowable for staff to be present behind the closed barrier to the public for the reasons of paperwork, maintenance or preparation when the pharmacy is closed to the public. Also in the section 32(2)(c)(iii) regulating that "non-pharmacist staff" will not perform any tasks which are prohibited by the act or this regulation. This restricts the pharmacy business by not allowing set up or preparation of blister packs or other labour intensive functions while the pharmacy is closed to the public. From patient safety perspective, how does the preparation and maintenance of the pharmacy function while the business is closed to the public a danger to the public?"

"Section 32(2)", "Hours requirement, entry."

"Section 32(2)", "A pharmacist under section 87 b would have to assess the patient in person if he or she were to prescribe a medication to the patient. You will get calls on what I could take for a cold fever and if this was during the period outside regular store hours (ie; telephone conversation) this would be contravening the act. It needs to be defined where exactly a pharmacist can be when the store is locked and what services they could provide. If I went home I may not have all the references needed or have a dpin link to provide service."

"Section 32(2)", "32(2) c(ii) prohibits a non-pharmacist from entering the pharmacy when lock & leave is in place. This contradicts 52(4)(H) which allows a technician to enter a pharmacy when closed"

"Section 32(2)", "none"

"Section 32(2)", "Lock and leave implies that the pharmacist is not available after dispensary is closed. If pharmacy is open 24 hours/week, pharmacist only needs to be available 24 hours. If pharmacy is closed, there is no access to pharmacist."

"Section 32(2)", "Appears to contradict 52(4)"

"Section 32(2)", "Non-pharmacists should have access to the pharmacy for the purpose of construction, hardware up grades, after hours as long as the owner/manager takes steps to ensure the info/stock in the pharmacy is protected (ie: hire a security guard). Also non-pharmacist staff should be able to re-order and stock the shelves for the schedule 3 drugs when the dispensary is closed.  
Also, I still don't agree that a pharmacist should have to be on call for more hours than the dispensary is open (ie: 37.5 hours vs 25 hours), leave that up to the owners/managers."

"Section 32(2)", "Can all out of town pharmacists do this?"

"Section 32(2)", "4 days a week opening may be too long. Most rural pharmacies are only open 5 days week now in the dispensary."

"Section 32(2)", "32(2)(c)(ii) prohibits a non-pharmacist from entering the pharmacy when the lock & leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

"Section 32(2)", "32(2)(c)(ii) prohibits a non-pharmacist from entering the pharmacy when the lock & leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

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"Section 32(2)", "32(2)(c)(ii) prohibits a non-pharmacist from entering the pharmacy when the lock & leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

"Section 32(2)", "Again, this section contains discretionary language."

"Section 32(2)", "32(2)c(ii) prohibits a non-pharmacist from entering the pharmacy when the lock and leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

"Section 32(2)", "Why is the minimum hours for the store to be open less than the minimum hours for a member to be available?"  
"

"Section 32(2)", "It prohibits a non-pharmacist from entering the pharmacy when lock and leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

"Section 32(2)", "32(2)c(ii) prohibits a non-pharmacist from entering the pharmacy when the lock & leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

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"Section 32(2)", "32(2)(c)(ii) prohibits a non pharmacist from entering the pharmacy when the lock and leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

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"Section 32(2)", "32(2)(c)(ii) prohibits a non-pharmacist from entering the pharmacy when the lock and leave is in place. This appears to contradict 52(4)(h) which allows a technician to enter the pharmacy when it is closed."

"Section 33(1)", "Why is this still in here unchanged if the council does not know how to deal with it. The notes will not be part of the regulations so if the regulations are passed in a blanket format( like the act) the regulations will stand as is. ????"

Where is the evidence that distance care is a risk to a patient? Pharmacists have been doing this for years in some form or another. This section is unworkable and needs to be removed or re-worked. It seems to be directed to close down IPS pharmacies but will have impact on many other Canadian practices. With the internet and online shopping etc, long distance care and shopping is

going to be the way business is done in the future. This act needs to look towards the future and embrace technology. MPHA should not regulate the business of pharmacy and stick to the mandate of patient safety. Where is the evidence that this practice is bad for patients?

"

"Section 33(1)", "I would limit the distance care component reporting only to pharmacies which are shipping internationally. It is not uncommon in any community based practice that the patient might never attend the pharmacy due to physical incapacity. Cases might exist where a patient who normally attended your pharmacy has temporarily moved to another jurisdiction in Canada and requires a refill of an ongoing prescription until finding a new family physician"

"Section 33(1)", "An agreement must be in place between the College of Pharmacists and the jurisdictions serviced by the pharmacy describing the terms and conditions under which the pharmacy can legally provide drug and services, sharing of information between jurisdictions and the process by which complaints are investigated. This is similar to the process being done in Alberta. However, Alberta has gone further to prohibit Alberta pharmacies from selling medication to patients residing outside of Canada. NOTE: the IPS business has been eliminated in Alberta due to this issue as well as dealing with out of province prescriptions easily... this seems to allow the MPHA to mandate the closure of IPS without blame as they are passing responsibility onto the MINISTER. It is unreasonable to suggest that individual pharmacies would set up jurisdictional agreements with other jurisdictions and this should be done by the MPHA under the Minister of Health mandate to keep IPS as a business in Manitoba.

The Minister of Health has advised the College (MPHA) of the importance to keep IPS as a business in Manitoba. The Minister can determine who is included as a practitioner through section 73(2) of the Act. In discussion prior to the December passing of Bill 41. Government officials announced the intention to include American physicians as "practitioners" in Manitoba. If Manitoba pharmacies continue to sell drugs for use by Americans, section 33 will overcome some of the difficulties experienced in gathering information and evidence from other jurisdictions and lack of authority for the College to compel witnesses. Under this section, Distance Care Pharmacies would continue international activities, now known as IPS, but the conduct now would be defensible and in a safe, legal and ethical manner. This section will also include non-0|IPS inter- and intra-provincial mail order activities.

Agreements regarding non-Manitoba patients. Note: the IPS business had been eliminated in Alberta due to this issue as well as dealing with out of province prescriptions easily... This seems to allow the MPHA to mandate the closure of IPS without blame as they are passing the responsibility onto the MINISTER. It is unreasonable to suggest that individual pharmacies would set up jurisdictional agreements with other jurisdictions and this should be done by the MPHA under the Minister of Health Mandate to keep IPS as a business in Manitoba.."

"Section 33(1)", "Not necessary."

"Section 33(1)", "33(1)(b) needs to be clarified further because it could encompass patients who receive their Rx on delivery"

"Section 33(1)", "none"

"Section 33(1)", "The Minister of Health has advised MPhA of the importance to keep IPS as a business in Manitoba."

"Section 33(1)", "Does this apply to delivery service"

"Section 33(1)", "33(1)(b) states that a community pharmacy must specify that it is applying for a distance care component if ""the pharmacy will also serve patients who will not attend the pharmacy in person"". This needs to be clarified further because it could encompass patients who receive their prescriptions on delivery."

"Section 33(1)", "33(1)(b) states that a community pharmacy must specify that it is applying for a distance care component if ""the pharmacy will also serve patients who will not attend the pharmacy in person."" This needs to be clarified further because it could encompass patients who receive their prescriptions on delivery."

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"Section 33(1)", "This section seems overly prescriptive and MPhA appears to be regulating pharmacy business and not pharmacy practice. This section appears out of the scope of MPhA's mandate which is protection of the public. This section also appears to target IPS."

"Section 33(1)", "33(1)(b) states that a community pharmacy must specify that it is applying for a distance care component if ""the pharmacy will also serve patients who will not attend the pharmacy in person."" This needs to be clarified further because it could encompass patients who receive their

prescriptions on delivery.

"

"Section 33(1)", "Too discretionary on the registrar plus we are not provided with enough info on the distance care component."

"Section 33(1)", "Too discretionary on the Registrar plus we are not provided with enough info on the distance care component."

"Section 33(1)", "I would limit the distance care component reporting only to pharmacies which are shipping internationally. It is not uncommon in any community based practice that the patient might never attend the pharmacy due to physical incapacity. Cases might exist where a patient who normally attended your pharmacy has temporarily moved to another jurisdiction in Canada and requires a refill of an ongoing prescription until finding a new family physician."

"Section 33(1)", "Specifically IPS

I find it difficult to support this type of pharmacy practice. The physicians are distant, the patients are never seen face to face, the technicians do most of the work with minimal pharmacist interaction. Lots of technicians and few pharmacists. Realizing the government supports this because of Manitoba jobs and amounts of money flowing into Manitoba, I feel we are wishy-washy (as a licensing body) allowing this type of practice to go on. Patient care cannot be protected ... I realize MphA is working on this."

"Section 33(1)", "The impact on international pharmacy services needs to be fully understood prior to a vote on those sections of the Regulations. As currently written, the draft language is broad and is subject to a variety of interpretations. More detailed language is needed to avoid impacts on pharmacy practice which may have not yet been identified. I agree with the Manitoba Society of Pharmacists and support the establishment of a Committee which brings together all appropriate stake holders - including the Manitoba Society of Pharmacists to address all proposed regulation of the Distance Care Component."

"Section 33(1)", "33(1)(b) states that a community pharmacy must specify that it is applying for a distant care component if ""the pharmacy will also serve patients who will not attend the pharmacy in person"". This needs to be clarified further because it could encompass patients who receive their prescriptions on delivery."

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"Section 33(1)", "Why and when would a hospital pharmacy operate as a community pharmacy when they got rid of out patient pharmacy services?"

"Section 33(2)", "decisions must be made in short order to certim this sec"

"Section 33(2)", "My pharmacy is a traditional bricks-and-mortar community pharmacy. Occasionally we mail medication to our regular local clients, for example those from a neighbouring town who on occasion request that we mail their meds as it would be onerous for them to travel to our town; or those who may be holidaying in BC and require an additional supply of medication"

"Section 33(2)", "the minimum hours the pharmacy is open should be the same as the minimum hours a section 12 member is available. The pharmacist shouldn't have to be available more hours then the pharmacy is open. "

"Section 33(2)", "Too speclative and open for interpretation  
Maybe over restrictive and unknown circumstance may prevail"

"Section 33(2)", "hours"

"Section 33(2)", "MD's can do distance care? Why not pharmacists?"

"Section 33(2)", "I think providing telephone access without cost is a business consideration that is not a mandate of MPhA. Yes we have to be accessible by telephone but to say we have to provide toll free service although good business sense is an economic issue between the patient and the pharmacy provider. If I want to do business with a company outside by own business district I will deal with the costs associated with that and make a decision"

"Section 33(2)", "Re Sec 36(1) Do Not agree that Pharmacists in a central fill do not qualify for Sec 12 license.

This would result in Recruiting challenges for regional health authorities trying to staff the central fill operations.

Sec 36(4) these hours should qualify under Sec 12(2)a"

"Section 33(2)", "none"

"Section 33(2)", "If pharmacy is open 24 hours/week; then pharmacist should only have to be available for that time. Again this is a business decision."

"Section 33(2)", "The minimum hours the pharmacy is open should be the same as the minimum hours a section 12 member is available. The pharmacist shouldn't have to be available more hours than the pharmacy is open."

"Section 33(2)", "This section seems overly prescriptive and MPHA appears to be regulating pharmacy business and not pharmacy practice. This section appears out of the scope of MPHA's mandate which is protection of the public. This section also appears to target IPS."

"Section 33(2)", "33(2)c - I don't believe there needs to be a minimum number of hours designated for the pharmacy to be open. However, it is imperative that a pharmacist be able or on call at least 37.5 hours/week. Since the pharmacy serves patients who do not attend the pharmacy in person, why is it necessary to be open to the public for a minimum number of hours? Since sections 33(3), (4) and (5) are impossible to implement, they should be removed from the document until such time that meaningful consultation has taken place with the Manitoba government."

"Section 33(2)", "Some contact with patient is necessary. Should we specify verbal contact with each Rx?"

"Section 33(2)", "See above."

"Section 33(2)", "IPS pharmacy should have their own regulations written out without having this distance care component. "

"Section C34", "No meaningful changes have been made. This section seems overly prescriptive and MPHA appears to be regulating pharmacy business and not pharmacy practice. This section appears out of the scope of MPHA's mandate which is protection of the public. This section needs to be eliminated until a Regulations Impact Study can be completed and pharmacists then understand the implications of this section. Any discretionary language needs to be replaced with objective standards that pharmacists can understand."

"Section C36", "Central fill component concerns: A central fill facility in my opinion is not even a pharmacy. It is a distribution/packaging warehouse facility. The practice of pharmacy does not occur in this facility. The distribution aspect of dispensing requires a technician only. This is further validated by the fact that a pharmacist who works in this type of facility is not satisfying their hours under section 12(2)a. If it is determined that this type of facility is in fact a "true" pharmacy under the definition than a pharmacist who works there should have these hours accumulated to qualify under section 12(2)a. It is difficult to comment on standards of practice without the written practice directives that go along with it."

"Section 37(2)", "I would never participate in such a practice. I would never put my license on the line and trust a non-pharmacist employee on the other end of a videoconference link to do everything completely as I would do it myself. If the videoconference link in question is the same quality as MB Telehealth, I am even more concerned. The video is choppy and the resolution is poor, resulting a blurry choppy image."

"Section 37(2)", "Lack of presence of the pharm on site lots can happen in 1 month never mind in 2 months"

"Section 37(2)", "The subjective language "satisfactory to the Registrar" should be removed in all regulations. The regulations should be clear and objective if all the pharmacists are to interpret and follow the regulations with clear understanding. Discretionary and subjective language should be removed from this and all sections of the regulations in favor of objective standards."

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"Section 37(2)", "very vague"

"Section 37(2)", "none"

"Section 37(2)", "Frequency of inspection and costs for doing to the membership/public"

"Section 37(2)", "Really concerned about the definition of reasonable access."

"Section 37(2)", "Only if the pharmacist can directly check the final dispensed product via video and confirm all required components of the hard copy Rx to the finished product."

"Section 37(2)", "Improved - If there are regulations in place (37(2)a) that prevent tele-pharmacy from opening up all over, this will prevent corporations from having one pharmacist overseeing multiple stores at the same time."

"Section 37(2)", "Is the new (h) supposed to read "the remote facility"?"

"Section 37(2)", "I do not understand why there is a "rush" for this tele pharmacy component. More time for discussion with possibly a study done on an example tele pharmacy."

"Section 37(3)", "f) Why are only medicinal products/devices allowed?  
i) will the inventory be safer if transported back and forth?"

"Section 37(3)", "Very vague."

"Section 37(3)", "none"

"Section 37(3)", "Isn't this section 37(3)?"

"Section 37(3)", "37(3)i - Seems impractical for a pharmacist to have to take all the drugs to and from a site if they are going there one or two times per week."

"Section 37(3)", "There could be confusion with satellite hospital pharmacy. I believe that the intent for hospitals in this situation is to be a "secondary" hospital component. Also, isn't the numbering for this section 37(3)?"

"Section 37(3)", "More discussion is needed on these subjects on tele pharmacy and satellite pharmacy ... why is there such a rush on these components without separate discussions?"

"Section 38(1)", "The wording under 38(1)a is unclear -- maybe remove second "not" if the intent is nothing is sold, period."

"Section 38(1)", "The subjective language "satisfactory to the "registrar" should be removed in all regulations. The regulations should be clear and objective if all the pharmacists are to interpret and follow the regulations with clear understanding. Discretionary and subjective language should be removed from this and all sections of the regulations in favor of objective standards."

"Section 38(1)", "I am not sure if I agree - does this mean that as a pharmacist practicing in an ambulatory care clinic within a hospital providing patient care without dispensing that I would need to get a license?"

"Section 38(1)", "none"

"Section 38(1)", "Seems to apply to training sites only - the public is not accessing these sites anyway, so what are they being protected from?."

"Section 38(1)", "Yes"

"Section 38(1)", "(c) What about patient care. Is this not limiting practice?"

"Section 38(1)", "When would pharmacist or pharmacy NOT dispense or see drugs? The pharmacy is for training and education? Is this the U of M Faculty of Pharmacy pharmacy?"

"Section 39", "I don't like the "or" I find it hard to believe any mgr training program could train a pharmacist in less than a year"

"Section 39", "since there are many concerns with staffing in rural locations, what if a new grad is allowed to become manager immediately but has up to say 6 months to complete the necessary training. "

"Section 39", "The training period seems short to me."

"Section 39", "I have concerns that this may limit the ability of remote or rural pharmacies to obtain a manager, particularly in a one pharmacist operation, and thus limit public access to pharmaceutical services"

"Section 39", "The regulations once again are using subjective and confusing terminology. Notes regarding the regulation are just interpretations and do not affect the regulation itself. If the wording continues to be subjective it is non enforceable. Wording such as "would like" qualify and "will demonstrate to the satisfaction of the Registrar that he or she will personally and adequately supervise the operation of the pharmacy" are discretionary and would be open to dispute."

"Section 39", "Section (b) is unnecessary. If someone completes the training to be a pharmacist and decides they can manage out of school, they should be able to."

"Section 39", "Subjective criteria"

"Section 39", "Not sure of the practicality of this - I think the majority of new grads would be uncomfortable managing but could there be an exception of the new pharmacist that has prior training etc?"

"Section 39", "The qualification of pharmacy Managers leads to the conclusion that a new graduate although now licensed to practice is not qualified to open their own pharmacy or manage a store. This seems to be an extraordinary professional limitation that impliedly seems to suggest a shortcoming in the educational process."

"Section 39", "Generally, I think the revised section strikes an appropriate balance, but I would like to understand better what would be "a professional development program that meets the learning objective established by Council..."."

"Section 39", "If the fight continues to have even the 2000 hrs decreased, I must suggest a minimum of at least 6 months (but I prefer the year as written). It is one thing for the faculty to teach (educate the students in pharmacy management education; but it is another completely different idea for the interns new grads to actually gain field work experience in order to manage a pharmacy appropriately.

In regards to pt safety, it may be possible to add situational exceptions to this section in order to incorporate those & management/business background (MBA's etc) & those who have worked in pharmacy all their lives & throughout their training. (past experience dependent)."

"Section 39", "Pharmacy managers must make decisions about patient care and standards of practice that require expertise.. Course work and success at examination are may not be adequate without knowledge and skill gained through experience."

"Section 39", "I don't think 'X' number of hours determines whether or not a person is qualified to become a manager. This should be left up to store owner or current manager who want to promote someone else to manager. I don't think the registrar would know whether or not someone would make a good manager. I do agree that the university could provide more training in that area."

"Section 39", "Generally, I think the revised section strikes an appropriate balance, but I would like to understand better what would be "a professional development program that meets the learning objective established by Council..."."

"Section 39", "Will the PD program be accredited? I still think you should leave the 4000 hours in."

"Section 39", "Since there are many concerns with staffing in rural locations, what if a new grad is allowed to become manager immediately but has up to say 6 months to complete the necessary training."

"Section 39", "Recognizing that there will be exceptions (eg: rural or chronically underserved markets) to this requirement, I still believe that most Rx managers should have some dispensing/Job experience."

"Section 39", "4000 hours be excessive, especially if manager training is provided under a section 12 pharmacist."

"Section 39", "RAC voted 8:0 in favor of removing this section. Council approved modification to 39(b) to include "equivalent training or experience satisfactory to Council. The changes made are not acceptable. The qualification of pharmacy managers leads to the conclusion that a new graduate, although now licensed to practice, is not qualified to open their own pharmacy or manage a store. This seems to be an extraordinary professional limitation that impliedly seems to suggest a shortcoming in the educational process."

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"Section 39", "This section contains discretionary language such as "satisfy the Registrar". The 2000 hour requirement to become a pharmacy manager is ridiculous. MPHA should regulate pharmacy practice and not pharmacy business. This will effectively eliminate any new grad from becoming a pharmacy manager."

"Section 39", "RAC voted 8:0 in favor of removing this section. Council approved modifications to 39 (b) to include "equivalent training or experience satisfactory to Council." The changes made are not acceptable. The qualifications of pharmacy managers leads to the conclusion that a new graduate, although now licensed to practice, is not qualified to open their own pharmacy or manage a store. This seems to be an extraordinary professional limitation that seems to suggest a shortcoming in the educational process."

"Section 39", "All pharmacists should be able to assume the positions of managers. What other profession puts limitations like this on their members? This grants an unfair advantage to corporate store -----(?) rural locations."

"Section 39", "All pharmacists should be able to assume the positions of managers. What other profession puts limitations like this on their members? This grants an unfair advantage to corporate store -----(?) rural locations."

"Section 39", "It has not been established that pharmacists with less than 2000 hours of experience as a pharmacist are not qualified or less qualified to assume the role of a pharmacy manager. All pharmacists should be able to assume the position of a pharmacy manager and should not be subject to arbitrary barriers. Other provinces do not enact similar provisions and these new proposed requirements may put Manitoba pharmacies at a disadvantage in recruiting new graduates and foreign trained pharmacists. As well, rural pharmacies may be impacted if new graduates or foreign trained pharmacists are not allowed to assume the role of pharmacy manager because they do not satisfy the 2000 hour requirement."

"Section 39", "Although there have been steps to improve this section, it still poses a problem to rural, mainly independent pharmacies. I know of several pharmacists who went and took over a business or managing a store right after graduation - which was necessary to keep these businesses open."

"Section 39", "39(b) - putting restrictions on who could be a manager should be at the discretion of the employer and the individual applying for the position."

"Section 39", "I have concerns that this may limit the ability of remote or rural pharmacies to obtain a manager, particularly in a one pharmacist operation and thus limit public access to pharmaceutical services."

"Section 39", "Is council going to arrange for training or professional development programs."

"Section 39", "Staffing in remote areas."

"Section 39", "It leads to conclusion that a new graduate is not qualified to open their private pharmacy."

"Section 39", "Pharmacy managers must make decisions about patient care and standards of practice that require expertise. Course work and success at examination may not be adequate without knowledge and skill gained through experience."

"Section 39", "RAC voted 8:0 in favor of removing this section. Council approved modifications to 39(b) to include "equivalent training or experience satisfactory to Council". The changes made are not acceptable. The qualification of pharmacy managers leads to the conclusion that a new graduate, although now licensed to practice, is not qualified to open their own pharmacy or manager a store. This seems to be an extraordinary professional limitation that impliedly seems to suggest a shortcoming in the educational process."

"Section 39", "The only satisfactory answer is zero hours ... upon graduation, I should be able to own and manager my own pharmacy given I have just graduated from a 5 year program with some business courses."

"Section 39", "RAC voted 8:0 in favor of removing this section. Council approved modification to 39(b) to include "equivalent training or experience satisfactory to Council". The changes made are not acceptable. The qualification of pharmacy managers leads to the conclusion that a new graduate, although now licensed to practice, is not qualified to open their own pharmacy or manage a store. This seems to be an extraordinary professional limitation that impliedly seems to suggest a shortcoming in the educational process."

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"Section 39", "Generally, I think the revised section strikes an appropriate balance, but I would like to understand better what would be "a professional development program that meets the learning objective established by Council.."."

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"Section 39", "I agree with this section except 39(b) completed a professional development program. I was unaware that such a program existed."

"Section C40", "This section seems overly prescriptive and MPHA appears to be regulating pharmacy business and not pharmacy practice. The surrendering of the pharmacy license during a renovation may actually negatively affect patient continuity of care. The pharmacy license should not be surrendered during a renovation. Pharmacists would benefit from a Regulations Impact Study to better understand the implications of this section."

"Section C41", "Again, pharmacists would benefit from a Regulations Impact Study to better understand the implications of this section.

"

"Section 42", "this seems like unnecessary paperwork to me. for a short period of time ie due to sickness, emerg etc. it shouldn't matter if it is a permanent change in hours then I agree"

"Section 42", "Cost"

"Section 42", "How should urgent or temporary hours changes be done? Eg) usual hours are till 10 pm but on Dec 24 & Dec 31 a decision is made to close at 8 pm This is not a permanent change in hours."

"Section 42", "none"

"Section 42", "Is this for long term change of hours or is it for the pharmacist who gets called away for an emergency medical appointment?"

"Section C43", "This section seems unnecessarily unwieldy and overly complicated. This regulation is overly prescriptive and appears to regulate pharmacy business and not pharmacy practice. This section also contains discretionary language which should be replaced with objective standards that pharmacists will understand. This section should be eliminated until a Regulations Impact Study can be completed so that pharmacists understand the implications of this regulation."

"Section C45", "This regulation is overly prescriptive and appears to regulate pharmacy business and not pharmacy practice. This section should be eliminated until a Regulations Impact Study can be completed so that pharmacists understand the implications of this regulation."

"Section C49", "Council should provide an interpretive document of what the Standards of Practice will look like prior to a vote by the membership."

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"Section 50", "Not enough detail"

"Section 50", "How does this apply to hospitals where pharmacists do not approve refills?"

"Section 50", "Are RN(EP), midwives, etc., included under definition of practitioners? (Sorry, don't have a copy of the Act handy)."

"Section 50", "? Not sure what sell means - does this prevent a tech or sales clerk putting rx through the till??"

"Section 50", "I don't understand what sell a drug by retail means, does a pharmacist have to ring the sale into the cash register or do you mean a pharmacist must be present for a sale to occur but a sale clerk or tech can ring it into the cash register."

Can interns do the tasks in sec 50 or not, look at sec 51 in the boxed area. It says: this sec allow all duties of a pharm, except those described under sec 50, to be delegated to an intern under supervision. However, this is not direct supervision and the intern will have greater latitude than a student. The difference being the interns can do the tasks described in sec 50. This is contradictory so WHICH IS IT?"

"Section 50", "I do not understand the meaning of 50 b"

"Section 50", "I would like the wording of this regulation to be specific to pharmacist tasks in this section stating that no persons "except a member" must "sell a drug by retain" or "provide copies of prescriptions". This regulation seems to be in direct contrast to the regulation allowing delegation of duties. We must be consistent throughout the regulations. If we are allowed to delegate to others under supervision is then inconsistent to restrict the same action to "members only". The regulations should be reevaluated by an impact committee who can check for these types of inconsistencies which would put the regulations at risk."

"Section 50", "Are RN(EP), midwives, etc. included under definition of practitioners? (Sorry, don't have copy of the Act handy)."

"Section 50", "Are RN(EP), midwives, etc., included under definition of practitioners? (Sorry, don't have a copy of the Act handy)."

"Section 50", "How does Sec 50 (d) facilitate Tech check Tech in the hospital setting? Unit dose cart exchange is currently checked by Validated Tech Checkers. In this setting what is definition of a "refill"?"

"Section 50", "none"

"Section 50", "Still not clear on 'any included practice'."

"Section 50", "I don't understand what sell a drug by retail means, does a pharmacist have to ring the sale into the cash register or do you mean a pharmacist must be present for a sale to occur but a sale clerk or tech can ring it into the cash register."

Can interns do the tasks in section 50 or not? Look at section 51 in the boxed area. It says: this section allow all duties of a pharmacist, except those described under section 50, to be delegated to an intern under supervision. However, this is not direct supervision and the intern will have greater latitude than a student. The difference being the interns can do the tasks described in section 50. This is contradictory so WHICH IS IT??"

"Section 50", "Can a Rx be assessed and approved in the forlong process, then OK."

"Section 50", "Are RN(EP), midwives, etc., included under definition of practitioners? (Sorry, don't have a copy of the Act handy)."

"Section 50", "This section appears to eliminate any sales interaction between a customer and a sales clerk within a pharmacy and does not make sense. This section is overly prescriptive and appears to regulate pharmacy business and not pharmacy practice."

"Section 50", "The ""refill"" function for hospital inpatients needs further clarification. Pharmacists approve the original order and subsequent supplies for those drugs would be until the order is discontinued. Reorders for those drugs would be again approved by a pharmacist."

"Section 50", "Are RN(EP), midwives, etc. included under definition of practitioners? (Sorry, don't have a copy of the Act handy)."

"Section 50", "(a + b) ??"

"Section 52", "In rural areas it is difficult to find a trained tech most are trained on site"

"Section 52(2)", "Discriminatory - would this survive a challenge? What about techs who finish high School when they ar 17, then do a short, but accredited course?"

"Section 52(2)", "I agree that technical support staff with the most advanced skill levels are a definite asset.  
If M.Ph.A. does not licence technicians and the Pharmacists in workplace refuse to allow the technical staff to do section 52(3) duties then why should we worry about this section at all.  
In light of section 54 ""other persons"" - it makes no difference what ""support personnel "" call themselves  
if they are not going to be permitted to do the duties outlined below . Under these circumstances  
I do not want MPhA telling me who I can/ cannot hire for support personnel.

"

"Section 52(2)", "I believe more tasks can be delegated to pharmacy technicians - tech check tech etc. Coming from small community hospital practice delegation of tasks is common practice and qualified technicians are quite able to do many functions as long as training has been provided. I believe the technician's scope of practice needs to be expanded. (Surely they can attach a label to a container ???)

Pharmacists need to stop being so ANAL and worrying about liability all the time  
- train your staff and take the responsibility.

"

"Section 52(2)", "It seems unrealistic at this time to have this regulation to try and regulate a portion of employees who do not have a regulatory or licensing board of their own. This would be more appropriately addressed under training and supervision duties of the pharmacist."

"Section 52(2)", "(a) looks mandatory"

"Section 52(2)", "Vague and subjective"

"Section 52(2)", "Discriminatory - would this survive a challenge? What about techs who finish high school when they are 17, then do a short, but accredited course?"

"Section 52(2)", "Discriminatory - would this survive a challenge? What about techs who finish high School when they ar 17, then do a short, but accredited course?"

"Section 52(2)", "How many hours of work experience? Who sets the competency assessment, another certified tech/a pharmacist?"

"Section 52(2)", "none"

"Section 52(2)", "If technicians are not licensed by MPhA, I'm not sure how they can be regulated."

"Section 52(2)", "At some point technicians will be organized and will want to negotiate job descriptions - I do not believe we should jump start this process."

"Section 52(2)", "Discriminatory - would this survive a challenge? What about techs who finish high School when they ar 17, then do a short, but accredited course?"

"Section 52(2)", "Delegating duties to technicians who are not governed by a governing body may pose a threat to public health and safety."

"Section 52(2)", "(c) is too vague (ie: what type of work experience?)."

"Section 52(2)", "I understand that NAPRA is working on regulations, registration etc. for pharmacy technicians - why would we also do this?"

"Section 52(2)", "I understand NAPRA is working on regulations, registration, etc. for pharmacy technicians. Why would we also do this?"

"Section 52(2)", "Is it necessary to add the age qualification to this section? - should have a \*or b or c -"

"Section 52(2)", "Discriminatory - would this survive a challenge? What about techs who finish high school when they are 17, then do a short, but accredited course?"

"Section 52(2)", "Was the reference in the notes meant to "language" fluency?"

"Section 52(2)", "A pharmacy technician should be a person who has taken a pharmacy technician program and has a certificate."

"Section 52(3)", "Too vague"

"Section 52(3)", "While we utilize technicians at the present to the maximum allowable level and I have always supported greater roles for technicians in Pharmacy - After much discussion among colleagues and staff I have come full circle on this issue. If M.Ph.A. cannot licence technicians and subject them to some level of liability then for most Pharmacists this section is totally immaterial .  
"

"Section 52(3)", "? I believe more tasks can be delegated to pharmacy technicians - tech check tech etc. Coming from small community hospital practice delegation of tasks is common practice and qualified technicians are quite able to do many functions as long as training has been provided. I believe the technicians scope of practice needs to be expanded. (Surely they can attach a label to a container ???)

Pharmacists need to stop being so ANAL and worrying about liability all the time - train your staff and take the responsibility.  
"

"Section 52(3)", "I have concerns the technician may not have the training or expertise to determine when the member should be consulted re drug related problems"

"Section 52(3)", "If the technician is unable to advise on medication or explain a medical devise, how is it possible for the technician to do 52(3)(c) Operating a tele-pharmacy remote site? Also, if in 52(4)(g) Section (g) does not allow a technician to perform any of the duties listed in 52(3) while the pharmacy is closed and there is not pharmacist located therein. How would it be possible to do the previous section of 52(3)(c)? If the pharmacist isn't available except through a link and the technician would have to set up the pharmacy prior to opening the satellite or remote pharmacy it would be unrealistic."

"Section 52(3)", "Duties"

"Section 52(3)", "I have worked with many Techs in different pharmacies. Most of them DO NOT even know the drug indication. This will jeopardize the public safety and only benefit pharmacy owners who will gladly apply it if this regulation passes."

"Section 52(3)", "Providing instruction on devices (in education on technical aspects) provided the technician refers to problems requiring intervention to a member."

"Section 52(3)", "none"

"Section 52(3)", "Not sure if this section needs to be in regulations"

"Section 52(3)", "There is no mention of ""tech-check-tech""."

"Section 52(3)", "Public safety."

"Section 52(3)", "In order to advance the profession of Pharmacy, techs need to be defined!"

"Section 52(3)", "I don't understand how a technician could deal with drug related problems. I think they should all be referred to the pharmacist."

"Section 52(3)", "50(d) (assess and approve a prescription for filling or refilling)."

"Section 52(3)", "Since the college will not have the ability to regulate technicians, their job descriptions and limits should not be included in the regulations. A technician under the supervision of licensed pharmacist should be able to assist the pharmacist in whatever capacity except those duties only delegated to a pharmacist. It should be up to the pharmacist's discretion as to what duties they can perform and their job description should not be spelled out in the regulations."

"Section 52(3)", "Can a section 13 pharmacist supervise a technician? If pharmacists who are in supervisory roles are licensed under section 13 instead of section 12, some of the regulations that mention the supervision of pharmacy technicians may need to include supervision by section 13 pharmacists."

"Section 52(3)", "I have concerns the technician may not have the training or experience to determine when the member should be consulted re drug related problems."

"Section 52(3)", "No, more discussion would have to be in place regarding operating a tele pharmacy remote site. I do not agree to this (52(3)(c) and 52(3)(d)). Not ALL technicians identify and assess problems and referrals to a pharmacist."

"Section 52(4)", "I think at each pharmacy setting it should be at the discretion of the pharmacist whether techs should be providing the final check of a Rx before it leaves the premises"

"Section 52(4)", "Tech checking techs on pre-packaging of drugs, containers and labelling of meds"

"Section 52(4)", "52(4)(h) contradicts 32(2)(c)(ii). If I understand the intent correctly, technicians will be able to enter the pharmacy when it is closed (for example, when the lock & leavegate is closed at lunchtime) and do preparatory tasks. I am happy to read this, as it will make the work flow much more smoothly at my pharmacy."

"Section 52(4)", "Fully support 52(4) b and c. How is subsection (h) reconciled with the requirement that the technician must be supervised by a section 12 member?"

"Section 52(4)", "I believe more tasks can be delegated to pharmacy technicians - tech check tech etc. Coming from small community hospital practice delegation of tasks is common practice and qualified technicians are quite able to do many functions as long as training has been provided. I believe the technicians scope of practice needs to be expanded. (Surely they can attach a label to a container ???)

Pharmacists need to stop being so ANAL and worrying about liability all the time

- train your staff and take the responsibility.

"

"Section 52(4)", "is this a typo 52(4) g ( should be labelled (h) )- enter the pharmacy when it is closed and , with the exception of (e), (f) and (g), perform the duties listed under this section. And what is listed as (h) should be (g).

52(4) f - inquiring of the practitioner....that was just added to the 2nd doc mean taking a verbal Rx from a practitioner and we just added that to the pharm only tasks in sec 50???? so how can it now be a tech duty?

Another area of confusion 52(4) - enter the pharmacy when it is closed and with exception of e, f, g, perform the duties listed under this sec. How can you allow this if under req for lock and leave component - sec 32(2) c ii - it says non pharm staff will not be able to enter the dispensary. You can't restrict techs from entering the dispensary in one sec but then allow it in another??"

"Section 52(4)", "I do not wish to abdicate my role of the final check on any prescription as the final liability resides with the member"

"Section 52(4)", "I agree that a technician can not counsel on drugs however, they should be able to demonstrate a medical advise as long as they do not offer explanation of results of a patients individual results. This also seems to contravene the ability in 52(3)(c) Operating a tele-pharmacy remote site."

"Section 52(4)", "(c) performing a fraud check prior to dispensing."

"Section 52(4)", "Too much responsibility on tech."

"Section 52(4)", "Fully support 52(4) b and c. How is subsection (h) reconciled with the requirement that the technician must be supervised by a section 12 member?"

"Section 52(4)", "As a hospital pharmacist, I wholly support the increased technician roll that this legislation will allow. If this section were to be removed, effectively forcing pharmacists to provide these technical services, it would set back pharmacy practice in hospital by 10 years."

"Section 52(4)", "I have difficulty with the fact that technicians have been given this responsibility without having any liability. I think technicians need to be licensed. I am not against their duties but when I practice part of the reason I do my duties and double check my work is one for the safety of the patient but also the fear of making a dispensing error and knowing it may affect my career. We have 80 plus pages of regulations for our profession which we are accountable for. If I was a consumer/patient and an error was made by a technician. I would be upset that a unlicensed undisciplinable individual would be given this responsibility. I also think that the technicians role will be increased in the future which in theory would be good but I do have a fear that their hours will be increased with a decrease in pharmacist hours with the idea of actually limiting the amount of pharmacists hours. The big corporations are already dictating store staffing now with this convenient cost cutting measure and you bet it will be used to their full advantage staffing models."

"Section 52(4)", "(c) Technicians should not be allowed to perform the final check if the pharmacist is liable. Even though this would be an option there

may be some employers who may enforce this new option at their workplace even though the pharmacists may not agree with it."

"Section 52(4)", "In regards to the tech being able to perform the final check, if the pharmacist feels the tech is not capable of"

"Section 52(4)", "I don't feel techs should have the ability to perform the final check when a prescription is being filled, especially since the pharmacists would still be to blame for any mistake. I have no problem when techs do the final check on pre-packed drugs, container selection and labelling of these pre-packaged drugs."

"Section 52(4)", "Sec 12 vs 13 issue.

If pharmacy Techs in a central fill have to be supervised by a Sec 12 licensed pharmacist then how could this pharmacist be licensed as Sec 13 only (Sec 36(1)? Pharm Tech should be able to be supervised by Sec 12 or Sec 13 licensed pharmacists (or we eliminate Sec 13 type from all hospitals & community Settings)"

"Section 52(4)", "Part "C", the final check must be pharmacist's duty as he is the one qualified to do so (4 Years of university study), Part "G" from what I understand the Tech can perform the final check while pharmacy is closed. Where is the pharmacist supervision here? So basically pharmacist has not even seen anything and still being responsible for it."

"Section 52(4)", "Limits access to technicians when the pharmacy is closed."

"Section 52(4)", "Techs should also be able to enter prescription into database & generate a directive label. (does it say this in just another manner?)"

"Section 52(4)", "OK if wording is inclusive of duties described in sec. 54(2)"

"Section 52(4)", "Do not agree with tech-check-tech. Techs are getting increased responsibility or liability. I do not want to be liable for their mistakes."

"Section 52(4)", "52(4) limites access to the pharmacy for technicians"

"Section 52(4)", "Is this a typo 52(4) (g) (should be labeled (h) - enter the pharmacy when it is closed and, with the exception of (e), (f) and (g), perform the duties listed under this section. And what is listed as (h) should be (g). 52(4) f - inquiring of the practitioner...that was just added to the 2nd discussion document mean taking a verbal prescription from a practitioner and we just added that to the pharmacist only tasks in section 50???? so how can it now be a technician duty?"

Another area of confusion. 52(4) - enter the pharmacy when it is closed and, with the exception of (e), (f), and (g), perform the duties listed under this section. How can you allow this if under requirements for lock and leave component - section 32(2) c (ii) - it says non-pharmacist staff will not be able to enter the dispensary. You can't restrict techs from entering the dispensary in one section but then allow it in another???"

"Section 52(4)", "A pharmacy technician should function & have duties as assigned by a sec 12 pharmacies. "

"Section 52(4)", "I fully support all the changes (e, f, and h are all good additions) and continue to support section c. I respect the uneasiness that some members have about unscrupulous employers, but I think that it is important to recognize that technical duties can be done by competent qualified techs. If we are to maximize the benefits of prescribing privileges and other additions to our scope of practice, we need to free up our time and get rid of monotonous and technical duties."

"Section 52(4)", "Having been a community pharmacist for more than ten years. I strongly disagree with the Council's assessment of section 52(4)(c). The community pharmacy sector, especially in urban centers, is now largely dominated by corporations. I am not here to vilify these business organizations, however, it is important to bare in mind that their foremost objective is to maximize profits from the provision of a health care service. Very often, business consideration take precedent over good patient care. Over the last ten years, the pharmacist's average hourly wage has more than doubled. This represents a powerful economic incentive for corporations to keep pharmacist hours to a bare minimum. In order to cut costs (and hence increase profits). In fact, many corporate pharmacies do not allow for overlapping pharmacist shifts unless the daily prescription count is high (a common benchmark is 200 or more). If pharmacy technicians are permitted to perform the final check, one can almost be certain that corporations will readily adopt this section in order to reduce or eliminate overlapping pharmacists shifts as another cost-saving measure. As a result, the pharmacist's workload will actually increase because there are fewer pharmacists available to share the burden. There will be less time for the pharmacist to provide patient care. Furthermore, allowing the pharmacy technician to perform the final check simply adds another worry to the pharmacist's practice. Once corporations adopt this section as a company policy, the pharmacist, being an employee, will have no choice but to follow."

"Section 52(4)", "If you want patients to be receiving the right medication and therapy the pharmacist needs to do the final check. This is the most important step to getting the right medication in the bottle."

"Section 52(4)", "If the final onus is on the member, I don't agree with 52(4)(c)"

"Section 52(4)", "More responsibility and no more liability. Problematic for pharmacists in large pharmacies."

"Section 52(4)", "52(4)(g) conflicts with 32(c)(ii) which prohibits a non pharmacist staff member access to the dispensary when lock & leave is in place. 52(4)(g) also limits access to technicians when the pharmacy is closed.  
"

"Section 52(4)", "52(4)(g) conflicts with 32(2)(c)(ii) which prohibits a non pharmacist staff member access to the dispensary when lock & leave is in place. 52(4)(g) also limits access to technicians when the pharmacy is closed."

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"Section 52(4)", "Fully suport 52(4) b and c. How is subsection (h) reconciled with the requirement that the technician must be supervised by a section 12 member?"

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"

"Section 52(4)", "As a practicing hospital pharmacist, I feel that defining and increasing the responsibilities (as defined in the Regulations and individual Institutional Policy) of pharmacy technicians is of paramount importance to enhancing the time available for pharmacists' clinical practice. Should this section be removed, the knowledge base acquired by pharmacists in their training would be underutilized due to an inappropriate amount of their time in a technical role. As a clinical pharmacist, I have been waiting for the day that the time allotted for my clinical practice finally exceeds my technical duties. I see this as a significant step forward and strongly support this section. "

"Section 52(4)", "(c) still an issue for some pharmacies (retail).  
"

"Section 52(4)", "Safety and liability are HUGE issues here. Under the "New Explanation" section I quote "ensuring patients are receiving the right medication and therapy". How better to ensure this than allowing only pharmacists to perform the final check!! Did you look at your mission statement when you drafted this compromise? "

"Section 52(4)", "If the mandate of MPHA is patient safety, what safeguards would be put into place to ensure pharmacy owners don't exploit tick-check-tech systems. I would never feel comfortable having even a qualified technician hand out a Rx when they have no liability associated with any potential errors."

"Section 52(4)", "Manitoba pharmacists have not requested the need for technicians to have the ability to do the final check on the preparation of a medication. At the 2001 special general meeting an amendment was passed that only technicians in a hospital setting were allowed to perform a final check and only after an analysis of this pilot project was it to be rolled out in the community setting. To date, nothing has been published regarding the impacts of these new technician duties in the hospital setting. It is unreasonable then to

roll out these "enabling" regulations into the community setting. Although community pharmacies are not obligated to follow these new proposed regulations and allow their technicians to perform the final check, it is unfair to put the pharmacist in a position where they may be in conflict with their corporate directives."

"Section 52(4)", "If section 52(4)c is going to go ahead, then pharmacy technicians must assume some liability. Pharmacists should not be held responsible for a final check that they did not complete."

"Section 52(4)", "Final check - unless technicians can be held liable for their work, I do not support this duty. With the removal of the pharmact: tech ratio, some employers may force pharmacists to work with many techs and use the tech check system but still leaving all the liability and responsibility on the licensed pharmacist."

"Section 52(4)", "I do not wish to abdicate my role of the final check on any prescription as the final liability resides with the member."

"Section 52(4)", "Can a technician be inside a lock and leave enclosure performing duties allowed when pharmacy is closed? I think they should be allowed to."

"Section 52(4)", "Regarding the technicians performing the "final check", there should be a provision for the pharmacist to have overriding power over this option. This is to protect the pharmacist and the public in case of an unscrupulous employer, especially since this section and the entire legislation has no requirements for pharmacist to technician ratios. No pharmacist should be forced to work under conditions where they feel patient safety may be compromised (i.e. if technicians are not properly prepared for the task). As well this override capacity should remain in place as long as pharmacists maintain liability for technician actions. Also, to clarify 52(4)(f) Who is the practitioner? Is this referring to health care professionals with the authority to prescribe? As well as their 'designated agents'? (i.e. a doctor's receptionist/nurse?) etc."

"Section 52(4)", "I agree that this section might be exploited by unscrupulous employers wanting to decrease the role of the pharmacist."

"Section 52(4)", "Final checks by technicians are a concern especially when liability is still with pharmacists."

"Section 52(4)", "I believe technicians should be able to advise patients on use of medical devices such as blood glucose monitors, pregnancy test kits, blood pressure monitors, etc."

"Section 52(4)", "If wording is inclusive of duties described in section 54(2)."

"Section 52(4)", "Fully support 52(4) b and c. How is subsection (h) reconciled with the requirement that the technician must be supervised by a section 12 member?"

"Section 52(4)", "52(4)(g) conflicts with 32(2)(c)(ii) which prohibits a non pharmacist staff member access to the dispensary when lock & leave is in place. 52(4)(g) also limits access to technicians when the pharmacy is closed."

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"Section 52(4)", "Can replenish drug storage containers and dispensing machines AFTER final check by a pharmacist. 52(4)(c) should NEVER perform final check on anything."

"Section 52(5)", "No purpose."

"Section 52(5)", "How can a Manager not supervise a Tech in training? & yet it is okay for a pharm tech to supervise them"

"Section 52(5)", "So one does not need to even be a certified Tech to dispense if I understand it right."

"Section 52(5)", "none"

"Section 52(5)", "Should be under control of pharmacists and managers. Not sure how MPhA could regulate this."

"Section 52(5)", "Under the supervision of a pharmacist would mean we can check the Rx info before it is erased or before the Dr. hangs up if we are responsible."

"Section 52(5)", "As with the last section 52(4)(c)."

"Section 52(5)", "Same reasons as above."

"Section 52(5)", "See above concerns regarding duties."

"Section 52(5)", "Change wording to "licensed pharmacy technicians". I still don't agree to letting "anyone" become a technician by having experience in a pharmacy. I think by going through a pharmacy technician course (licensed) or certified, this would prove who was serious and whom was not. Also, if pharmacists must undergo a criminal record check and a child abuse registry check, I think all employees working behind the counter in a pharmacy should have these mandatory checks prior to employment. The technicians and assistants should have the respect of the job...they are around medications."

"Section C53", "Pharmacists need a Regulation Impact Study completed to better understand the implications of this regulation."

"Section 53(2)", "How can a student receive verbal Rx when he/she may not know most of the generic or brand names"

"Section 53(2)", "I preferred the last draft"

"Section 53(2)", "Don't work hard enough. All want to leave early."

"Section 53(2)", "The way Sec 12 & 13 are set up right now, Students & Techs report to me but according to Sec 13, I cannot supervise them. This has to be changed."

"Section 53(2)", "Dispensing errors still will be pharmacist's responsibility."

"Section 53(2)", "(a) & (i) seem to be crossed out and maybe were not intended to be? Could not find those two statements elsewhere in the document."

"Section 53(2)", "none"

"Section 53(2)", "If a student misinterprets a verbal prescription, then the pharmacist would be liable if any consequences occurred."

"Section 53(2)", "Students may have different levels of experience and their duties should be up to the discretion of the supervising pharmacist."

"Section 53(2)", "Performed by a pharmacy student."

"Section 53(2)", "(b) Receiving and recording verbal prescriptions - I don't believe someone in the early years of pharmacy should be allowed to do this."

"Section 54(2)", "I believe this section should be narrowly defined instead of wide open. I believe that, if it is the intention of the profession to move toward a second level of higher skilled non-professional staff, "other persons" should be restricted to emergency situations. In terms of security and confidentiality is it really the best idea to have the "high school student" in the dispensary at all."  
"

"Section 54(2)", "Sec 12 vs 13 issue again"

"Section 54(2)", "Not sure I agree on this section. I realize that there may be a difficulty in acquiring techs in some remote/rural areas, however, as we head towards increasing pharmacist duties we should be pushing to move properly trained techs (not high school students) in our practices even if distance Ed/Certification may need to be done to acquire the position as tech. (pt. safety concern).  
Abide by technician definition & qualifications in the bill."

"Section 54(2)", "The wording seems to indicate the duties may be done by persons "other than a member, intern, pharmacy tech or student". Is that the intent??"

"Section 54(2)", "54(1) and 54(2) contradict each other - 54(1) says other persons cannot engage in pharmacy practice, yet 54(2) lists duties they can perform!"

"Section 54(2)", "The wording seems to indicate the duties may be done by persons "other than a member, intern, pharmacy tech or student". Is that the intent??"

"Section 54(2)", "Do not agree with this whole section."

"Section 54(3)", "I think we should steer away from these individuals performing these tasks, leaving them for pharmacy technicians."

"Section 54(3)", "none"

"Section 54(3)", "If a mistake were to occur, who would be liable - say for eg: the other health care professional gave the drug to the wrong person, even though we have already checked the prescription"

"Section 54(3)", "I don't think there needs to be a signature for patient counseling."

"Section 54(3)", "Far too vague and open."

"Section 54(3)", "If other health professionals can be delegated the dispensing aspect of our practice, pharmacists should be allowed to be delegated other health professionals practice such as prescribing under certain circumstances."

"Section 58(1)", "how would hospitals comply with this section? How does this apply to automatic technology such as Pyxis machines?"

"Section 58(1)", " In hospital pharmacy practice the record of who authorizes the drug is maintained electronically however that may not be considered an electronic signature."

"Section 58(1)", "The "new Explanation" is not part of the regulations - so it says if it is the same person performing all functions then only one signature is required - where does it say this in the regulations"

"Section 58(1)", "Still seems like over redundant records and signing by members"

"Section 58(1)", "I am concerned with the amount of time required to keep these records."

"Section 58(1)", "No"

"Section 58(1)", "With all the records that need to be kept, the original prescription form may need to be standard sized. Now we are getting a 4x6 inch piece of paper with 12 drug orders. There is absolutely no room on the paper to record anything! Perhaps we need to go to the USA Standard which only allows one drug per piece of paper. This would allow easier electronic storage (scan the Rx ) of the Rx as well"

"Section 58(1)", "For inpatients - the chart order is the permanent retained record. The only other documentation is the initials of the pharmacist that

entered the order in the computer.No Tech filling is documented or final signed Rx retained"

"Section 58(1)", "58(1)(A) requires date and signature of authorizing member"

"Section 58(1)", "none"

"Section 58(1)", "Seems like a lot of signatures on one rx! Where would they all go and how would you know which signature was for what step? It seems we are being treated like children and being told to go through all these steps just to fill a prescription. How have prescriptions been filled up to this point in time? Is EVERYONE doing it wrong?"

"Section 58(1)", "Too much record keeping"

"Section 58(1)", "In hospital pharmacy practice the record of who authorized the drug is maintained electronically however that may be considered an electronic signature."

"Section 58(1)", "Date & signature of authorizing member."

"Section 58(1)", "Still seems like over redundant records and signing by members."

"Section 58(1)", "In general there is too much documenting required."

"Section 58(1)", "Explanation is clear."

"Section 58(1)", "58(1)(a) requires the "...date and the signature of the authorizing member"."

"Section 58(1)", "58(1)(a) requires the "...date and the signature of the authorizing member...""

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"Section 58(1)", "58(1)(a) requires the "...date and the signature of the authorizing member..."."

"Section 58(1)", "Full signature is time consuming when initials would suffice."

"Section 58(1)", "In the case of a pharmacist or technician authorizing refills (or a pharmacist taking a verbal order), there should be the option of signature

OR initials for efficiency of workflow. This would only be for authorizations that remain as internal records and do not need to be distinguished by unknown third parties in the same way as doctor's prescriptions."

"Section 58(1)", "How can pharmacists who are run off their feet manage to keep all these records? The intent may be fine (especially in large pharmacies with different people doing each task) but the practice is onerous! Not just the authorization prep., check and council prescription record, acquisition records, test interpretation records, etc. etc. etc. etc.

"

"Section 58(1)", "58(1)(a) requires the "...date and the signature of the authorizing member..." "

"Section 58(1)", "58(1)(a) requires the "...date and the signature of the authorizing member...."" "

"Section 58(1)", "58(1)(a) requires the "..date and the signature of the authorizing member.."" "

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"Section 58(1)", "58(1)(a) requires the "..date and the signature of the authorizing member..."" "

"Section 58(1)", "58(1)(a) requires the "..date and signature of the authorizing member""."

"Section 58(2)", "Hospital practice in Winnipeg is complex and diverse. There are many drug distribution systems in place including, floorstock, CIVA, Pyxis, and Cart Exchange Unit Dose. Order entry will soon be done in a paperless system and only electronic records will be kept. Maintaining preparation records in these situations is not reasonable or practical. regarding final checks I have concerns regarding any requirement for further documentation or signatures beyond the final check. If we are delegating the responsibility for the checking why would a co signature be required."

"Section 58(2)", "I simply look at my present practice and do not understand what all this would achieve in delivery of care to my patients . I recognize that perhaps I may not understand what Council is hoping to achieve but to me this is more complicated than what we have now ,will be more time consuming and slow down this dispensary process. For operations with one Pharmacist this section and in fact all of 58 will become very repetitious . For prescriptions with multiple Rx on them ( our record to date is 17 on one page) filled at various dates the whole thing will be a mess of initials ,signatures dates etc. If you use a process whereby the Pharmacist hands out all Rx including all refills I cannot see why one set of initials would not suffice.

"

"Section 58(2)", "see above"

"Section 58(2)", "see 58(1)"

"Section 58(2)", "Rx is entered into hospital system & unit dose cart is billed by techs. Fill sheets are not retained for more than a few days & no possible way to alternate this documentation"

"Section 58(2)", "none"

"Section 58(2)", "Hospital practice in Winnipeg is complex and diverse. There are many drug distribution systems in place including floorstock, CIVIA, Pyxis, and Cart Exchange Unit Dose. Order entry will soon be done in a paperless system and only electronic records will be kept. Maintaining preparation records in these situations is not reasonable or practical regarding final checks I have concerns regarding any requirement for further documentation or signatures beyond the final check. If we are delegating the responsibility for the checking why would a co-signature be required."

"Section 58(2)", "Pharmacist to do final check."

"Section 58(2)", "Technicians should not be permitted to do final check if the pharmacist will continue to be responsible for them."

"Section 58(2)", "If the same pharmacist does both duties maybe the Rx could be signed only once?"

"Section 58(2)", "Why do we need section (i)? The member is still responsible."

"Section 58(2)", "If by having a technician perform the final check's purpose is to remove the pharmacist from the dispensary, why must a pharmacist put their initial on something they did not do."

"Section 58(2)", "These records should all be in the same place (ie: all recorded on the original hard copy)."

"Section 58(2)", "Final check by student/intern/technician: unless they are fully liable for the prescription, a licensed pharmacist should be the only person able to perform a final check and initial the prepared drug."

"Section 58(2)", "If a person other than a pharmacist or intern does the final checks then the record would need the initials of the supervising pharmacist. How does this save time to have the pharmacist do the required counseling."

"Section 58(2)", "Final check should only be allowed by a pharmacist."

"Section 58(2.1)", "Too constraining for hospital practice"

"Section 58(2.1)", "The responsibility in hospital practice is not clear. This is not practical for hospital pharmacy for many of the reasons stated in 58(2)"

"Section 58(2.1)", "See 58(2.23) for rationale"

"Section 58(2.1)", "Keeping a counselling record does/will not lead to better patient counselling. If the record is the intent technicians will be trained to make sure the records are intact -

Pharmacists still have to  
TAKE THE TIME TO COUNSEL - records or not  
"

"Section 58(2.1)", "see above"

"Section 58(2.1)", "it says signature or initials of member or intern providing counselling but section 50 is still worded such that only a member can perform this task, if the intent is to let intern do it then fix section 50, it's not clear!!!

Keep in mind just because we sign to say we counselled someone doesn't mean that patient won't come back and say NO ONE TOLD ME ie say no one counselled them, so what does the sig really prove???"

"Section 58(2.1)", "Implementing this would require a change in hardware/software. Likely increased waste."

"Section 58(2.1)", "Time consuming"

"Section 58(2.1)", "See 58(2.23) for rationale."

"Section 58(2.1)", "See 58(2.23) for rationale"

"Section 58(2.1)", "Patient's who are inpatients of a personal care home are akin to inpatients of hospitals in that their medications are administered by a healthcare professional (usually a nurse). Also, these patients are extensively monitored by these healthcare professionals. As such, the value and requirements for counselling patients in a PCH on every new prescription is limited. Provincial regulations insure that each patient's entire medication profile is reviewed by a pharmacist every 3 months to insure the appropriateness of therapy."

"Section 58(2.1)", "This is a normal part of dispensing a prescription. Why do we now need to record?"

"Section 58(2.1)", "see 58(1)"

"Section 58(2.1)", "58(2.1)(a) need to define confirmation of drug; 58(2.1)(b) requires that a member only be able to document refusal of counseling, this should be expanded to include "or Designate" ""

"Section 58(2.1)", "none"

"Section 58(2.1)", "I don't think it would be realistic to have a separate record of all counseling. Just document if counseling refused."

"Section 58(2.1)", "There is no mention about pharmacists work in ambulatory care setting. Also, I wonder how truthful some pharmacists may be about counseling their patients. Perhaps time may be an issue."

"Section 58(2.1)", "The responsibility in hospital practice is not clear. This is not practical for hospital pharmacy for many of the reasons stated in 58(2)."

"Section 58(2.1)", "Yes"

"Section 58(2.1)", "It would have to be part of the fill process in our software system, otherwise it would be too cumbersome."

"Section 58(2.1)", "58(2.1)(a) further define confirmation 58(2.1)(b) expanded to include "designate" ."

"Section 58(2.1)", "It says signature or initials of member or intern providing counseling but section 50 is still worded such that only a member can perform this task, it the intent is to let intern do it then fix section 50, it's not clear!!!

Keep in mind just because we sign to say we counseled someone doesn't mean that patient won't come back and say NO ONE TOLD ME ( ie: say no one counseled them), so what does the signature really prove???"

"Section 58(2.1)", "A pharmacist can sign this record even if the counseling provided does not meet practice standards. Therefore, what is the merit of keeping this record when it does not reflect the quality of the counseling provided by the pharmacist? In the event of a complaint by a patient, this record is useless in settling the matter for it does not contain any details of the counseling. In order to make this section meaningful, it is the contents of the counseling (ie: what was actually discussed with the patient during counseling) that should be recorded.

The requirement for the patient to sign if counseling is declined does not foster good patient-pharmacist relationship because it takes on the tone that the pharmacist does not trust that the patient can make his/her own health care decisions. It is downright tedious for those patients who are stabilized on chronic medications and have no questions for the pharmacist. The pharmacist's time could be utilized much more efficiently if the patient is empowered to monitor his/her health and to approach the pharmacist whenever there are concerns."

"Section 58(2.1)", "I think it is too time consuming to sign for every Rx. If counseling is refused, I can see a signature for that."

"Section 58(2.1)", "If you are the only pharmacist on duty, time does not permit us to work our counseling efforts."

"Section 58(2.1)", "58(2.1)(a) requires "confirmation" of the drug being dispensed. Need to define "confirmation" further. 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include "...or designate"."

"Section 58(2.1)", "58(s.1)(a) requires "confirmation" of the drug being dispensed. Need to define "confirmation" further 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include " ..or designate"."

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"Section 58(2.1)", "See 58(2.23) for rationale"

"Section 58(2.1)", "58(2.1)(a) requires "confirmation" of the drug being dispensed. Need to define "confirmation" further. 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include "... or designate".

"Section 58(2.1)", "Inpatients of a personal care home are more similar to inpatients of a hospital as they are administered their medications by another health care professional, such as a nurse. Therefore, I would move the section pertaining to inpatients of a personal care home from section 58 (2.2) to Section 58 (2.1)."

"Section 58(2.1)", "I believe this is very impractical in the community setting. Prescriptions may sit for days before being picked up. How are we to keep records in a timely fashion. If a patient refuses counseling, I doubt they'll provide their name for documentation."

"Section 58(2.1)", "This is going to require a lot of time for filing all these records. Normally prescriptions are filed by date/transaction number. The hard copy would only be filed once the prescription has been picked up and counseled and signed by the member. Since there may be a time delay between when the prescription is first filled and then counseled on these prescriptions files would be out of order and it would cause a great deal of time filing."

"Section 58(2.1)", "Do we have to keep a record of just new Rx's counselled or does a pharmacist have to offer counselling on every repeat Rx and mark if this is done or refused. What are the ideas for where records are kept? Not practical to go back to original to mark that counselling was done."

"Section 58(2.1)", "Regarding 58(2.1)(a)(ii): Where the counseling is done by the student - the provision of the signature/initials of the member should not be mandated since it is an unnecessary step. Pharmacists should have the discretion to delegate a student to appropriate counseling situations in the same manner as an intern. In practice - BOTH interns and students are assessed for ability by pharmacists etc. before they engage in patient contact; supervision and liability in the end, remains in the pharmacist's possession regardless of where signatures/initials are placed on records."

"Section 58(2.1)", "I don't think you should have to sign when you do the counseling "

"Section 58(2.1)", "Not sure."

"Section 58(2.1)", "Exactly where would this counseling record be kept and what would it consist of?"

"Section 58(2.1)", "See 58(2.23) for rationale."

"Section 58(2.1)", "58(2.1)(a) requires ""confirmation"" of the drug being dispensed. Need to define ""confirmation"" further. 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include ""..or designate..""."

"Section 58(2.1)", "58(2.1)(a) requires ""confirmation"" of the drug being dispensed. Need to define ""confirmation"" further. 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include ""..or designate""."

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"Section 58(2.1)", "58(2.1)(a) requires ""confirmation"" of the drug being dispensed. Need to define ""confirmation"" further. 58(2.1)(b) requires that a member only be able to document refusal of counseling. This should be expanded to include ""..or designate""."

"Section 58(2.1)", "Sometimes you do not always get the name of the individual whom is acting on the behalf of the patient whom refuses counseling."

"Section 58(2.2)", "Same as above"

"Section 58(2.2)", "Should not include residents of personal care homes - RNs or LPNs administer or supervise administration of meds in PCH, so they should be treated the same as hospital inpatients."

"Section 58(2.2)", "I do not think it should be necessary to keep the name of the caregiver "

"Section 58(2.2)", " If the intent of med reviews covers this in a personal care home."

"Section 58(2.2)", "No changes have been made to the regulations. Information has been qualified in notes however these notes will not be part of the regulations and thus are not to be considered. This regulation is overly prescriptive. Are there qualifications for the continuing evolution of technology? Retention times, destruction times and procedures. The increased number of signatures does not increase patient destruction times and procedures. The increased number of signatures does not increase patient safety if the pressure to increase signatures results in reduced time for patient/pharmacist interaction. A regulatory impact statement would be appreciated with qualifications with regards to types of technology being utilized in practices across the country and in the USA etc.

Also hospital record keeping has unique challenges with regards to record keeping and their audit trail as there is much greater potential for error due to the increased interaction with nurses, teachers, interns, etc. as well as the fact the patient is not in control of their treatment while in a hospital setting and does not have the same authority as in a community setting where they question and double check their therapy the information would be doubly necessary."

"Section 58(2.2)", "Time"

"Section 58(2.2)", "Should not include residents of personal care homes - RNs or LPNs administer or supervise administration of meds in PCH, so they should be treated the same as hospital inpatients."

"Section 58(2.2)", "Should not include residents of personal care homes - RNs or LPNs administer or supervise administration of meds in PCH, so they should be treated the same as hospital inpatients."

"Section 58(2.2)", "See discussion for 58(2.1), patients in a PCH differ from patients that are in a group home or in the care of other individuals in that nurses are responsible for drug administration. Thus there is limited value in counselling the agent (nurse) administering the medications."

"Section 58(2.2)", "see 58(1)"

"Section 58(2.2)", "Caregiver name; a patient may have multiple caregivers."

"Section 58(2.2)", "What about pharmacy providers to nursing homes, personal care homes, or group homes. Who is the counseling directed to and how?"

"Section 58(2.2)", "none"

"Section 58(2.2)", "I have never worked in a personal care home, but I assume there are hundreds of blister packs going to them, so how could you document counseling on all those meds and the name of every nurse who receives them."

"Section 58(2.2)", "I think this would be difficult especially for inpatients of personal care home too many people involved - patient, pharmacist & several different nursing staff."

"Section 58(2.2)", "Same as above"

"Section 58(2.2)", "Yes"

"Section 58(2.2)", "If signing off the med review accomplishes this, I would be in favour."

"Section 58(2.2)", "Places undue burden on pharmacy to nursing homes and personal homes"

"Section 58(2.2)", "Regarding section 58(2.2)(a), an inpatient of a personal care home does not usually receive medications from a community pharmacy."

"Section 58(2.2)", "Same as above."

"Section 58(2.2)", "This section puts an undue burden on any pharmacy that provides care to nursing homes, personal care homes, or group homes. Who is the counseling to be directed toward and how?"

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"Section 58(2.2)", "58(2.1) (2.2) - seems like a lot of signing!!"

"Section 58(2.2)", "Should not include residents of personal care homes - RNs or LPNs administer or supervise administration of meds in PCH, so they should be treated the same as hospital inpatients."

"Section 58(2.2)", "This section puts an undue burden on any pharmacy that provides care to nursing homes, personal care homes or group homes. Who is the counseling to be directed toward and how?"

"Section 58(2.2)", "As inpatients of a personal care home are more like patients of a hospital in the way their medications are administered by health care professionals, I do not see the same requirements for a counseling record being necessary to PCH residents as I do for individuals such as those in a group home who would be self-administering medications."

"Section 58(2.2)", "Strike out student."

"Section 58(2.2)", "What is the purpose of these records, are they for liability concerns? Has there been a problem in the past regarding patient safety and the need for counseling records???"

"Section 58(2.2)", "Personal care home - notes are sent up on medications, nurses are contacted if there will be a concern, med reviews every 3 months - but is practical to talk to somebody; record this on every new Rx that goes up."

"Section 58(2.2)", "I don't think this should have to be done."

"Section 58(2.2)", "Same as 58(2.1)."

"Section 58(2.2)", "Should not include residents of personal care homes - RNs or LPNs administer or supervise administration of meds in PCH, so they should be treated the same as hospital inpatients."

"Section 58(2.2)", "This section puts an undue burden on any pharmacy that provides care to nursing homes, personal care homes or group homes. Who is the counseling to be directed toward and how?"

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"Section 58(2.2)", "This section puts an undue burden on any pharmacy that provides care to nursing homes, personal care homes or group homes. Who is the counseling to be directed toward and how?"

"Section 58(3)", "Once again today's hospital systems are complex and changing into an electronic format. These sections reflect historical practices and are not in sync with current practice. 58(3,4,+5) will all create issues for hospital pharmacy practice as written. "

"Section 58(3)", "Does 58(5) supercede 58(3) in respect to hospitals? This is unclear."

"Section 58(3)", "why is there a separate section for authorization record & prescription record, isn't the authorization record really part of the prescription record or vice versa, the signatures authorizing it are on the prescription with all the other requirements to make it a valid Rx so why are they listed in 2 separate sec and not all as one sec?"

"Section 58(3)", "Does 58\*5) supercede 58(3) in respect to hospitals? This is unclear."

"Section 58(3)", "Does 58(5) supercede 58(3) in respect to hospiotals? This is unclear."

"Section 58(3)", "For hospital practice in 58(5) it is not explicitly clear that this section overrides 58(3). In similar situations such as 59(1) where medication label requirements are not applied to hospital practice, a statement 59(3) - is included that specifies the exception. Should a statement of this nature be included for Prescription Records."

"Section 58(3)", "see 58(1)x"

"Section 58(3)", "Not all hospital Rx's contain 58(3) c-pt address, e - manufacturer, h - price, l(address of prescriber is not present)."

"Section 58(3)", "none"

"Section 58(3)", "If this is the record that would automatically be kept in the computer, then I have no problem with it. If it is supposed to be some kind of new record that we have to keep, then I would object to more record keeping."

"Section 58(3)", "Does this apply to both hospital & community settings."

"Section 58(3)", "Once again todays hospital systems are complex and changing into an electronic format. These sections reflect historical practices and are not in sync with current practice. 58(3, 4, & 5) will all create issues for hospital pharmacy practice as written."

"Section 58(3)", "Why is there a separate section for authorization record & prescription record, isn' t the authorization record really part of the prescription record or vice versa, the signatures authorizing it are on the prescription with all the other requirements to make it a valid prescription so why are they listed in 2 separate sections and not all as one section???"

"Section 58(3)", "Does 58(5) supercede 58(3) in respect to hospiotals? This is unclear."

"Section 58(3)", "With section 59 (1), it is made clear that hospitals have different requirements and this is detailed in Section 59 (3). Could a similar statement of clarity for hospital pharmacy prescription records be applied to Section 58 (3)? Information such as price charged is unlikely to be captured in most hospital dispensing records."

"Section 58(3)", "Could the address be the name of the hospital/clinic name, etc.?"

"Section 58(3)", "58(3)(e) The manufacturer of the drug. I can see if you are dispensing a generic drug (i.e. prednesone) that you put Nooo, Apo, etc. but a trade name drug (i.e. lipitor (atorvastatin) is only made by one manufacturer and everyone knows it is Pfizer. Delete this requirement. Name and address of practitioner: Would Carberry be enough of an address for a doctor having and working in Carberry. For a doctor that does locumes, what address?"

"Section 58(3)", "It is not clear what is being required. Are we talking on the back of the original prescription or some other journal? How would it be done electronically?"

"Section 58(3)", "Does 58(5) supercede 58(3) in respect to hospitals? This is unclear."

"Section C58(5)", "Hospital Records - in section (c) the person preparing the medication for dispensing and performing the final check is often a technician - how would that fall into this guideline, particularly when, as at this institution everything is done through PYXIS? Also, due to the fact that many brands are considered interchangeable in hospital, but only one "name" is used in the computer system, generally the generic. What are the logistics behind this, and how could the manufacturer be recorded in any consistent way?"

"Section 59(1)", "? I do not think the price should be required on the label - what is the point of this w.r.t. patient safety."

"Section 59(1)", "No changes have been made to the regulations. Information has been qualified in notes however these notes will not be part of the regulations and thus are not to be considered. This regulation is overly prescriptive. Are there qualifications for the continuing evolution of technology? Retention times, destruction times and procedures. The increased number of signatures does not increase patient safety if the pressure to increase signatures results in reduced time for patient/pharmacist interaction. A regulatory impact statement would be appreciated with qualifications with regards to types of technology being utilized in practices across the country and in the USA, etc. Also hospital record keeping has unique challenges with regards to record keeping and their audit trail as there is much greater potential for error due to the increased interaction with nurses, teachers, interns, etc. as well as the fact the patient is not in control of their treatment while in a hospital setting and does not have the same authority as in a community setting where they question and double check their therapy the information would be doubly necessary."

"Section 59(1)", "none"

"Section 59(1)", "I do not think the price needs to be on the label - this can be misleading if patient gets it paid by a third party and hasn't paid anything themselves."

"Section 59(1)", "What is (e) etc?? - Is this price not required?"

"Section 59(1)", "Section 59 (1)(k) price should not be mandatory on the prescription label as this is irrelevant from a pharmacy practice perspective. It appears to apply different standards to hospital pharmacy labeling requirements."

"Section 59(1)", "Section 59(1)(e) I don't think the number of refills has to be on the label."

"Section 62(1)", "Why seven years"

"Section 62(1)", "Why not keep 62(2)?"

"Section 62(1)", "What is the need or purpose of this whole section ? We must keep purchase invoices for 7 years . 62 -4 (5) seems like a lot of overkill to me . Internal auditing of an item that is covered in the examples given would be a waste of time . The original purchase is

covered by invoice ,  
the return to stock is accounted for in the computer inventory system and the  
DPIN reversal .  
Unless someone can give me a rationale need and concern I would not accept 62-  
4-5 in any form.

"

"Section 62(1)", "The Executive Summary still says 2 years and the updated  
Second Discussion Document now says 7 years. Which is it? Also, what is the  
intent for paper versus electronic? If it is 7 years for both, I think that is  
too much paper storage for everything as we are adding to the list of items to be  
kept."

"Section 62(1)", "Too long."

"Section 62(1)", "Why not keep 62(2)?"

"Section 62(1)", "What are the "motives"?"

"Section 62(1)", "Why not keep 62(2)?"

"Section 62(1)", "62(4) This would be quite onerous."

"Section 62(1)", "Sec 62(4) - No  
Lots of meds are returned from nursing units to pharmacy for re-use -  
documentation of all these doses on an acquisition record is not feasible"

"Section 62(1)", "none"

"Section 62(1)", "Why seven years?"

"Section 62(1)", "One document says 2 years - another 7 years?"

"Section 62(1)", "I agree to the changes now."

"Section 62(1)", "Why not keep 62(2)?"

"Section 62(1)", "This regulation is overly prescriptive and introduces  
cumbersome and unnecessarily unwieldy record keeping requirements. Pharmacists  
time would be better spent counseling patients than keeping records. This  
regulation appears to regulate pharmacy business and not pharmacy practice. "

"Section 62(1)", "Could create a problem when large number of prepackaged drugs  
are returned from teh PCH lot/expiry date on all prepacks? 62(a)(c)"

"Section 62(1)", "Why not keep 62(2)?"

"Section 62(4)", "Does not work in hospital."

"Section c62(4)", "The record keeping regarding returning drugs to inventory is  
unnecessary and will be cumbersome to administer, especially in hospital  
settings where ward-stock returns are constantly occurring. It is unclear to me  
how the inclusion of this section protects the public, when realistically the  
requirements in 62(4) insure that inventory that is returned is of known  
quality. If council chooses to include this section, at minimum, I recommend  
the removal of part (e) of this section. When product is issued as ward stock

to a unit, it is not issued or labeled with a prescription number. Thus it would not be possible to record that number if acquisition record keeping was required."

"Section 63(3)", "huge workload for hospital with minimal/no benefit seen"

"Section 63(3)", "Not applicable in hospital pharmacy setting. We retain records of N & CD disposed but not other drugs as that would be onerous."

"Section 63(3)", "Why are we wasting our time documenting the expired medications we destroy. Shouldn't we be spending our time helping our patients with their medications, counselling etc. This documentation is a waste of time and doesn't need to be done except for narcotics ( as currently done)"

"Section 63(3)", " This is too cumbersome to administer."

"Section 63(3)", "Many generic companies do not physically take back the expired drugs that they give us credit for at store level. We then are left to destroy the drugs at our own expense. I think the generic mfg should have to process the return of expired drugs through the wholesaler and pay the disposal cost"

"Section 63(3)", "I would limit the wording to the current wording ie only controlled drugs and substances for example if a metformin tablet drops on the floor why would you take the time to record the destruction of that tablet."

"Section 63(3)", "Time consuming."

"Section 63(3)", "The addition of destruction records for product other than controlled drugs and substances will be very difficult to administer and adds questionable value to public protection. If the desire is to ensure that drugs are disposed of in an appropriate manner (ie: not flushed in the sink), then the regulations should indicate that drugs shall be destroyed in an appropriate manner. The addition of record keeping regarding destruction of all products is unnecessarily bureaucratic."

"Section 63(3)", "No patient benefit to recording the destruction of expired medication."

"Section 63(3)", "This is still very cumbersome."

"Section 63(3)", "Maintaining destruction records for all unit dose packaged meds being destroyed is NOT feasible"

"Section 63(3)", "Should only be drugs in the controlled drugs and substances act."

"Section 63(3)", "none"

"Section 63(3)", "This is extremely time consuming and unnecessary - the only drugs that would be destroyed would be expired drugs that couldn't be returned for credit, or expired drugs that customers may have brought back. It would be too time consuming to list the lot #'s etc. in the first case, and you wouldn't know them in the second case."

"Section 63(3)", "Not applicable in hospital pharmacy setting. We retain records of N & CD disposed but not other drugs as that would be onerous."

"Section 63(3)", "Completely unworkable. Does this apply to outdated drugs??"

"Section 63(3)", "Need to define pharmacy stock. Should apply only Controlled Drugs and Substances Act."

"Section 63(3)", "While I can appreciate that the licensing body would like to be able to track complete acquisition and destruction records for some pharmacy sites (like IPS sites). I have great concern about how destruction records are required to be maintained in hospitals. Hospitals with an I.V. admixture program have a considerable amount of drug wastage associated with these programs. If hospitals were to document in a manner similar to that outlined in the discussion document, the time to document would be prohibitively time consuming. I fail to see any advantage of this in our setting."

"Section 63(3)", "Why are we wasting our time documenting the expired medications we destroy. Shouldn't we be spending our time helping our patients with their medications, counseling, etc. This documentation is a waste of time and doesn't need to be done except for narcotics (as currently done)."

"Section 63(3)", "Need to have ""pharmacy stock"" defined as it pertains to the comments in the explanation box provided in the document. This section should pertain only to those drugs in the Controlled Drugs and Substances Act."

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"Section 63(3)", "Need to have ""pharmacy stock"" defined as it pertains to the comments in the explanation box provided in the document. This section should pertain only to those drugs in the Controlled Drugs and Substances Act."

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"Section 63(3)", "I wonder the scope of this section should be narrowed to controlled drugs only. This requirement could generate a significant amount of workload and may not do much more than capture how many drugs expire when kept in inventory. What is the rationale behind such detailed destruction logs? If an institution has a drug destruction policy that meets a requirement for licensing, for example, could this section be modified/omitted?"

"Section 63(3)", "I don't understand the need for this documentation."

"Section 63(3)", "Why is it necessary to record the destruction of outdated non-narcotic/controlled medications? There doesn't seem to be a valid reason for this that I can see, aside from creating more paperwork. I do not see what benefit to patient safety this step would provide. If this is for environmental safety, then state it as such as require that non-narcotic/controlled etc. medications be disposed of in an environmentally safe manner and for this process to be recorded."

"Section 63(3)", "I don't see the need for putting down the lot # and the name of the product."

"Section 63(3)", "Onerous for pharmacist."

"Section 63(3)", "Onerous for pharmacist."

"Section 63(3)", "More clarification."

"Section 63(3)", "Need to have "pharmacy stock" defined as it pertains to the comments in the explanation box provided in the document. This section should pertain only to those drugs in the Controlled Drugs and Substances Act."

"Section 63(3)", "It could be a company that destroys the drugs not necessarily a person."

"Section 63(3)", "This section should pertain only to those drugs in the Controlled Drugs and Substances Act."

"Section 63(3)", "Need to have "pharmacy stock" defined as it pertains to the comments in the explanation box provided in the document. This section should pertain only to those drugs in the Controlled Drugs and Substances Act. "

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"Section 63(3)", "This section should pertain only to those drugs in the Controlled Drugs and Substances Act."

"Section 63(3)", "I don't agree with 63(3)(e) - a pharmacist should be the only one destroying."

"Section C64", "This regulation is unnecessary and will place a burden on pharmacy business. This regulation is overly prescriptive and introduces cumbersome and unnecessarily unwieldy record keeping requirements. Pharmacists time would be better spent counseling patients than keeping records. This regulation appears to regulate pharmacy business and not pharmacy practice. This section should be eliminated."

"Section 65(1.1)", "The 3 day period is too short of a period it should be increased."

"Section 65(1.1)", "none"

"Section 65(1.1)", "Valid concerns were raised in the first document response - ie; what if you need to use 2 strengths of drug to fill prescribed dose - that I haven't seen addressed."

"Section 65(1.1)", "If the doctor writes, for example, hydromorph contin 9 mg BID, does the pharmacist have the right to make 2 prescriptions, one of 3 mg and one of 6 mg?"

"Section 65(2)", "What Limits???"

"Section 65(2)", "none"

"Section 65(2)", "Too vague - what are reasonable steps - again we are 'policing' doctors and could be liable for their mistakes."

"Section 65(2)", "All M3P's must be accompanied by a PHIN and go to DPIN unless proof they are from another province."

"Section 65(2)", "Practice direction!!"

"Section 65(2)", "(d) 3 days. A patient with limited mobility who receives a repeat Rx from a physician at 1700 hours Friday at the beginning of a long weekend cannot easily present Rx within 3 days (Since some physicians practice only 2 - 3 days a week, patient may have few options re time of appointment)."

"Section c65(4)", "Section 65(4) if a prescription is post dated the pharmacist should give the prescription back to the patient explaining the prescription is too old to fill. One I think it is not only the responsibility of the patient to fill the prescription with 3 days but also the physician to inform the patient to get it filled within 3 days. This prescription is no longer valid and under the act we cannot fill a prescription with errors. I don't believe we should be legally obligated to call the physician at this point it is the patients issue. To put a prescription on our system through dpin requires at least 1 unit sent which would throw off our narcotics count. If it an abuse situation or therapeutic issue yes that section applies."

"Section 66", "I'm still not clear what is meant by (a) and (b)"

"Section 66", "Access"

"Section 66", "If a Rx has not been filled for over 2 years it seems unreasonable to be able to generate a duplicate Rx label"

"Section 66", "none"

"Section 66", "What exactly is "'rx label record'? OK to give them a duplicate receipt if necessary, or a printout of purchases from say, the previous year."

"Section 66", "Is there an age cutoff? For ex: if a mother comes in and asks for her 16 year old daughter's medication history for income tax purposes? Let's say for Ex: that 16 year old is on birth control pills & doesn't want her mother to know?"

"Section 66", "Prescription not filled in over 2 years."

"Section 66", "If a prescription has not been filled for over two years, it seems unreasonable to be able to generate a duplicate prescription label. Also, 66 (d) says "...any other record maintained by the pharmacy". this is too all encompassing and should be defined further."

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"Section 66", "(a)(b)(c) - ok  
(d) - copy of ANY RECORD??"

"Section 66", "If a prescription has not been filled for over two years, it seems unreasonable to be able to generate a duplicate prescription label. Also, 66(d) says "...any other record maintained by the pharmacy". This is all too encompassing and should be defined further."

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"Section 66", "If a prescription has not been filled for over 2 years, it seems unreasonable to be able to generate a duplicate prescription label. Also, 66(d) says "...any other record maintained by the pharmacy". This is too all encompassing and should be defined further."

"Section 66", "66(d): pt has access to any other record maintained by the pharmacy - what other record would this be?"

"Section 67(1)", "The concerns regarding the maintaining of some of these records in a hospital setting other than those currently maintained electronically was voiced earlier. Storage of any records greater than 2 years is unreasonable and should be avoided with the exception of those records that must by law be maintained for greater than 2 years."

"Section 67(1)", "After the district meetings - just some confusion - This whole area of retention of records is a mess. We need some definite legal opinion here as this is an expensive space consuming problem in most retail stores."  
"

"Section 67(1)", "In the light of new technology could the records not be kept as a electronic image - pdf file etc - this would be a true image of the original - keeping paper records for 7 years would need an awful lot of space. The electronic image could be printed out at any time if a paper copy is needed."

"Section 67(1)", "7 years is excessive. If most of these records are kept on the hard copy of the prescription then we need to keep the hard copies for 7 years. This would be excessive and takes up way too much space, where are we supposed to store all that paper. "

"Section 67(1)", "I think 7 years hard copy is too cumbersome."

"Section 67(1)", "The length of time hardcopies must be kept."

"Section 67(1)", "Time consuming"

"Section 67(1)", "Too much paper to keep for 7 years; the college of physicians must be informed to inform doctors not to write Rx that easily fades away (some Rx are like that) before such a regulation takes place what would be the use if after a while all you have in hand is a blank piece of paper with pharmacy labels and documentation, being the only thing remaining."

"Section 67(1)", "Years is too onerous - we need patient care, not paper warehousing."

"Section 67(1)", "none"

"Section 67(1)", "Rx's which were refused - you wouldn't have them - they would have been returned to customer"

a) What exactly is authorization record? - If Rx is ok to fill, wouldn't that be on the Rx already?"

"Section 67(1)", "The concerns regarding the maintaining of some of these records in a hospital setting other than those currently maintained electronically was voiced earlier. Storage of any records greater than 2 years is unreasonable and should be avoided with the exception of those records that must by law be maintained for greater than 2 years."

"Section 67(1)", "If it means 7 years of hard copy,"

"Section 67(1)", "Too onerous on the pharmacy. 2 years is enough to be efficient in patient care. Longer may create tedious work distracting from patient care."

"Section 67(1)", "7 years is excessive. If most of these records are kept on the hard copy of the prescription then we need to keep the hard copies for 7 years. This would be excessive and takes up way too much space, where are we supposed to store all that paper?"

"Section 67(1)", "Although it seems quite tedious and a logistic nightmare. I agree that it is safer to save record for the 7 years as suggested."

"Section 67(1)", "Again, not patient counseling records."

"Section 67(1)", "Prescribing record? Communication record? Test records - is this necessary?"

"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

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"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

"Section 67(1)", "If the counseling record & other records were recorded on the hard-copy - does this mean that hard-copy must remain in pharmacy for 7 years? I am concerned about storage of all these documents."

"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

"Section 67(1)", "We keep records for 7 years - is that not clear?"

"Section 67(1)", "No specification on how the records must be kept; electronically and/or hard copy."

"Section 67(1)", "Currently, hard copies are retained for 2 years since the last time the prescription was filled. However, since the hard copy is the likely place where the authorization, preparation and counselling record are retained, this would mean that these hard copies would now have to be retained for a minimum of 7 years. Currently, storage room for the 2 year requirement is difficult and increasing it to 7 years would be extremely difficult and perhaps costly. It would be cost prohibitive to have to rent extra storage place for your files."

"Section 67(1)", "7 years."

"Section 67(1)", "(j) Patient refuses Rx - we return to patient (no record of this).

(l)(m)(n) What is this regarding my practice?"

"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

"Section 67(1)", "It will take up a lot of physical space to house 7 years of hard copy for all dispensing/counseling/prescribing etc. records. Section 62(1) deals only with drug acquisition and sales which are also kept for financial reasons."

"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

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"Section 67(1)", "A 7 year requirement for retention of all records is too onerous for a pharmacy to maintain. Pharmacists should be focused on patient care, not warehousing paper."

"Section 67(1)", "Shouldn't have to keep a counselling record."

"Section 68(1.1)", "But remove reference to Sec 12 license."

"Section 68(1.1)", "none"

"Section 68(1.1)", "I don't work in a hospital so I don't feel qualified to comment."

"Section 68(1.1)", "Hospital formulary substitution often cause problems when patients return to the community. It's a common occurrence that patients are changed to a hospital interchangeable product in the hospital (ie: a particular PPI). When they are discharged, the substitution is written on their discharge prescription form yet the patient may still have a supply of their previous PPI at home. When they return they begin to use both medications."

"Section 68(1.1)", "A new prescription deemed equivalent... does this include automatic/therapeutic substitutions? This should also apply to other areas of a hospital or regional facility (i.e. ambulatory care clinics such as oncology, dialysis, home care etc.)."

"Section 68(1.1)", "If this recording requirement is unrealistic in hospital practice, then I believe it is unrealistic in community practice too then. There should be same rules for both."

"Section 68(4)", "I'm concerned about including (f) the drug lacks therapeutic value to the patient. This is a real grey area and I think pharmacists will be exposed to too much liability if it is included. For any drug, there will be differing opinions among health professionals and other "experts" as to whether it has therapeutic value or not I think (e) adequately covers the intent of (f).."

"Section 68(4)", "It is unreasonable to expect pharmacists to police physicians w.r.t. the rules governing the practitioners practice of his profession - I have not studied the medical act so how can I be responsible for if a physician is practicing ethically. The same applied to judging the therapeutic value of a prescription. As a retail pharmacist I cannot possibly know exactly what the physician is thinking or treating."

"Section 68(4)", "Allowance has to be made for eg a vitamin prescribed as a placebo ie no therapeutic benefit"

"Section 68(4)", "Pharmacist is not aware of all patient clinical information and "Off Label" use of drugs by some physicians."

"Section 68(4)", "This section does not involve whether or not a pharmacist believes a certain set of facts to be in existence but rather imposes upon the pharmacist an obligation to determine if he or she should have reason to believe

in a certain set of facts. This therefore involves a certain amount of objectivity and possible risk of hindsight judgement that may then place upon pharmacists the burden of going through an exercise of second guessing questions of judgement."

"Section 68(4)", "Section 68(4)(c) is clearly aimed at the IPS industry, and would make it easier for the MPhA to bring discipline proceedings against IPS pharmacists and pharmacies. It is a very difficult task for either the MPhA or a Manitoba pharmacist to know when a doctor wrote a prescription in contravention of the rules governing his or her practice, and (with respect) the MPhA's pronouncements in the past regarding this have been inaccurate and incorrect. An open and honest dialogue on this issue is needed if such a provision is to remain (whether or not the definition of "authorized practitioner" is amended in the fashion I've suggested above)"

"Section 68(4)", "none"

"Section 68(4)", "68(4) requires too much "policing" by pharmacists - how can we know every doctor's "usual" scope of practice- there are often mitigating circumstances where Dr. may prescribe outside his specialty. We seem to be assuming that we know more than doctors and that they are the ones who will be making the mistakes. We are not doctors and should not be responsible for deciding that a drug "lacks therapeutic value for the patient". This would increase our liability - if we fill a prescription correctly and there is a problem, we would be liable. What happens if we refuse to fill a prescription for one of these reasons, & the person complains to MPhA about us? Would you then put on our profile that there is a complaint against us even though we're just following these regulations?"

"Section 68(4)", "Section 68(4)(c) is clearly aimed at the IPS industry, and would make it easier for the MPhA to bring discipline proceedings against IPS pharmacists and pharmacies. It is a very difficult task for either the MPhA or a Manitoba pharmacist to know when a doctor wrote a prescription in contravention of the rules governing his or her practice and (with respect) the MPhA's pronouncements in the past regarding this have been inaccurate and incorrect. An open and honest dialogue on this issue is needed if such a provision is to remain (whether or not the definition of "authorized practitioner" is amended in the fashion I've suggested above). "

"Section 68(4)", "Needs clarification - re: Judgements pharmacists and hindsight."

"Section 68(4)", "Therapeutic value is very subjective."

"Section 68(4)", "B) Outside his or her scope of practice. What about when one doctor covers for another one who is away (continued care)?"

"Section 68(4)", "F) This is diagnosing?"

"Section 68(4)", "This section does not involve whether or not a pharmacist believes a certain set of facts to be in existence, but rather imposes upon the pharmacist an obligation to determine if he or she should have reason to believe in a certain set of facts. This therefore involves a certain amount of objectivity and possible risk of hindsight judgement that may then place upon pharmacists the burden of going through an exercise of second guessing questions of judgement."

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"Section 68(4)", "Allowance has to be made for eg a vitamin prescribed as a placebo ie no therapeutic benefit."

"Section 68(4)", "There should be a section to include authority for a pharmacist to refuse dispensing when there is reason to believe that patient has not been followed up in the last 12 months by the authorizing prescriber. This would be especially relevant in the case of medications for chronic illness where a once yearly follow-up would be reasonable or even for acute conditions that should have been resolved within a short time frame. Currently there are no limitations on prescription validity so that patients are able to abuse this loophole in terms of inappropriate drug use/purchase since pharmacists have limited legal power to stop them. This issue is partially covered by (e) but having a statement to clarify the timeline for validity would be more powerful in aiding a pharmacist's refusal to fill."

"Section 68(4)", "(f) The drug lacks therapeutic value for the patient. Sometimes drugs are prescribed for "off label use" and with very different doses than those given in references like the CPS."

"Section 68(4)", "This section does not involve whether or not a pharmacist believes a certain set of facts to be in existence, but rather imposes upon the pharmacist an obligation to determine if he/she should have reason to believe in a certain set of facts. This, therefore, involves a certain amount of objectivity and possible risk of hindsight judgement that may then place upon pharmacists the burden of going through an exercise of second guessing questions of judgement."

"Section 68(4)", "Would it be a cleaner statement to just say "prescriber" rather than practitioner or the extended practice pharmacist? They are all prescribers."

"Section 68(4)", "This section does not involve whether or not a pharmacist believes a certain set of facts to be in existence, but rather imposes upon the pharmacist an obligation to determine if he or she should have reason to believe in a certain set of facts. This, therefore, involves a certain amount of objectivity and possible risk of hindsight judgement that may then place upon pharmacists the burden of going through an exercise of second guessing questions of judgement."

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"Section 69(1)", "Many ingredients used in compounds are not Health Canada approved and some ingredients do not have any DIN's or NDC number and would then make the product unapproved as well."

"Section 69(1)", "Should allow importation."

"Section 69(1)", "none"

"Section 69(1.1)", "Many ingredients used in compounds are not Health Canada approved and some ingredients do not have any DIN's or NDC number and would then make the product unapproved as well."

"Section 69(1.1)", "Should allow importation."

"Section 69(1.1)", "none"

"Section 69(1.1)", "See above."

"Section C69(2)", "See above section 60(1)(c) for my comments."

"Section C69(2)", "See above section 60(1)(c) for my comments."

"Section C69(2)", "See above section 60(1)(c) for my comments."  
"

"Section C69(2)", "See section 60(1)(c) for my comments."

"Section 70(2)", "70(2)(b) What does the statement mean ???????? Does it mean that a practitioner could waive safety vials for all his patients carte blanche ??? Is so I'm definitely opposed. Even if it means a practitioner could waive safety vials on a patient by patient basis I'm not so sure . Is this not a patient decision ? Why would we even consider the opinion of a practitioner in this scenario?"  
"

"Section 70(2)", "Documentation."

"Section 70(2)", "I would like to see some discussion about what the MPhA considers to be a declaration "reasonable in the circumstances"."

"Section 70(2)", "none"

"Section 70(2)", "Concern with 70(2)c - while we should be competent to decide that 1 90 year-old patient with severe arthritis does not need a safety vial and in fact probably couldn't open one. I'm afraid that any decision we make now will only open us up to more liability in the rare cases where something unforeseen happens-such as for eg: his 2 year old great-grandson gets into his pills and swallows some"

"Section 70(2)", "I would like to see some discussion about what the MPhA considers to be a declaration "reasonable in the circumstances"."

"Section 70(2)", "What about all of the blister packs, many drugs come in non-child resistant containers. We can't document all of them."

"Section 70(2)", "By the member (iii) should be iii because you have 2 (ii)'s and should end as below."

"Section 70(2)", "After a verbal request by the patient or their designate for non safety containers, the request can be documented in the pharmacy software."

"Section 70(2)", "4(c) Member does not use safety container because of patient physical condition (i.e. arthritis, etc.)."

"Section 70(2)", "Does the statement about the practitioner not want any of their prescriptions in a child proof container or just for the prescription issued at the time for one patient?"

"Section 70(2)", "I would like to see some discussion about what the MphA considers to be a declaration "reasonable in the circumstances"."

"Section 72(1)", "Scope and enforcement."

"Section 72(1)", "Should include reference to sale of exempted codeine products

This comment if made in support of adding provision to the regulations to permit better control and monitoring of the sale of exempted codeine products.

It is with regret that I notice there is no mention of this in the draft regulations. Omission appears to be inconsistent with the MPhA mission statement. Many provinces, Alberta and Saskatchewan and others, have added regulations to control and monitor sale of these products. It would appear that they have seen need for this. My experience as a community pharmacist suggests that there is need for such a regulation in Manitoba.

My concern as the regulation now stands is that many pharmacists ignore their responsibilities regarding the OTC sale of codeine containing products. Pharmacists who attempt to exercise their professional obligations receive criticism and risk being censured by their employers. The problem of misuse and pharmacists' failures are so blatant that it is a mockery for any pharmacist to attempt to exercise control of sales as required by present standards of practice.

Questions about use and subsequent limits on quantity or refusal to sell is always met by surprise by members of the public. Most simply say they will go to another pharmacy where they have no need to answer questions or have supplies limited. NAPRA recognized the potential for problems in the Spring of 2001 and undertook to review issues in the hope that there could be some better definition of the problems. The issue was put on the record say "many pharmacists understand the poor risk benefit ratio of these products, and the difficulties associated in responsibly caring for patients under the current regulations. A study of this nature is long overdue and through NAPRA and NDSAC, pharmacy can work to improve the health and well being of Canadians." The hope at the time was that there could be merit in removing entirely the products from OTC sale.

To my knowledge, there has been no action on this issue over the past 6 years, save what has been undertaken by individual provincial associations. They (Alberta, Saskatchewan, Newfoundland, and perhaps others) seem to have recognized the value of, at least, documenting sale and maintaining a patient profile within the individual pharmacy. Manitoba has potential to make use of DPIN to allow monitoring of use. If leadership is needed, Manitoba should rise to the challenge and make appropriate changes to the proposed regulations. Resistance to this effort seems to come from pharmacy owners who fear the labour cost associated with the need for more defined involvement and do not see the potential for lost sales as a positive event.. I do not understand our reluctance to move forward on this issue.

Pursue and implement meaningful change or remove the present practice standard concerning pharmacists' responsibilities in the sale of exempted codeine products."

"Section 72(1)", "Where does delivery of RM's come in?"

"Section 72(1)", "Should include reference to sale of exempted codeine products (see note in attached (faxed) addendum). (see comments section)."

"Section C72(1)", "Re: Limitations on sale of particular drugs (72(1))

This comment is made in support of adding provision to the regulations to permit better control and monitoring of the sale of exempted codeine products.

It is with regret that I notice there is no mention of this in the draft regulations. Omission appears to be inconsistent with the MphA mission statement. Many provinces, Alberta and Saskatchewan and others, have added regulations to control and monitor sale of these products. It would appear that they have seen need for this. My experience as a community pharmacist suggests that there is need for such a regulation in Manitoba. My concern as the regulation now stands is that many pharmacists ignore their responsibilities regarding the OTC sale of codeine containing products. Pharmacists who attempt to exercise their professional obligations receive criticism and risk being censured by their employers. The problem of misuse and pharmacists' failures are so blatant that it is a mockery for any pharmacist to attempt to exercise control of sales as required by present standards of practice. My personal experience with a corporate employer who operates a major number of pharmacies in Manitoba was to be reprimanded for refusing a sale of an exempted codeine product. It was my professional assessment that the sale was inappropriate. I left the employer as a result. I did not feel I could continue to work in an environment that did not allow me to practice in a manner consistent with the standards. My current employer has chosen to discontinue the OTC sale of exempted codeine products because the current standards are not being enforced and abuse of these products is rampant. Questions about use and subsequent limits on quantity or refusal to sell is always met by surprise by members of the public. Most simply say they will go to another pharmacy where they have no need to answer questions or have supplies limited. NAPRA recognized the potential for problems in the spring of 2001 and undertook to review issues in the hope that there could be some better definition of the problems. The issue was put on the record to say "many pharmacists understand the poor risk benefit ratio of these products, and the difficulties associated in responsibly caring for patients under the current regulations. A study of this nature is long overdue and through NAPRA and NDSAC, pharmacy can work to improve the health and well being of Canadians." The hope at the time was that there could be merit in removing entirely the products from OTC sale. To my knowledge, there has been no action on this issue over the past 6 years, save what has been undertaken by individual provincial associations. They (Alberta, Saskatchewan, Newfoundland, and perhaps others) seem to have recognized the value of, at least, documenting sale and maintaining a patient profile within the individual pharmacy. Manitoba has potential to make use of DPIN to allow monitoring of use. If leadership is needed, Manitoba should rise to the challenge and make appropriate changes to the proposed regulations. Resistance to this effort seems to come from pharmacy owners who fear the labour cost associated with the need for more defined involvement and do not see the potential for lost sales as a positive event. I do not understand our reluctance to move forward on this issue. Pursue and implement meaningful change or remove the present practice standard concerning pharmacists' responsibilities in the sale of exempted codeine products.

"

"Section 72(1)", "Did you mean ""directives"" instead of ""directions""?"

"Section 72(4)", "none"

"Section 72(4)", "The way I understand this section, pharmacies could no longer sell drugs to doctors or dentists for office use."

"Section 72(4)", "Should have a Rx - what type of practitioner are we referring to. The words medical, dentist, vet. surgeon etc. are stroked out."

"Section 73", "Loyalty points is a non event"

"Section 73", "Inducements cheapen the profession, detracting from our role as health professionals and presenting pharmacists to some degree as sleazy salespeople. I'm concerned that the big business interests behind inducements will hold sway and succeed in removing this section."

"Section 73", "I do not believe a simple inducement plan, providing air miles for example, is a patient safety issue. It is the same as free parking free coffee etc. I do however do not agree with "double your points days" etc is appropriate. If pharmacies provide an inducement strategy it needs to be consistent through out the year with no bonus miles etc that could cause a patient to delay filling a prescription to take advantage of a special deal on a specific day."

"Section 73", "take it out completely. Loyalty programs do not result in reduced patient safety, this is a business practice issue plain and simple ( patient safety just sound like a better reason than our profit margins are shrinking and we don't like it )

Many steps can be done to help patient receive loyalty point without "going without Meds" filling early etc. If someone fills their Rx every 1-2 or 3 months exactly on time ie every 4, 8 or 12 weeks. Is that a patient safety issue - I don't think so. Many people stock up on 3 month of med at pharmacare year end and no one is complaining that this is a patient safety issue. You can still teach people that pharmacare rules, rules for early fills to insurance companies etc. have to be followed first before filling just so they can get the bonus points."

"Section 73", " We are in the "business" of people's wellness, not in the business of future travel considerations!"

"Section 73", "I feel that inducements are not conducive to proper pharmaceutical care"

"Section 73", "There is no evidence that loyalty programs affect patient safety. There are many loyalty programs that the bill has not mentioned."

"Section 73", "This regulation fails to acknowledge the role of the "Professional Pharmacist". A professional pharmacist puts patient safety number one and allows for the person to refuse to fill a prescription if the professional pharmacist feels the patient is at risk. For this reason no professional would be influenced by inducements. Inducements would only bring a person into a business not change the way the pharmacist protects and monitors health and thus is not an issue for these regulations"

"Section 73", "I agree that inducements are an issue of patient safety and professional practice."

"Section 73", "No concerns, I believe that this section should remain as written. This is not an issue of business practice, it is an issue of patient safety and promoting of optimal pharmacotherapy. This presence of inducements is contrary to our professional goal of promoting rational use of medications."

"Section 73", "This section needs to remain due to patient safety. A patient should not chose their pharmacy based on loyalty programs. I have concerns

about patients waiting for bonus days until they fill their prescriptions and then stocking up as well."

"Section 73", "Inducements should not be available on prescriptions. The quality of care the pharmacy provides, and not the type of inducement offered by the pharmacy should influence the patient's decision of when, where, and what quantity of medication to purchase."

"Section 73", "Inducements influence patients decisions on filling prescriptions in a negative way. By banning inducements on prescriptions, patients will fill their prescriptions when they actually require the drug and this will also help prevent patients from trying to stock up on drugs."

"Section 73", "Inducements do not have a place when selling prescriptions. This is a patient safety issue in many ways. The ' practice of pharmacy' should be the factor which influences the patient's choice of pharmacy -- not the bonus points that can be accumulated on a particular day!"

"Section 73", "The feedback I received from students completing their experimental education at these sites mentioned examples where patient safety was compromised during these days of "reward", not to mention the quality of their education. Also I imagine the cost to the MB government is greatly increased unnecessarily by this practice."

"Section 73", "There has been no evidence to suggest that inducements pose a risk to the public."

"Section 73", "On some intellectual level, I (believe I) understand the concern that leads the MPhA to want legislation on this point. However, I haven't seen enough from the MPhA explaining exactly what their concerns, or any discussion of what the alternative ways of dealing with the issue are, what other jurisdictions are doing, what their experiences have been, etc. At first glance, this would appear to be legislating something that's almost entirely a "business" issue; I know there's more to it than that, but I haven't heard enough from the MPhA on the point explaining why that's not the case (other than the general statement that it is at least in part an issue of patient safety and professional practice) and I'd like to.

Certainly, anything that inappropriately motivates a person to medicate (or not to medicate) would seem to be something that should be prevented, but immediately this requires a discussion of what is "inappropriate". Similarly, in a very real sense anything that motivates a consumer to have a prescription filled at a particular pharmacy (convenience, hours of operation, product selection, price, service standards exhibited by staff, etc.) is an "inducement" to the consumer. Which of them are inappropriate?

This is a very large, very contentious issue, and reasonable people could reasonably come to very different conclusions on the point. I would think that a necessary starting point before beginning such a discussion would be to identify "what the mischief?", and I don't feel that's been done. Everyone's got an opinion on this point, and there isn't likely to be any consensus reached easily. I'd really like to know whether there's a real problem here that needs to be addressed, or are we just arguing because it's a good argument? On the other hand, it's only the good fights that are worth having."

"Section 73", "Pt. safety & ethics - we should not be offering inducements in any kind of pharmacy practice ie) How many Pts. get/fill Rx's they don't even need just to get the air miles".

Secondly - how many of these pts. have 3rd party payers that pay for the drugs (they don't) & they still get to claim the air miles?? That doesn't seem right by any means."

"Section 73", "This comment is made in support of leaving the section as is in the final draft regulations position.

I am a Community Pharmacist working in a setting that provides inducements. Any suggestion that the offers are solely issues of business practice fails to recognize the day to day examples that I wish to share. I will list them randomly as they come to mind. Each and every one has direct negative impact on the health and wellness of the patients we serve. Most have significant negative impact on the overall cost of health care in our province. I will allow you, the reader of this, to form your own opinions about the outcomes of each of the examples and to decide how they best fit the MPhA mandate to protect the health and well being of the public by ensuring and promoting safe, effective and progressive pharmacy practice. I am a pharmacist whose primary concern is to contribute to the MPhA mandate and to protect the integrity of our profession. Inducements are detrimental to all principles of good pharmacy practice. Inducements must come to an end if we are to retain professional credibility and public confidence.

Please note, all these comments are submitted in CONFIDENCE.

"I've had this bad chest for a week. Can't catch my breath and I'm really coughing. Just went to the walk-in and got this prescription. Dr. said I had bronchial pneumonia. Do you have Air Miles today? Oh, no, not until next Tuesday? Well, I've waited a week anyway, I won't die over the weekend. Put is on file and I'll come for it Tuesday, if I'm still sick."

I've got this coupon for bonus points if I transfer my prescriptions from my regular pharmacy. The pharmacist there has been really good but I can get extra points from you. She'll still answer my drug questions when I call her. I've even called her at her home late at night. She is such a fine person."

"I know my Dr. and family want me and my wife to get medications in bubble packs. We have some trouble keeping our drugs straight. I don't want the packs because refills cycle every 28 days. That doesn't coincide with the once a month bonus Tuesdays. If I get the packs I don't get the Air Miles. I'll take my chances with taking the drugs properly."

"I know I'm a week overdue on my bubble packs. I didn't get them refilled because Senior's Day wasn't until this Wednesday. Oh, I've missed my digoxin and warfarin before. I'm saving for a new camera. I just need 250 more Air Miles. This refill does it."

"Can I have 3 months of each of these?" Ma'am, the DPIN shows you had 3 months filled at another pharmacy 5 weeks ago, and 3 months just 4 weeks before that. "So what? I don't reach my deductible and don't care about Pharmacare. Either my private insurance or my husband's will reimburse me. I went to the walk-in especially to get these prescriptions for 3 months. You have 10X Air Miles this week. Fill my prescriptions. If you won't, I'll take it to another Air Miles store that will."

"Is this Tuesday 10X Air Miles? OK, please fill my Betaseron for pick up

Tuesday" (\$1300 and covered 100% by Pharmacare). Prescription is valid for 1 year, original fill date 7 months ago. 5 refills remain. Prescribing physician has left province, still licensed in Manitoba. Even though Rx has valid refills remaining. Pharmacist's decision is to check with program to renew Rx and have it authorized by the physician now caring for patient. Program is phoned.

Response to inquiry: "Oh, Mrs. D's MS became active again 4 months ago.

Betaseron is only to be used during remission. She doesn't need to be on it now, and our notes show that she has been told that." Follow-up with patient:

"Yeah, I know I'm not using it anymore. I'm pretty sure I'll go into remission again and will be started on it again. It's free and I get the bonus Air Miles so I was getting it filled. It's stable stuff and will keep. You don't even have to keep it in the fridge anymore". Prescription was deactivated and not filled. Customer was very unhappy.

Unresolved question: do you pursue reversal of the Pharmacare payments and attempt to recover costs from patient? In absence of the Air Mile bonus, the issue would never have arisen. Is this an isolated instance of abuse? I expect not.

"I've learned that I can get 44 boxes a year of my One Touch glucose strips and lancets and have them covered by Pharmacare. It's 10X Air Miles today so here is my prescription good for a years supply of strips and lancets. Can I have 4 boxes? (\$320). I get 3 or 4 boxes every month; every time you have the 10X offer." Pharmacist checks DPIN and store RX Hx and finds patient using glyburide 5 mg BID. Use has been continual at single drug and same dosage for 6 months. Store Rx Hx goes back 2 years and shows same pattern. Physician is called to verify frequency of testing to determine the appropriate supply for a month. Physician's response is that the patient test whenever he wants. "I don't care how much he uses. If he wants to test 10 times a day, it's OK with me. He says it's covered by Pharmacare and you guys give some kind of bonus once a month. Whatever he wants is OK with me".

"If I buy glucose strips do I get a monitor for free? I've met my deductible, Do I get Air Miles for the meter and strips and the bonus Air Miles" OK, Here is my prescription for strips and lancets. How long do I have to wait? Prescription is filled and meter is set aside. Patient has submitted a name, address, DOB and PHIN. Patient does have a DPIN Hx showing some use of oral hypoglycemics but has no Rx record at the pharmacy. On picking up to Rx patient admits to this being his 3rd new meter in as many months.

"The next bonus Air Miles day is next Tuesday. I'm going to run out of my blood pressure medications on Friday. Can you advance me enough until Tuesday? No! I don't want to have to pay for them. Just put a few pills in a bottle so I will have enough. I'll get the prescriptions filled Tuesday. If you don't do that, my blood pressure will go out of control and it will be your fault!"

"I've been waiting in line for 20 minutes. All I want to do is pick up my prescription and get home. I went to the Dr. because I was so sick. Waited in his office for 2 hours and now I have to wait again. Why the line up? My prescription should be ready. The Dr. phoned it in while I was in his office an hour ago". Sir, I'm sorry. You have the misfortune of coming to us for your Rx on an Air Miles bonus day. Your Rx may not be filled yet. Let me check. No, we have been so busy, we haven't even started.

"Thank you for putting this through the cash for me. The drug is new for me. I thought I could speak with the pharmacist. Why are you so busy? I guess no one has any time. Ma'am, it is Air Miles bonus day. If you step over here, I'll get the pharmacist for you".

"We're really busy. Did you want to speak to the pharmacist about your medications? Oh, I see they are all refills. You've had them before. No problems, eh?" Customer, "I've waited in line long enough. No, I don't have any questions now".

"Oh, he's on holidays this week. We have no staff replacement and it's Air Miles all week. I guess they will finally get the script count over 7 per man hour. Well, last week was normal and we ended at 4.5 per hour. It was nice to be able to do things properly. We won't do much counseling this week".

"Section 73", "I don't have a problem with pharmacies offering points to patients as long as they pay for their prescriptions. If a person is receiving medication for free ie: pharmacare, welfare, DVA, FCH, etc., they they should not be getting points or incentives....."

"Section 73", "On some intellectual level I (believe I) understand the concern that leads the MPhA to want legislation on this point. However, I haven't seen enough from the MPhA explaining exactly what their concern is, or any discussion of what the alternative ways of dealing with the issue are, what other jurisdictions are doing, what their experiences have been, etc. At first glance, this would appear to be legislating something that's almost entirely a "business" issue. I know there's more to it than that, but I haven't heard enough from the MPhA on the point explaining why that's not the case (other than the general statement that it is at least in part an issue of patient safety and professional practice), and I'd like to.

Certainly, anything that inappropriately motivates a person to medicate (or not to medicate) would seem to be something that should be prevented, but immediately this requires a discussion of what is "inappropriate". Similarly, in a very real sense anything that motivates a consumer to have a prescription filled at a particular pharmacy (convenience, hours of operation, product selection, price, service standards exhibited by staff, etc.) is an "inducement" to the consumer. Which of them are inappropriate?

This is a very large, very contentious issue, and reasonable people could reasonably come to very different conclusions on the point. I would think that a necessary starting point before beginning such a discussion would be to identify "what's the mischief?", and I don't feel that's been done. Everyone's got an opinion on this point, and there isn't likely to be any consensus reached easily - I'd really like to know whether there's a real problem here that needs to be addressed, or are we just arguing because it's a good argument? On the other hand, it's only the good fights that are worth having."

"Section 73", "Our concern should be patient safety not business decisions."

"Section 73", "Keeping pharmacy professional"

"Section 73", "I have heard the arguments made by both sides and I still believe that we need to separate the business aspect from the practice of Pharmacy. After repeatedly asking for proof that public safety is compromised. I still have not seen any evidence that loyalty points pose a public safety issue. I would agree that event days (10X bonus days) tend to create some anxiety in the workplace for some members (as per comments at various sessions) and as such, I would support the exclusion of these inducements as responsible business

practice. I still believe that as rational and ethical practitioners, we have the ultimate power in deciding when a patient gets their prescription and that, ultimately, patients come to us for our knowledge and not for how many optimum points or air miles they will receive. I still support the omission of this section."

"Section 73","I think you should allow all inducements or allow none. If you take away inducements in all pharmacies compliance in all pharmacies will go down. For people that have to take so many meds (and getting side effects that-med no), this gives them a little bit more of a push to come in in time, and refill their very important medication. If all pharmacies do this, this is helpful to patient compliance all over. Keeps them from coming in late. It makes it more difficult for us a bit, but it is great for compliance (that they come in regularly). If you take away inducements (like free parking also) there are more negatives and less positives to the trip into the pharmacy"

"Section 73","I am not in favor of inducements. Why should you get rewards for Rx's paid for by pharmacare - ie; diabetic strips after you reach your deductible. "

"Section 73","The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a businesses right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned, the onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=29>, the NBPS & NSCP Final Research Results (February 2005) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=28>, as well as the Ratiopharm CFP Report on Pharmacy Services: Consumers' Perception of Pharmacy (2004) available for viewing at [http://www.ratiopharm.ca/pdf/cfp\\_eng.pdf](http://www.ratiopharm.ca/pdf/cfp_eng.pdf)."

"Section 73","The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a businesses right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned, the onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=29>, the NBPS & NSCP Final Research Results (February 2005) available for viewing at <http://www,msp.mb.ca/bill41-regulationsview.asp?ID=28>, as well as the Ratiopharm CFP Report on Pharmacy Services: Consumers' Perception of Pharmacy (2004) available for viewing at [http://www.ratiopharm.ca/pdf/cfp\\_eng.pdf](http://www.ratiopharm.ca/pdf/cfp_eng.pdf)"

"Section 73","Consumers' Perception of Pharmacy (2004) available for viewing at [http://www.ratiopharm.ca/pdf/cfp\\_eng.pdf](http://www.ratiopharm.ca/pdf/cfp_eng.pdf)"

"Section 73", "Inducements can lead to poor patient compliance and can add huge costs to the health care system."

"Section 73", "This section appears to regulate pharmacy business and not pharmacy practice."

"Section 73", "The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a business' right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned. The onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=29>; the NBPS & NSCP Final Research Results (February 2005) available for viewing at <http://www.msp.mb.ca./bill41-regulationsview.asp?id=28>; as well as the Ratiopharm CFP Report on Pharmacy Services: Consumers' Perception of Pharmacy (2004) available for viewing at [http://www.ratiopharm.ca/pdf/cfp\\_eng.pdf](http://www.ratiopharm.ca/pdf/cfp_eng.pdf)."

"Section 73", "While I am not a retail pharmacist, I am a member of the profession and do not see a role for inducements as a health care professional. If this section is not included, there exists a potential conflict of interest for a profession involved in selection of drug therapy but also providing patients with rewards for medications of higher expense."

"Section 73", "There must be clear definitions of loyalty points, gifts, rebates, bonus or inducements. I do not believe that any type of service that is related to the person receiving their medication should be considered an inducement (ie: free delivery of free parking is not an inducement because if it were not offered it may actually increase barriers to access). Health pamphlets/brochures and clinics are not considered an inducement either because it is a part of the pharmaceutical care model. I do not believe that the fear mongering from the corporate lawyers threatening legal action if inducements are regulated be considered."

"Section 73", "My only concern would be is if this section doesn't make it through to regulations. Patient safety is of course a concern with current inducement practices. Improper filling of unnecessary medications, patients not filling medications according to when they need them, increased workload on certain days, government paying for people to collect rewards, "cheapening" the pharmacist's professional role by associating us with rewards; these are just some of the reasons that inducements on prescriptions should be eliminated."

"Section 73", "Pharmacies use many different inducements to attract patients to their pharmacy and if MPHA wants to ban some of them (ie: loyalty programs) then they must ban all of them (free parking, or free delivery)."

"Section 73", "I feel that inducements are not conducive to proper pharmaceutical care."

"Section 73", "These pharmacy practice legislation should not be concerned with inducements as they are a matter of pharmacy business. As long as pharmacists

are held responsible for public safety, patients will be provided for. It is not the place of pharmacy practice legislation to penalize/limit pharmacy business when there are other factors in play such as lack of responsible prescribing practices and patient autonomy over their own health care choices. As well, if concrete proof is unable to be provided regarding patient harm, these legislations should not be allowed to pass. That being said, inducements should be available everyday on a regular basis without any "special days" or limited time offers as manipulation of inducements has a greater risk for changes in patient drug consumption behaviors. As for patient profiting over \$0 co-pay prescriptions, the ability to receive inducements should be up to the third party payer."

"Section 73", "I do not think that any kind of loyalty or affinity program should be offered on any prescription drug."

"Section 73", "No risk to the public in any studies."

"Section 73", "See note in attached (faxed) addendum. (see comments section)."

"Section C73", "Re: Inducements

This comment is made in support of leaving the section as is in the final draft regulations position.

I am a Community Pharmacist working in a setting that provides inducements. The setting does not provide for "bonus" inducements. The practice is very different from my previous employer where bonuses were the rule and tended to encourage abuse and misuse of medications. Inducements that encourage loyalty may represent good business practice where they foster the use of a single pharmacy and encourage strong relationships between the pharmacist and the patient. This can lead to improved pharmaceutical care. The risk of inducements remains when they encourage excessive and inappropriate use of prescription drugs. Inducements need not be part of pharmacy practice with respect to prescriptions. Total restriction would allow the creation of a level playing field. If inducements are allowed, even the benign nature of the ones currently available at my pharmacy, one has to recognize that they add to the cost of service and do nothing to enhance the pharmacy resources available to be used in patient care. I support a total ban on inducements as defined in the draft document."

"Section 73", "The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a business' right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned. The onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=29>, the NBPS and NSCP Final Research Results (February 2005) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=28>, as well as the Ratiopharm CFP Report on Pharmacy Services: "

"Section 73", "I really hope that council stands its ground on this issue."

"Section 73", "The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a business' right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned, the onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.ca/bill41-regulationsview.asp?ID=29>; the NBPS and NSCP Final Research Results (February 2005) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=28>; as well as the Ratiopharm CFP Report on Pharmacy Services: Consumers' Perception of Pharmacy (2004) available for viewing at [http://www.ratiopharm.ca/pd/cfp\\_eng.pdf](http://www.ratiopharm.ca/pd/cfp_eng.pdf)."

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"Section 73", "On some intellectual level, I (believe I) understand the concern that leads the MphA to want legislation on this point. However, I haven't seen enough from the MphA explaining exactly what their concern is, or any discussion of what the alternative ways of dealing with the issues are. What other jurisdictions are doing, what their experiences have been, etc. At first glance, this would appear to be legislating something that's almost entirely a "business" issue. I know that there is more to it than that but I haven't heard enough from the MphA on the point explaining why that is not the case (other than the general statement that it is at least in part an issue of patient safety and professional practice) and I'd like to. Certainly, anything that inappropriately motivates a person to medicate (or not to medicate) would seem to be something that should be prevented but immediately this requires a discussion of what is "inappropriate". Similarly, in a very real sense anything that motivates a consumer to have a prescription filled at a particular pharmacy (convenience, hours of operation, product selection, price, service standards exhibited by staff, etc.) is an "inducement" to the consumer. Which of them are inappropriate? This is a very large, very contentious issue and reasonable people could reasonably come to very different conclusions on the point. I would think that a necessary starting point before beginning such a discussion would be to identify "what's the mischief?" and I don't feel that's been done. Everyone's got an opinion on this point, and there isn't likely to be any consensus reached easily. I'd really like to know whether there is a real problem here that needs to be addressed or are we just arguing because it's a good argument? On the other hand, it's only the good fights that are worth having."

"Section 73", "WITH ADJUSTMENTS!!

The proliferation and increasing inducements for refilling will lead to intense competition amongst large chain stores, leading to increased abuse and waste of expensive medication which is not consistent with good health maintenance. I fear that would lead to large unnecessary increases in health care cost to taxpayers. The solution? All dispensaries in chain store pharmacies have separate cash registers so it would be relatively simple to change their inducement recording and collection process at the dispensary location in the store.

"

"Section 73", "The RAC vote was tied 4:4 in regards to removing this section. There has been no evidence to suggest that inducements pose a risk to the public in any studies done to date. There is legal precedent to show that this section would violate a business' right to advertise and promote itself under the Charter of Rights and Freedoms. The onus should not be upon members or business to prove that there would be harm to the public if inducements were banned, the onus should be on the Association to prove that harm is inherent with inducements or to remove this section in its entirety. To support this position there have been a number of studies done including the SCP Final Research Results (July 12, 2006) available for viewing at <http://www.msp.ca/bill41-regulationsview.asp?ID=29>; the NBPS and NSCP Final Research Results (February 2005) available for viewing at <http://www.msp.mb.ca/bill41-regulationsview.asp?ID=28>; as well as the Ratiopharm CFP Report on Pharmacy

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"Section 73", "Customers do not come to the pharmacy I work in since they do not get airmiles or shopper's points for their purchase. At one of my previous jobs a customer asked me WHY she should get her prescriptions with me.. do I offer any incentives as to why she should get her prescription filled with me. I was taken aback at that comment and thought is this what these programs i.e airmiles etc. have done for people... they have to get SOMETHING else for every dollar paid? I say airmiles and shoppers points are okay for everything in their store EXCEPT prescriptions and tobacco. But this is how these companies get people to come to their stores. I'm surprised something has not been done sooner regarding these ""bonus"" incentives."

"Section C75(1)", "Application for dispensing practitioner: Where in the act does it cover physician dispensing or giving drug samples to patients."

"Section C76(1)", "This phrase makes absolutely no sense under any context - could this be clarified???"

"Section C76(3)", "A dispensing practitioner cannot delegate the following task:  
(a) sell a drug by retail.

When you take your dog or cat to a Vet, he/she says your pet needs a drug (penicillin/heart worm medicine), the girl behind the counter goes and gets it, gives it to you, takes your money and away you go."

"Section 84(1)", "none"

"Section 84(1)", "III. Competency assessment acceptable for council?"

"Section 84(1)", "This seems to be a new area and I believe that specialty qualifications should go through a specialty board. If they are in the middle of establishing these boards, perhaps waiting for the board and consulting with them on the qualifications would be in order."

"Section 84(2)", "none"

"Section 85(1)", "none"

"Section 85(1)", "No pharmacist member is present in the committee."

"Section 85(1)", "Make up of committee - could be conflicts with nurses as the extend their practice."

"Section 85(1)", "Do pharmacists and/or members of other professional bodies sit on the advisory committees for nurses/doctors etc."

"Section 85(1)", "What is the difference from a specialty practice pharmacist and an extended practice pharmacist? Are they not the same? Why not call it the specialty AND extended practice pharmacists advisory committee?"

"Section 86(1)", "I agree with prescribing medical devices approved by Health Canada, I shouldn't have to call the doctor to get someone an aerochamber. I do think we are opening up a can of worms if patients know we can prescribe OTC meds. most insurance companies don't cover OTC meds anyway so why do we need to write a Rx for them"

"Section 86(1)", "Maybe it is just me, but I find this section confusing -- what about products without DIN or natural health product numbers? Are there any outside of all these sections that we might need to worry about?"

"Section 86(1)", "Issue is the restriction to Sec 12 pharmacists"

"Section 86(1)", "none"

"Section 86(1)", "Drugs we can 'prescribe' are basically OTC meds - most drug plans do not cover OTC meds even when they have a prescription. This seems to only increase record keeping, increase liability and inconvenience patients due to all the documentation we will now have to provide for our recommendations. Also, as someone else pointed out, many people want OTC on prescription, just to save the tax - also very time consuming. My main concern though is with the increased liability - we are being expected to prescribe given limited information - we do not have test results, know exactly what else patient is on, what other conditions patient may have. Also, recommendations for products are often for someone who is sick at home and not even in the pharmacy. How can you expect us to prescribe for someone we don't even see. In spite of our knowledge, we are NOT doctors, and those who want to be should go to med school."

"Section 86(1)", "How would this apply to hospital pharmacists, or will this be clarified in the Standards?"

"Section 86(1)", "I agree with prescribing medical devices approved by Health Canada, I shouldn't have to call the doctor to get someone an aerochamber. I do think we are opening up a can of worms if patients know we can prescribe OTC meds most insurance companies don't cover OTC meds anyway so why do we need to write a prescription for them."

"Section 86(1)", "Very disappointed that we have not initiated any small formulary of schedule drugs with additional training."

"Section 86(1)", "Will conflict with 3rd party payers?"

"Section 86(1)", "This is a worthless addition - we already do this - it is merely a matter of who preps."

"Section 86(1)", "I don't believe that this goes far enough. Although we have had the authority to continue care prescriptions for some time, there are certain times/conditions when a pharmacist has the expertise to prescribe a schedule I product. I hope that in the near future we can expand the scope from schedule 2 and 3 products to include schedule 1 products with certain conditions. Will insurance companies and NIHB consider a pharmacist as an authorized practitioner for the prescription to be valid for billing. With many NIHB audits underway, it is very important to find out the ramifications of these regulations. Will NIHB in fact consider these prescriptions to be valid."

"Section 86(1)", "I only agree to 86(1)(d) = the rest, one would have to get and document a medical history that not all pharmacists have time or get paid to do. ie: to get patient's name, address, phone #, allergies, medications that they were on and what if they can't remember the drug names & they had them filled at another pharmacy? This seems a lot of work to place on pharmacists. Medical devices are okay, but products with DIN or NPN - you would have to take the time

to get a more complete medical history. This is doubling up on a physicians work ie taking a medical Hx."

"Section 87", "Typo in (a) "...a reasonable inquiry..."

"Section 87", "87(b) This clause is too restrictive and not practical in many cases - elderly , challenged patients etc.

We and physicians now provide service to many patients through agents, home care nurses/workers , palliative care services or via electronic means that we rarely if ever see "in person". Often these patients are the most vulnerable with the least ability to access traditional care and have the greatest need of medical service in any form.

"

"Section 87", "should prohibit internet pharm from prescribing for US clients but what if the pharm travels to a us location to provide the assesement? We need to be sure this doesn't happen"

"Section 87", "Typo in (a) "...a reasonable inquiry..."

"Section 87", "Typo in (a) "...a reasonable inquiry..."

"Section 87", "Should 87(c) be modified to take out "drug" or modified to say "drug or device" as medical devices are now within the prescribing authority."

"Section 87", "Your definition of "prescribe" means to authorize the dispensing of a specified drug in a specified amount for use by a named individual. Does this mean we are prescribing when refills and new prescriptions are ordered. According to the above definition we are. Under section 58(1) the pharamacist must authorize the filling of a schedule 1 drug. If this is the case then under 86(1) schedule 1 drugs we would not be able to dispense because they are not defined. Also if this is the case we would not be able to fill a prescription unless the person was assessed. Under 87(b) in person at the pharmacy. Section 87 (b) says patient must be assessed in person however 87 (g) says you can talk to patient or agent which contradicts 87(b). How does 87(b) apply to telepharmacy to prescribe for these patients who are miles away from me in person is in front of me physically. I also have a concern about "assessed in person" I being a retail pharmacy in rural area have to deal with patients agents all the time and under this prescribing by members regulations puts me in a ethical dilemma. Do I prescribe for a wife a schedule 3 drug which the husband is picking up say for the flu and has asked your advice since we our the drug experts. I tell him no sir I have to speak to her in person my regulations says I can't help you "make your choice. "I think this part of the regulations need to be addressed: Health Links uses a telephone assessment protocol as do other health agency and I can't see no reason for this to be incorporated into our regulations. I find I get better response by telephone then in person due to privacy concerns. Documentation can take place who the drug should be for and how to release it to the patient or agent. Section 87(c) covers drugs that must be counseled in person as with plan B."

"Section 87", "none"

"Section 87", "As above section 86(1), plus what exactly is our usual scope of practice or specialty 87(c) - if we are a community practice pharmacist, also

(g) how would we be expected to know all alternative therapeutic options and their costs?? This is putting unrealistic expectations on pharmacists and increasing their liability."

"Section 87", "I wouldn't feel comfortable prescribing."

"Section 87", "Typo in (a) "...a reasonable inquiry...""

"Section 87", "87(b) There are many times that a patient's designate visits the pharmacy to pick up a schedule 2 or 3 product. It is not always possible to assess the patient in person before prescribing a schedule 2 or 3 product."

"Section 87", "Typo in (a) "...a reasonable inquiry...""

"Section 87", "I feel pharmacists can advise patients. I am not too sure if we understand the implications of prescribing. Our insurance (liability) will sharply increase and we are also leaving out an important factor in the equation of beneficial health care to the patient... the medical doctor. Their doctor will not know what other medicines they are getting. by prescribing for the patient for the fact to be "covered as a benefit under a drug plan" seems to me to be taking advantage of your pharmacist."

"Section 90(1)", "I agree with adding b but if we can't contact prescriber, how can we comply with 90(2) a"

"Section 90(1)", "A Pharmacy Manager in a hospital needs to be allowed to make a decision about continous care RX's"

"Section 90(1)", "none"

"Section 90(1)", "How could we know exactly when a doctor died or retired? What if we were off by a few days, would we be liable for that?"

"Section 90(1)", "This means we cannot emerg fill a ventolen inhaler unless we have previously have to contact the Dr. and he hasn't responded. So if someone shows up on the weekend, we cannot do any emerg fill????

b) Or the pharmacist believes that the Dr. would refill the Rx if the Dr. could be contacted (ie: this Dr. does do repeats without being seen."

"Section 90(1)", "e) maybe could fill from another pharmacy if the original pharmacy was confected like a copy for patients who are away and forgot their meds, etc."

"Section 90(1)", "How is this different from what we already do?"

"Section 90(1)", "90(1)e - if sections a, b, c, d, and f are all fulfilled, could we not find a way to modify e so that a pharmacist can give an emergency supply of medication to a patient if there is no repeats on an Rx when you call for a copy and you are able to verify all necessary information with the patient's regular pharmacy. (ie: there are often people who are traveling who run out of meds or forget them and when you contact their pharmacy there are no repeats, doctor is not available and then there is little we can do to assist them in getting their blood pressure meds, etc."

"Section 90(1)", "I agree to all sections but 90(1)(b) = if a physician has retired or moved to anothe province, their prescribing number is still valid

past the day they retired or left. I believe a death is a separate matter but I believe for a retirement or move to another province does not cut off a patients medications - they are still valid for a short time to help patients have their medications until a new doctor is gotten."

"Section 90(2)", "In certain cases, contacting the original clinic would be preferable to contacting the original practitioner. For example, if one doctor has left rural Manitoba for another location, be it Winnipeg, elsewhere in Canada, or the U.S., it doesn't make sense to contact the original prescriber. On the other hand, it makes a lot of sense to contact the clinic where that prescriber was practicing until recently, to keep the patient's chart accurate and give the new doctor a more complete picture."

"Section 90(2)", "90(2)a seems to need rewording or a new statement as it is in conflict with 90(1)b - if the practitioner has DIED or is RETIRED it would be impossible /useless to try to notify him/her."

"

"Section 90(2)", "When we phone the doctors to let them know of a continued care prescription the doctors don't care."

"Section 90(2)", "Where an original prescriber has died or left the province it may be impossible to comply with sec 90(2)(a)"

"Section 90(2)", "If we are being trusted to add one more refill, for someone with a chronic condition, why do we have to promptly tell the doctor. Most doctors wouldn't know or care how many refills a patient has left on their Rx - they just want them to keep taking their meds. This would be bothering them about a minor detail."

"Section 90(2)", "Continued care prescriptions are not a norm in our practice but have been given out to patients who are unable to see their regular physicians (eg: absence of physician because of holidays) and to whom a trip to the walk-in clinic would not be convenient. In these cases, immediate notification of physician is not possible."

"Section 90(2)", "Regarding the statement of advising the "original prescriber" of the continued care prescription, there should be an exception to be made when the original prescriber has passed away or are no longer in practice/unreachable. There should be clarification as to who gets contacted after a continued care prescription is dispensed."

"Section 90(2)", "Where an original prescriber has died or left the province, it may be impossible to comply with Sec 90(2)(a)."

"Section 90(3)", "In 90(3)(b), which regulations? The regulations of the Pharmaceutical Act or the regulations of the Controlled Drugs and Substances Act?"

"Section 90(3)", "none"

"Section 90(3)", "Sometimes in elderly a sleeping pill Rx is needed - patient has been on medication for long time. We can not give if benzodiazepine?"

"Section 90(3)", "90(3)(a) the pharmacist should use his best judgment possible ie: authorize the smallest amount. ie: one month only. Also should not allow refills on hypnotics ie: zopiclone, benzos, controlled, narcotics or targeted products."

"Section 90(4)", "Now we are req to keep a record as if it was an original Rx, but we won't have to under these regs this correct??"

"Section 90(4)", "none"

"Section 90(4)", "All the documentation would be available on the profile & stated clearly under the drug that is "refilled" as continuing care. My current practice assigns a new Rx # to continued care Rx"s & documented as such."

"Section 90(4)", "Why shouldn't a prescribing record be required to be kept? A doctor makes a note on a patients file when a prescription is given to protect himself and keep records up to date. Why shouldn't we do that too?"

"Section 91(1)", "Typo in (b): "...otic...".  
What about other routes eg pr, pv, etc? If pharmacists want to administer drugs, they should have authority to administer by all routes, not just the "non-icky" ones. This could be included under 91(4) if it is felt additional training is required."  
"

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"

"Section 91(1)", "Here again, an intern has privileges that a Sec 13 pharmacist does not."

"Section 91(1)", "none"

"Section 91(1)", "I don't mind giving someone a pill to take, but I don't really want to be putting in their eye drops."

"Section 91(1)", "Typo in (b): "...otic...".  
What about other routes eg pr, pv, etc? If pharmacists want to administer drugs, they should have authority to administer by all routes, not just the "non-icky" ones. This could be included under 91(4) if it is felt additional training is required."  
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What about other routes i.e. pr, pv, etc? If pharmacists want to administer

drugs, they should have authority to administer by all routes, not just the "non-icky" ones. This could be included under 91(4) if it is felt additional training is required."

"Section 91(1)", "Otic is spelled incorrectly."

"Section 91(1)", "Inconsistent wording - insert "which is" (i.e. a drug which is listed..)"

"Section 91(1)", "I do believe that pharmacists doing tasks other than 91(1) should have or take additional training."

"Section 91(4)", "none"

"Section 91(4)", "I don't think it is practical for pharmacists to be giving injections - there will be misunderstanding on the part of the public - they will think all pharmacists can do this and will show up for their vaccines or whatever and expect us to inject them. By the way, what is the remuneration for this."

"Section 91(4)", "Subcutaneous injection of epinephrine during an emergency."

"Section 92(1)", "All this information is included in the patient chart for hospital patients."

"Section 92(1)", "All this information is included in the patient chart for hospital patients."

"Section 92(1)", "All this information is included in the patient chart for hospital patients."

"Section 92(1)", "none"

"Section 92(1)", "More cumbersome and time-consuming record-keeping."

"Section 92(1)", "Record keeping for drug administration"

"Section 92(1)", "All this information is included in the patient chart for hospital patients."

"Section 92(1)", "All this information is included in the patient chart for hospital patients."

"Section 92(1)", "This requirement should be waived if a member:  
(1) administers meds from a bubble pack, dosette, etc., either in the pharmacy or in the patient's home; or  
(2) administers eye drops etc. in patient's home (including teaching of technique) - provided an entry is made in any administration record kept in the patient's home."

"Section 94(1)", "Too constraining for hospital pharmacists"

"Section 94(1)", "it is not practical to record every blood glucose interpretation or blood pressure interpretation. If we start asking patients all kinds of personal questions I'm afraid people will stop asking us questions or they will get offended. We don't have to document what we spec said to

patients when we counsel them, it is implied that we will be following the standards of practice, we just have to document that we did the counselling so why do we have to document what we said when we interpret a test. We don't have to document when someone calls us to ask a drug related question so once again why do we need to have a test interpretation record. for the most part we are simply going to tell the patient that they need to see a doctor or reassses things, however we may intrepret that they need to go right away vs waiting to make an appt. but I don't feel this needs to be documented."

"Section 94(1)", "According to 94(1) a member who interprets and advises a patient-administered test must make and retain a record in the pharmacy. This is to what value? If it was a pharmacist administered test, this would make sense however a patient administered test seems unnecessary. It may be more valuable to say, if a patient has a medical review of tests whether patient or pharmacist administered, a record of the review should be kept. This would allow for a regular counseling and rudimentary advice to be given in the course of the pharmacy practice and if the patient would like a comprehensive answer which would require time and research, then this activity would be recorded and kept for record keeping."

"Section 94(1)", "What if patient refuses to give his/her name because of sensitive nature of tests such as pregnancy tests?"

"Section 94(1)", "none"

"Section 94(1)", "Time-consuming and cumbersome recording requirements."

"Section 94(1)", "Does this also apply to the hospital setting?"

"Section 94(1)", "Yes"

"Section 94(1)", "Too much documentation for patient administrative test."

"Section 94(1)", "A community pharmacist makes numerous recommendations daily, why does this section arbitrarily single out patient administered tests? Why do recommendations on health care or OTC products need not be recorded? Any recommendation given by the pharmacist as a result of the misinterpretation of information provided by the patient has the potential to cause harm. Furthermore, the pharmacist is not likely to have time for a follow-up with the patient given the current workload at the community level.

This section intrudes on personal privacy and may deter the patient from seeking advice from the pharmacist. If the patient wishes to have the advice from the pharmacist without having to disclose personal information but the pharmacist insists on collecting such information, the patient-pharmacist relationship can be severely strained . Recall the prominent media reports of various women's groups' negative reactions to the requirement for documenting the dispensing of Plan B. The lesson that we should learn from that experience. is that we are supposed to facilitate, not to hinder patient care. "

"Section 94(1)", "This is better than before, but if someone walks in to test their bp it's not like we have their name and address already. How do we get that if they don't want to give it. Does this include the bp reading and sending them to emergency?"

"Section 94(1)", "This is part of counseling and not necessary."

"Section 94(1)", "Does recommendation include referral to physician or other health care provider?"

"Section 94(1)", "This regulation introduces cumbersome and unnecessary record keeping requirements. It appears to regulate pharmacy business and not pharmacy practice. Pharmacist's time would be better spent counseling patients instead of keeping records. "

"Section 94(1)", "Would this include questions regarding fever (thermometer readings) and advice?"

"Section 94(1)", "The changes from the previous document are improved, however, the recording will still be a challenge. Currently not all software programs have the capacity to record this type of information so that leaves recording information on a hard copy."

"Section 94(1)", "All these records may still prevent pharmacists from giving advice. For example, pharmacies with blood pressure monitors have people who just shoot out their BP readings. If somebody states a high reading and you recommend retesting later or making an appointment with doctor, you then have to find out name, address, etc. from a person who might not want to take the time to provide you with information and many would question why it is necessary."

"Section 94(1)", "This will limit pharmacists as the most accessible health care professional as many pharmacists may not advise patients on their blood pressure/sugar levels if they have to document every little detail."

"Section 94(1)", "This section should be clarified. The test interpretation record should be recorded only if a test has been interpreted AND recommendations made by an extended practice pharmacist who has the authority to make drug therapy changes. Recommendations made by a pharmacist unable to alter drug therapy as a result of interpreting test results would ultimately lead to the patient seeing a doctor or a doctor being involved which would mean the final recommendation would not be made by the pharmacist."

"Section 94(1)", "We do this hundreds of times a day - why do we need to make a record?"

"Section 94(1)", "Is a member who examines a patient's log book of blood glucose results ""interpreting"" a test?"

"Section 94(1)", "Some people may not want to give their name and address ie pregnancy test. I find it difficult to understand why test interpretation results/advice given must be recorded when a prescribing record doesn't have to be noted?! I do not understand this rationale."

"Section 96(1)", "Too constraining for hospital pharmacists"

"Section 96(1)", "All this information is included in the patient chart for hospital patients. Subsection (h) is only applicable if another health professional is contacted under 95(4)"

"Section 96(1)", "I feel that 96 I, h is still not clear enough. How does (d) differ from (h)"

"Section 96(1)", "All this information is included in the patient chart for hospital patients. Subsection (h) is only applicable if another health professional is contacted under 95(4)"

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"Section 96(1)", "In cases of test ordering in hospital, the most logical place for a documentation record would be the patient's chart as opposed to a record within the pharmacy. In hospital inpatients and outpatients, all test orders must be written in the chart, the results are placed in the chart and the communication regarding interpretation usually occurs in the chart. Thus requiring all the documentation to occur in a pharmacy record would be redundant."

"Section 96(1)", "If I have the authority to order a test it should be with the responsibility of interpreting and recommending treatment otherwise your just becoming an administrative assistant to some other health care professional. If in (h) you are to forward results to health professionals responsible for patient care says the pharmacist isn't responsible for patient care which I personally think is insulting."

"Section 96(1)", "Documenting in pharmacy is not as appropriate as chart documentation for hospitals"

"Section 96(1)", "none"

"Section 96(1)", "Time-consuming and cumbersome recording requirements."

"Section 96(1)", "Does this also apply to hospital setting?"

"Section 96(1)", "Record keeping for patient self-administered tests."

"Section 96(1)", "All this information is included in the patient chart for hospital patients. Subsection (h) is only applicable if another health professional is contacted under 95(4)"

"Section 96(1)", "In a hospital setting, the pharmacist will utilize the patient hospital chart for documenting this information and I would like to see this incorporated as an acceptable place to record these results."

"Section 96(1)", "All this information is included in the patient chart for hospital patients. Subsection (h) is only applicable if another health professional is contacted under 95(4). What changes would you like to make? "

"Section 96(1)", "I am unaware of screening or diagnostic tests that I would be able to interpret. That is why there are radiologists - I find this section too bold for my liking and feeling like I am stepping on toes of another profession."

"Section 97", "Hospital pharmacists are covered under the umbrella of the hospital insurance plan. "

"Section 97", "Should this state members must be covered by personal professional liability insurance? As currently written, members may think that the liability insurance of their employers is sufficient."

"Section 97", "If you have concerns about the section, please provide a description of the concern? I do not think this is the concern of the MPHA - it is a business issue related to risk - this should have no impact on pat safety. This could also prevent certain types of practices, IPS for example. With all the expanded practice directives it may be difficult to get insurance for certain type of pharmacy components. Where is the proof that this impacts pat care and safety."

"Section 97", " May not be enough."

"Section 97", "I am concerned with the cost of maintaining proper liability insurance."

"Section 97", "Cost and need."

"Section 97", "Should this state members must be covered by personal professional liability insurance? As currently written, members may think that the liability insurance of their employers is sufficient."

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"Section 97", "Insurance providers may increase their rates unreasonably and some members of public may be more prone to filing unreal complaints."

"Section 97", "There is a possibility that this provision would call for insurance that IPS pharmacies cannot acquire."

"Section 97", "none"

"Section 97", "This is more of a business concern. It also mandates insurance that IPS may not be able to acquire."

"Section 97", "Does this apply to both hospital & retail pharmacy?"

"Section 97", "Hospital pharmacists are covered under the umbrella of the hospital insurance plan."

"Section 97", "There is a possibility that this provision would call for insurance that IPS pharmacies cannot aquire."

"Section 97", "Should be a minimum \$5 million annual aggregate"

"Section 97", "Should this state members must be covered by personal professional liability insurance? As currently written, members may think that the liability insurance of their employers is sufficient."

"Section 97", "This section appears to target IPS pharmacy as it is common knowledge that IPS pharmacy may not be able to obtain this type of insurance."

"Section 97", "I think there is a difference between professional liability insurance, which could be provided through an employer's coverage, and personal professional liability insurance, which would belong solely to the member."

"Section 97", "I agree that everyone should have insurance."

"Section 97", "Specific reference to hospital pharmacy insurance should be addressed - Hospital responsible for coverage or member?"  
"

"Section 97", "Hospital pharmacists have always been told in the past that they are covered under the hospital's malpractice insurance and only recommended if the pharmacist is also working as a pharmacist in the community. Questions will arrive from hospital pharmacists on this requirement."

"Section 97", "If I work in a hospital and am covered under some type of corporate liability insurance, do I still need my own coverage?"

"Section 97", "Should this state members must be covered by personal professional liability insurance? As currently written, members may think that the liability insurance of their employers is sufficient."

"Section 97", "There is a possibility that this provision would call for insurance that IPS pharmacies cannot acquire."

"Section 97", "By increasing liability insurance unnecessarily, you only encourage more nuisance lawsuits, leading to more higher insurance costs!"

"Section 97", "But what happens to our liability insurance with the above changes?? Surely one would need a lot more than \$2,000,000 especially if they are prescribing, have a specialty, are an extended care pharmacist, interpreting results etc?"

"Section C", "This is a very good document. My concerns as a hospital pharmacy manager reside primarily in the documentation and record keeping sections and I am sure many hospital pharmacists and managers share the same concerns. While the intent may be there, it is not clear where hospitals are required and not required to meet said standards and how those standards are applied in the complex drug distribution systems in hospital pharmacy. Clarification on the intent of these standards in hospital practice is required. Further concerns are regarding record keeping regarding any activities delegated to a pharmacy technician. The requirement for a signature of a supervising pharmacist in any of these situations is redundant. If we are comfortable delegating these activities and the technicians have been appropriately delegation of pharmacist technician."

"Section C", "At my pharmacy, the dispensary software program is older and showing its age. With all the extra documentation required under these regulations, it seems that upgrading the software now would be foolish. I am hopeful that MPHA will work with software providers, and provide guidance to members, to ensure that the new documentation will be automated as much as possible. I don't want to reduce my patient care time to an hour a day, and spend the remaining 7 hours writing up what I did in that one hour."

"Section C", "2(3)(A) - That the date of a members death be removed to prevent identity theft."

Section 3(d) - This section should be reevaluated and potentially broadened to include registries such as the child abuse registry, where a conviction is not required. This area also need to be considered from the members' perspective and their rights if no conviction has occurred.

Section 20(2)(1)(B) - The members sex should be mandatory on their profile as many names are unisex and the public may consider the sex of the pharmacist before approaching them on a sensitive health issue (Ecp, Ed)"

"Section C", "Section 60(1)(C) This regulation should not be implemented until Manitoba Health has a pseudo phin available to use for out of province prescriptions and those prescriptions where the patient refuses to give their phin number. There should also be a pseudo phin when the dpin help desk is unable to find a phin number when requested by the dispensing pharmacist and the patient is unable to provide the phin number"

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"Section C", "Section 19(1)(b) remove ""by"" in phrase ""by orally in response to a telephone inquiry:"

"Section C", "Section 14 (1) and (2)  
Despite the premise provided that a section 12 or section 13 license does not confer a ""hierarchy"" of practice, converting from a section 13 to section 12 license still requires approval of a section 12 member. Converting to a section 13 license however, does not involve an internship or approval of a section 13 member"

"Section C", "My biggest concerns are around part 5 (pharmacy license) especially the various components and part 7 (duties & delegation) especially pharmacy technicians."

"Section C", "Section 2(3)(a): Recommend that the date of a member's death be removed to prevent identity theft."

"Section C", "Section 3 (d): This section should be reevaluated and potentially broadened to include registries such as the Child Abuse Registry, where a conviction is not required. This area also needs to be considered from the members' perspective and their rights if no conviction has occurred. There may be value in tabling this pending further legal advice or discussion.."

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"Section C", "Section 25: Every member should receive a copy of their profile that is to be posted at least 60 days prior to it being posted. This should not be "on request", but a given.

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Section 22: There is an explanation box in the second discussion document that clarifies that "section 22 only pertains to a general description of the profiles and profile categories and does not include council providing an

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"Section C","Discretionary language should be removed from any and all sections of the Regulations and replaced with objective standards that pharmacists can understand. Many of the regulations are overly prescriptive and appear to regulate pharmacy business and not pharmacy practice. There needs to be evidence of harm or risk of harm to patients before a regulation should be introduced that regulates pharmacy business. The component and categories of licenser systems are overly complicated and appear to cause more problems that they would solve. The Regulations introduce cumbersome record keeping for pharmacists who would better spend their time counseling patients. Many times the Regulations appear to target IPS pharmacy; in light of the fact that the Government of Manitoba has repeatedly stated that they want IPS pharmacy to continue as a business here in Manitoba. A Regulation Impact Study needs to be completed so that pharmacists fully understand the implications of many of these regulations. This time I did not leave the Yes or No columns blank for fear that by doing so I may have ""spoiled"" my previous response document.  
"

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"Section C","With regards to Section 14(1) ""Converting from Section 12 practicing license"", would council consider a change in part (b) to include ""register as an intern for educational purposes in a health care practice for a period of time determined by The Board of Examiners and to the satisfaction of a Section 12 member acting as a supervisor.."". This change is more closely in line with the approach taken in Section 15 (2)(a), whereby The Board of Examiners is involved in determining the internship necessary for those members who have been out of practice for extended periods of time."

"Section C","16(b)(ii) regarding professional development ""consistent with the requirements approved by council"". Would this eliminate the pharmacist's involvement in decisions regarding continuing competency programs?"

"Section C","20(2)If the member's full name is on the profile, isn't their sex in many cases obvious? Are initials for first names to be used or full names?"

"

"Section C","20(1)Is 10 years the standard time frame for profiles to reflect disciplinary actions?"

"Section C","62(4)I disagree with this section. I think it should only apply to drugs that have left the dispensary, not those that were put in vials, placed in drawers and not picked up."

"Section C","DPIN required - very onerous! i.e. People approved for Family Services new from out-of-province but are having to pay for meds because they do not have a PHIN. The four children involved have medical issues. We, as a pharmacy, have repeatedly told them to register. We have given them the forms, offered to fax them but to no avail. If this bill passes, how do we justify not giving meds to kids because parents are too lazy, too poorly educated, too busy, or overcome with issues in their lives to register!"

"Section C","2(3)(a): Recommend that the date of a member's death be removed to prevent identify theft."

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"Section C", "Section 69(2): See above section 60(1)(c) for my comments.  
"

"Section C", "Section 20(2)(i)(b): The member's sex should be mandatory."

"Section C", "Section 2(3)(a) Recommend that the date of a member's death be removed to prevent identify theft."

"Section C", "Section 3(d) This section should be reevaluated and potentially broadened to include registries such as the Child Abuse Registry, where a conviction is not required. This area also needs to be considered from the members' perspective and their rights if no conviction has occurred. There may be value in tabling this pending further legal advice or discussion."

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"Section C", "Section 30(c) It is overly prescriptive to suggest that the Registrar must approve a workflow plan for a pharmacy in its pre-opening inspection. The Registrar is not the best judge of an ideal workflow."

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"Section C", "Section 69(2) See above section 60(1)(c) for my comments."

"Section C", "I think that we should review the terminology used in the proposed regulations in how they refer to persons writing the prescriptions. Should it

be practitioner, prescribing practitioner, prescriber, health care practitioner, health care professional, extended practice pharmacist etc? All these terms are used in the document and interchangeable in some instances."

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"Section C(22)", "Section 22: there is an explanation box in the second discussion document that clarifies that "section 22 only pertains to a general description of the profiles and profile categories and does not include council providing an explanation of any member's specific record". This statement should be included in the regulation."

"Section C(25)", "Every member should receive a copy of their profile that is to be posted at least 60 days prior to posting. This should be mandatory, not by request."

Section 25(4)(B) An appeal process should be considered in the event that the member disputes the revised info."

"Section C(30)", "It is overly prescriptive to suggest that the Registrar must approve a workflow plan for a pharmacy in its pre-opening inspection. The Registrar is not the best judge of an ideal workflow."

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