



June 19, 2008

Ms. B. Sullivan, Chair  
Health Professions Regulatory Advisory Council  
55 St. Clair Avenue West  
Suite 806, Box 18  
Toronto, ON M4V 2Y7

Dear Ms. Sullivan:

The Ontario College of Pharmacists is pleased to enclose its submission respecting the Review of the Scope of Practice of Pharmacy for consideration of the Health Professions Regulatory Advisory Council. In preparing this submission, the College consulted with many stakeholders, including the Ontario Pharmacists' Association and the Deans from both Faculties of Pharmacy. The Council of the College reviewed this submission at its meeting on June 16, 2008 and unanimously supported the proposed changes to the scope of practice for pharmacy.

We look forward to the outcome of your review. Please contact us should you require any further information or clarification.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "D. Williams", is written in black ink.

Deanna L. Williams, R.Ph., B.Sc.Pharm., C.Dir., CAE  
Registrar

Enclosure

Cc: D. Darby, CEO, Ontario Pharmacists' Association  
M. Jacquin, Policy Analyst, HPRAC  
B. O'Riordan, Executive Coordinator, HPRAC  
A. Schiefer, Project Manager, HPRAC

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## Health Professions Regulatory Advisory Council Submission Scope of Practice of Pharmacy

### Introduction and Executive Summary

*"If pharmaceuticals are a key cost driver in the system, isn't it simply common sense to make better use of those who are experts in pharmaceuticals? To tap their knowledge, use their skills and bring their expertise to bear in creating a more rational system of drug therapy? Leaving pharmacists on the sidelines is like having Wayne Gretzky on your team – and benching him. It makes no sense and it must change."*

Roy Romanow

Canadian Pharmacists Association Conference, May 13, 2002

The Ontario College of Pharmacists (the College) as the licensing and regulatory body for Pharmacy in Ontario is pleased to respond to the Health Professions Regulatory Advisory Council (HPRAC)'s Applicant Questionnaire respecting the scope of practice review for Pharmacy.

Our submission, and the contents therein, support an amended scope of practice statement that more accurately reflects what pharmacists do today. Within the College, there are currently three classes of registrants - registered pharmacy students, interns and pharmacists. All practice within the same scope of practice subject to any terms and conditions placed on the certificates of registration of a respective class. The scope of pharmacy practice has *evolved* rather than changed over the past thirty years from a prescription-focused model to a patient-centred pharmaceutical care approach. While in the 1960's pharmacists were prohibited by law from putting the name of the drug on the prescription label and were strongly discouraged from speaking to patients about their prescriptions, today it is an expected standard of practice that pharmacists provide both information and education to their patients or agents respecting the use of drugs, health care aids and devices. While pharmacists were once the only persons in a dispensary able to dispense prescriptions, the technical functions of dispensing have gradually been assumed by pharmacy assistant personnel freeing up pharmacists to focus on their areas of expertise. With extensive education and training in such areas as medicinal, physical, biological, and pharmaceutical chemistry, anatomy, physiology, biopharmaceutics and pharmacokinetics, therapeutics, pharmacology and pathology, pharmacists have a unique body of knowledge and an expertise that no other health professional has respecting drugs, their actions, interactions and effects. While pharmacists continue to oversee and ensure that safe and effective drug distribution systems are in place, pharmacists today are called upon to use their expertise to fully realize their roles in medication therapy management.

Pharmacists today no longer "count and pour, lick and stick" - they don't want to, and they don't have to. There are pharmacy technicians who will be regulated by 2010 and are trained to safely and effectively perform the technical aspects of compounding and dispensing drugs. Today this is done under the direct supervision of a pharmacist but regulated technicians will be able to assume certain aspects of dispensing independently. It is a long standing position of the College that the authorized acts of "selling, compounding and dispensing a drug" involve both *technical and cognitive* components, and pharmacists are expected to competently perform both.

Medication therapy management, or "MTM" as it is referred to within North America, is the term that best describes the cognitive role that pharmacists play before making the decision

to dispense a drug and while monitoring ongoing drug therapy. The role reaches far beyond dispensing as pharmacists must first gather information from the patient or agent or the prescriber to determine whether the prescribed drug is appropriate based on the patient's medication and relevant history. Once a diagnosis has been made, and before a drug is prescribed, pharmacists can play a key role in partnership with physicians and other prescribers to ensure that the right drug is prescribed or that, where no drug is prescribed, the patient understands why. Many pharmacists promote health and wellness in their practice settings by hosting clinics on smoking cessation, flu prevention and infection control, healthy weight and exercise, and women's health issues. Monitoring patient compliance and effectiveness of medication therapy is a key component of medication therapy management. All of this should be reflected in the scope of practice.

Accordingly, we are proposing that the existing scope of practice for pharmacy simply be amended through the addition of two phrases which we believe more accurately reflect pharmacist practice today. The added phrases are in bold:

***The practice of pharmacy is the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy; the monitoring and management of medication therapy; the custody, compounding and the dispensing of drugs; the provision of health care aids and devices and information related to their use.***

In day-to-day practice pharmacists are called upon to perform acts that are considered to be part of two controlled acts "administering a substance by injection or inhalation" and "performing a procedure on a tissue below the dermis" which are not currently authorized to the profession of pharmacy. Specifically, because pharmacists are expected to provide information and education to patients or their agents when providing drugs, health care aids and devices, pharmacists will:

- pierce a patient's finger with a lancet to obtain blood for the purpose of demonstrating the proper use of a glucose monitoring device
- administer insulin by injection for demonstration purposes when teaching new diabetic patients or their agents how to properly do so
- administer a substance by inhalation when providing education respecting the proper use of inhalers and inhalant devices.

Therefore, the College asks HPRAC to consider recommending that pharmacists have the controlled acts of "administering a substance by injection or inhalation" and "performing a procedure on a tissue below the dermis" subject to certain terms and conditions relating to the pharmacist's role in providing information and education to the public. This would allow pharmacists to do what they are trained and expected to do within their scope of practice in a manner that allows clarity and transparency to pharmacists, other health care practitioners, and the public. Although this section was never intended as a means to circumvent the controlled acts model, an alternative is to rely on the exemptions provided within s.29 (1)(e) of the *Regulated Health Professions Act* which provides exemption to persons performing "administering a substance by injection or inhalation" if done in the course of:

- (e) assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6, subsection 27.

Pharmacists are not trying to replace physicians, nurses or any other health care professionals. But pharmacists do seek the recognition and authority to fully perform their role in medication therapy management. The following is a list of the key activities that pharmacists are currently autonomously and within their scope of practice, engaged in on a daily basis:

- compound, prepare, dispense, and sell drugs
- supervise and manage the part of a pharmacy where drugs are kept and other drug distribution systems to maintain public safety and drug system security
- assist and advise patients and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use,
- monitor responses and outcomes to drug therapy and collaborate with physicians and other health care providers respecting their patient's care
- provide information and education to patients respecting the use, administration of their drugs, health care aids and devices
- where, in the patient's best interest, and where, in the professional judgement of the pharmacist, it is appropriate to do so, provide an emergency supply of prescribed medication(s), injections of flu shots or other vaccinations (i.e. SARS, pandemic)
- assess patients seeking advice for minor ailments and recommend appropriate treatment and follow up
- promote health and wellness through advice on smoking cessation, diet and other lifestyle matters, drug and non-drug therapy, and host, in participation with other professionals, educational and screening clinics
- conduct or administer drug and other health-related programs,
- conduct or collaborate in drug-related research.

The following activities are those that pharmacists do as a daily and routine part of current practice but legally only with the express consent of a prescriber, or through the use of delegation, medical directives, or professional judgement. As family physicians are increasingly unavailable for consultation in a timely manner, we are seeking the authority for pharmacists to be permitted to do the following without further authorization from a prescriber. Pharmacists will communicate these prescription changes to the family physician, nurse practitioner, and other health professionals in a timely manner, in order to ensure that other members of the patient's health care team are informed of changes in the patient's medication therapy. We consider pharmacists to currently possess the knowledge, skills and abilities within their scope of practice to:

- dispense a prescription without further authorization from a prescriber under certain circumstances, including:
  - adapting an existing prescription to facilitate patient compliance, such as changing the dosage form (e.g. from a capsule or tablet to an oral liquid formulation for patients who have difficulty swallowing); changing the dosage regimen (e.g. from one tablet twice a day to two tablets once a day to facilitate compliance); changing the dosage form to one reimbursable by the patient's third party drug benefit plan (e.g. capsule to tablet); and when the prescribed dose or dosage form is not commercially available (e.g. 50 mg only comes in 52.5 mg)
  - authorizing further extension of a prescription where there are no existing refills for continuity of care
  - providing Schedule II and III drugs as a prescription where required for reimbursement under drug plans
  - adjusting dosage of medication in response to monitoring (e.g. lab tests).
- administer drugs, including through injection and inhalation, for patient education

Many other jurisdictions, across Canada and around the world have taken steps to permit pharmacists to fully engage in the activities required to optimize their roles in medication therapy management. In all other provinces, *once a diagnosis has been made* pharmacists are or will be permitted to prescribe or adapt prescriptions, and to provide refills of medications already prescribed. This College has not pursued the controlled act of *prescribing* for pharmacists and within the timeframe allocated for this submission, was not able to undertake the extensive consultation with members and other stakeholders required to change this position. Permitting pharmacists to legally dispense a prescription without further authorization from a prescriber under specific conditions as set out above would bring Ontario into line with what prescribing pharmacists are able to do in other Canadian jurisdictions and falls squarely within the pharmacists scope and abilities as experts in medication management. Without doubt, pharmacists possess the knowledge, skills, ability and judgement required to safely adapt a dosage form, dosing regimen, or dose strength to facilitate drug coverage and to authorize prescription extensions for continuing therapy. College Council acknowledged that these activities are called *prescribing* in other jurisdictions such as Alberta, Saskatchewan, Manitoba and the Atlantic provinces. The College further acknowledges the need for all stakeholders to clearly understand that those pharmacists permitted to "prescribe" in other jurisdictions only do so once a diagnosis has already been made by another health care professional authorized to diagnose. This College is recommending "dispensing without further authorization from a prescriber subject to terms and conditions" over "prescribing" on the basis that these activities fall within the cognitive aspects of the controlled act of dispensing and are already thus within the realm of the pharmacists scope of practice. The College is aware that while the terminology of prescribing is used in other jurisdictions to describe activities that fall within a pharmacist's scope, the perception exists amongst the public and other health professions that prescribing must follow differential diagnosis- an activity that currently does not fall within the realm of pharmacy training and practice. Should HPRAC consider that granting pharmacists in Ontario the ability to adapt or alter a dosage form, dosing regimen or dose strength and to authorize prescription extensions for continuation of care is more appropriately done through *prescribing* than *dispensing*-subject to the terms and conditions cited above, the Council of the Ontario College of Pharmacists would support such a recommendation as long as it is clear that such activity would occur within the pharmacists medication therapy management role and only after a diagnosis has been made. The College supports the legislative and regulatory changes that are necessary to give effect to these proposals.

## **Health Professions Regulatory Advisory Council Submission Scope of Practice of Pharmacy**

The Ontario College of Pharmacists (the College) is pleased to provide the following response to the Health Professions Regulatory Advisory Council (HPRAC)'s "Applicant's Questionnaire" respecting the scope of practice review for pharmacists. While we have summarized the key components of the College's position in the rather comprehensive Introduction and Executive Summary attached to this document, many of the same points may be reiterated in our attempt to fully respond to the questions posed below.

Our proposals are intended to:

- reflect current practice, education and competencies of pharmacists,
- increase patient access to timely health services,
- increase efficiencies within the system and enhance cost-effectiveness by decreasing duplication, and
- clarify and enhance pharmacist accountability.

### **Applicant's Questionnaire**

#### **Profession Information**

**1) Does your current scope of practice accurately reflect your profession's current activities, functions, roles and responsibilities?**

No. The scope of pharmacy practice has not changed for many years but what pharmacists actually do within their scope has *evolved*. As the technical aspects of the dispensing function have been gradually but steadily assumed by pharmacy assistant personnel, and the education and training of pharmacists have become more extensive, the pharmacist's practice has evolved from a product-centred model to a patient-centred pharmaceutical care model. Currently the scope of practice for pharmacy as set out in S.3 of the *Pharmacy Act* is:

*The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.*

The authorized acts for Pharmacy under S.4 are:

*In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug or supervise the part of a pharmacy where drugs are kept.*

It is our view that the current scope of practice and authorized acts do not adequately reflect or accommodate pharmacist practice today which is focused to a lesser degree on dispensing of a drug and to a greater degree on the cognitive aspects of medication therapy management. Currently any activities performed by pharmacists outside the existing authorized acts are performed through the use of delegation or medical directives, professional judgement or under S.29(1) of the *Regulated Health Professions Act* (RHPA) which provides exceptions to permit persons to perform controlled acts when rendering first

aid or temporary assistance in an emergency S.29(1)(a) and assisting a person with his or her routine activities of living S.29(1)(e). On a daily basis, pharmacists are called upon to use their professional judgement to take action that is in the best interest of the patient.<sup>1</sup>

### ***Health Promotion and Wellness***

The current scope of practice of pharmacy does not acknowledge the pharmacist's key role in the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy. The public routinely seek out pharmacists as their primary source of advice and care for numerous minor ailments and because pharmacists are easily seen without appointments they have long been recognized as the most accessible health care professionals. In 1990, the Lowy Report cited pharmacists as under-utilized professionals and the advantages of expanding the role of the pharmacist.<sup>2</sup> In collaboration with nurses and other professionals, pharmacists routinely host screening clinics, flu shot clinics and educational days on various topics respecting health and wellness promotion, such as smoking cessation. Many pharmacists offer screening clinics for cholesterol and diabetes management, and consultation/information services respecting hormone replacement, menopause and aging, and maternal and child health. The Ontario government has been a leader in recognizing and reimbursing pharmacists for their role in colorectal screening and the MedsCheck program.

### ***Accessible Health Care Professionals***

While pharmacists are not currently trained in differential diagnoses or formally trained in prescribing, it must be recognized that in the area of minor ailments and non-prescription medications and self-care, pharmacists are both competent and capable in assessing their patients and recommending the best options. These recommendations may include medications, other therapies, lifestyle changes, or a referral to physicians or other health professionals. This constitutes a considerable part of a pharmacist's daily practice. In England, Ireland, Scotland and Wales, the National Health Service (NHS) has implemented, with the support of physicians, pharmacists and the public, the Minor Ailments Scheme which reimburses pharmacists for their role in first line assessments of a number of identified minor ailments. (See Appendix 1.) In certain instances pharmacists may prescribe medications for their patients within the Minor Ailments Scheme. The minor ailments and drug benefits vary with the jurisdiction. While the products prescribed under this scheme generally are not prescription-requiring by law, they may require a prescription in order for the patient to obtain drug coverage by the NHS. Preliminary data, included in the attachments, demonstrates increased access by the public to necessary health services for minor ailments, increased access to physicians by patients who are more seriously ill, and overall cost savings to the NHS. Implementation of such a scheme in Ontario would more fully utilize the training and expertise of the pharmacist, but could also be expected to increase the public's access to health services involving minor ailments and free up family physicians to see more seriously ill patients. It could also improve access to walk-in clinics and emergency rooms as patients also use these services for minor ailments.

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<sup>1</sup> Professional judgement involves four key areas:

1. taking actions that are in the best interest of the patient, including the patient having an active role in the decision-making process as well as understanding all the options and choices that are available to him/her;
2. having knowledge and expertise to make the judgement;
3. making decision that pharmacist peers would consider reasonable given the circumstances; and
4. documenting all relevant actions including what happened and why, names of the professionals with whom you conferred and when, and all outcomes.

<sup>2</sup> Lowy F, Jordan M, Moulton R, et al. *Prescriptions for Health: Report of the Pharmaceutical Inquiry of Ontario*. Toronto: Ministry of Health. Ontario; 1990.

Pharmacists currently host screening and flu shot clinics in their pharmacies and provide information on many diseases and health issues. The College does **not** consider pharmacists who assess a patient for a minor ailment or condition and then recommend a drug (e.g. Schedule II or III) to be *communicating a diagnosis*. The College considers that such activities fall clearly within the pharmacist's role and expertise in medication therapy management and constitute the **cognitive** components of dispensing and selling drugs.

### ***Patient Education***

It is an expected standard of practice that all pharmacists educate patients or their agents respecting prescribed medications and how to use accompanying health care aids and devices and non-prescription therapies. This frequently entails teaching patients or their agents how, through demonstration, to administer a drug by injection and inhalation and how to use self-monitoring devices by using lancets to obtain blood samples. While these activities, which we consider fall within the College's interpretation of the existing scope of practice, are currently performed either through delegation/medical directives (which are not practical in community pharmacy practice) or using the exemption permitted under S.29 (1) (a) and (e) of the RHPA, pharmacists are trained to, and routinely do prick the skin to demonstrate the proper use of glucose monitoring devices, administer a substance by injection when educating patients how to self-inject their insulin, and/or administer a substance by inhalation when educating a patient or their agent on the proper administration of a drug using an inhalant device. Many pharmacists have sought out training on their own, and the two schools of Pharmacy in Ontario will incorporate training pharmacy students on administering injections in anticipation of a pandemic.

The College strongly supports pharmacists being able to perform certain parts of these controlled acts (administering a substance by injection or inhalation; performing a procedure on tissue below the dermis....) subject to terms and conditions limiting these activities to the pharmacist's role in patient education and medication therapy management.

### ***Use of Professional Judgement***

Pharmacists routinely are called upon to extend or modify prescriptions, and to refill part of a prescription without further authorization from a prescriber where prior authorization from the patient's physician in a timely manner is not available or when patients cannot get a timely appointment with their physician.<sup>3</sup> In other jurisdictions, such as the UK, Alberta and New Brunswick, this is considered to be performing the controlled act of **prescribing a drug**. Almost daily, pharmacists will be called upon to alter or adapt an existing prescription where it is clearly in the patient's interest to do so. For example, switching a dosage form to facilitate compliance (e.g. providing an oral liquid formulation when a patient cannot swallow the tablets or capsules that have been prescribed); changing the prescribed drug to a strength or dosage form that is commercially available when they cannot get prior authorization from the original prescriber; authorizing the refilling of part or all of a prescription where patients are unable to see a physician or he/she is not available to provide approval. This year, the College in collaboration with the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, and the Ontario Pharmacists Association agreed to conditions under which a pharmacist may authorize and dispense an extension of a prescription for continuing care when the prescribing physician is unavailable

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<sup>3</sup> The Ontario Health Quality Council reported that only 39 percent of Ontarians who need to see their doctor can do so that day or the day after. Ontario Health Quality Council. 2008 *Report on Ontario's Health System*. 2008: [www.ohqc.ca](http://www.ohqc.ca).

to provide refill authorization.<sup>4</sup> The PAPE (Pharmacist Authorization of Prescription Extensions) has been approved by the Councils of these four organizations and a regulatory amendment to the *Drug and Pharmacies Regulation Act*, is needed to give effect to this agreement at the point of care. Currently pharmacists provide limited refill authority for their patients in situations where they are called upon to exercise professional judgement.

**2) If the answer to question #1 is no, then please answer the remaining questions (only those that apply) as thoroughly as possible:**

**2. Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment**

Profession: Pharmacy

Professional Act: *Pharmacy Act 1991* and regulations under the *Pharmacy Act (Regulation 202/94)*

*Drug and Pharmacies Regulation Act* and regulations under the *Drug and Pharmacies Regulation Act*

**3. Describe the change in scope of practice being sought**

The College is proposing the existing scope of practice statement be amended through the addition of two phrases which we consider more accurately reflect pharmacy practice today. The suggested amendment, in bold, for the new scope of practice for pharmacy is:

***The practice of pharmacy is the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy; the monitoring and management of medication therapy; the custody, compounding, and the dispensing of drugs; the provision of health care aids and devices and information related to their use.***

Under this scope, pharmacists:

- compound, prepare, dispense, and sell drugs
- supervise and manage the part of a pharmacy where drugs are kept and other drug distribution systems to maintain public safety and drug system security
- **dispense a prescription without further authorization from a prescriber under certain circumstances,<sup>5</sup> including:**
  - adapting an existing prescription to facilitate patient compliance, such as **changing the dosage form (e.g. from a capsule or tablet to an oral liquid formulation for patients who have difficulty swallowing); changing the dosage regimen (e.g. from one tablet twice a day to two tablets once a day to facilitate compliance); changing the dosage form to one reimbursable by the patient's third party drug benefit plan (e.g. capsule**

<sup>4</sup> Ontario College of Pharmacists, Ontario Pharmacists Association, Ontario Medical Association, College of Physicians and Surgeons of Ontario. Pharmacist Authorization of Prescription Extensions (PAPE) Agreement. Draft. January 2008. (See Appendix 2E.)

<sup>5</sup> These activities currently are done through use of delegation, medical directive or professional judgement.

- **to tablet); and when the prescribed dose or dosage form is not commercially available (e.g. 50 mg only comes in 52.5 mg)**
- **authorizing further extension of a prescription where there are no existing refills for continuity of care**
- **providing Schedule II and III drugs as a prescription where required for reimbursement under drug plans**
- **adjusting dosage of medication in response to monitoring (e.g. lab tests)**
- assist and advise patients and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use,
- monitor responses and outcomes to drug therapy and collaborate with physicians and other health care providers respecting their patient's care
- provide information and education to patients respecting the use, administration of their drugs, health care aids and devices
- **administer drugs, including through injection and inhalation for patient education**
- assess patients seeking advice for minor ailments and recommend appropriate treatment and follow up
- promote health and wellness through advice on smoking cessation, diet and other lifestyle matters, drug and non-drug therapy, and host, in participation with other professionals, educational and screening clinics
- provide, dispense and administer drug therapy in an emergency, including administering drugs through injection and inhalation
- conduct or administer drug and other health-related programs,
- conduct or collaborate in drug-related research.

The activities included under dispensing without further authorization are a key part of the day-to-day practice of a pharmacist. The College considers that pharmacists possess the knowledge, skills and ability to perform them safely. Pharmacists will communicate these prescription changes to the family physician, nurse practitioner, and other health professionals in a timely manner, in order to ensure that other members of the patient's health care team are informed of changes in the patient's medication therapy. Accordingly we are seeking the legal authority for pharmacists to be permitted to do these activities without further authorization from a prescriber.

#### **4. Name of the College/association/group making the request, or sponsoring the proposal for change, if applicable**

Ontario College of Pharmacists

#### **5. Address/website/e-mail**

Address: 483 Huron St, Toronto, ON M5R 2R4

Website: [www.ocpinfo.com](http://www.ocpinfo.com)

E-mail: [info@ocpinfo.com](mailto:info@ocpinfo.com)

#### **6. Telephone and fax numbers**

Telephone: 416-962-4861; toll free 1-800-220-1921

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**7. Contact person (including day telephone numbers)**

Deanna L Williams, Registrar  
Ontario College of Pharmacists  
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**8. List other professions, organizations or individuals who could provide relevant information applicable to the proposed change in scope of practice of your profession. Please provide contact names, addresses and contact numbers where possible.**

**PROFESSIONAL REGULATORY BODIES IN ONTARIO**

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## **ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE**

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## FOR ASSOCIATIONS

### 9. Names and positions of the directors and officers

Not applicable

### 10. Length of time the association has existed as a representative organization for the profession

Not applicable

### 11. List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application. Please provide contact names, addresses and contact numbers where possible.

Not applicable

## DETAILS OF THE PROPOSAL

### Legislative Changes

**12. What are the exact changes that you propose to the profession's scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, standards of practice, guidelines, policies and by-laws developed by the College, other legislation that may apply to the profession, and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?**

### **Scope of Practice**

The proposed change to the Scope of Practice statement for Pharmacy is as follows:

S.3 of the *Pharmacy Act* would read:

*The practice of pharmacy is the promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy; the monitoring and management of medication therapy; the custody, compounding, and the dispensing of drugs; the provision of health care aids and devices; and information related to their use.*

### **Controlled Acts**

The proposed change to the Authorized Acts is as follows:

S.4 of the *Pharmacy Act* would read:

*In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration to dispense, sell or compound a drug; to supervise the part of a pharmacy where such drugs are kept; to administer a substance by injection or inhalation and to perform a procedure on tissue below the dermis.*

Pharmacists perform controlled acts other than dispensing, selling, and compounding drugs, currently through delegation, medical directives, professional judgement or the exceptions provided under S29 (1) of the *Regulated Health Professions Act*. In all other provinces, *once a diagnosis has been made* pharmacists are or will be permitted to prescribe or adapt prescriptions, and to provide refills of medications already prescribed. This College has not pursued the controlled act of *prescribing* for pharmacists and within the timeframe allocated for this submission, was not able to undertake the extensive consultation with members and other stakeholders required to change this position. Permitting pharmacists to legally dispense a prescription without further authorization from a prescriber under specific conditions as set out above would bring Ontario into line with what prescribing pharmacists are able to do in other Canadian jurisdictions and falls squarely within the pharmacists scope and abilities as experts in medication management. Without doubt, pharmacists possess the knowledge, skills, ability and judgement required to safely adapt a dosage form, dosing regimen, or dose strength to facilitate drug coverage and to authorize prescription extensions for continuing therapy. College Council acknowledged that these activities are called *prescribing* in other jurisdictions such as Alberta, Saskatchewan, Manitoba and the Atlantic provinces. The College further acknowledges the need for all stakeholders to clearly understand that those pharmacists permitted to “prescribe” in other jurisdictions only do so once a diagnosis has already been made by another health care professional authorized to diagnose. This College is recommending “dispensing without further authorization from a prescriber subject to terms and conditions” over “prescribing” on the basis that these activities fall within the cognitive aspects of the controlled act of dispensing and are already thus within the realm of the pharmacists scope of practice. The College is aware that while the terminology of prescribing is used in other jurisdictions to describe activities that fall within a pharmacist’s scope, the perception exists amongst the public and other health professions that prescribing must follow differential diagnosis- an activity that currently does not fall within the realm of pharmacy training and practice. Should HPRAC consider that granting pharmacists in Ontario the ability to adapt or alter a dosage form, dosing regimen or dose strength and to authorize prescription extensions for continuation of care is more appropriately done through *prescribing* than *dispensing*- subject to the terms and conditions cited above, the Council of the Ontario College of

Pharmacists would support such a recommendation as long as it is clear that such activity would occur within the pharmacists medication therapy management role and only after a diagnosis has been made.

We consider most of these activities to fall within a pharmacist's ability to dispense a prescription without the further authorization of a prescriber under certain circumstances:

- adapting an existing prescription to facilitate patient compliance, such as changing the dosage form (e.g. from a capsule or tablet to an oral liquid formulation for patients who have difficulty swallowing); changing the dosage regimen (e.g. from one tablet twice a day to two tablets once a day to facilitate compliance); changing the dosage form to one reimbursable by the patient's third party drug benefit plan; and when the prescribed dose or dosage form is not commercially available (e.g. 50 mg only comes in 52.5 mg)
- authorizing further extension of a prescription where there are no existing refills for continuity of care
- providing Schedule II and III drugs as a prescription where required for reimbursement under drug plans
- adjusting dosage of medication in response to monitoring (e.g. lab tests)

The College proposes that pharmacists be permitted, in the course of engaging in their role as provider of information and education to patients in the course of practicing pharmacy to:

- Perform a procedure on tissue below the dermis
- Administer a substance by injection or inhalation

Pharmacists when educating patients or their agents to use monitoring devices (e.g. blood glucose monitoring) often use a lancing device to obtain a small amount of blood from the patient so that the patient may learn how to use the lancing device and test their blood. This involves the controlled act of *performing a procedure on tissue below the dermis*.

Pharmacists when educating patients or their agents through the actual demonstration or administration of a drug through injection (e.g. insulin) or through inhalation (e.g. asthma therapy), perform the controlled act of *administering a substance by injection or inhalation*. Pharmacists also administer by injection, flu shots and other vaccines in emergency situations. Including this controlled act within the scope of practice, would ensure pharmacists would be trained and use the skill routinely, rather than performing it only in emergencies.

The College asks HPRAC to consider recommending that pharmacists be granted the above two controlled acts subject to terms, conditions and limitations relating to the pharmacist's role in providing education to the public. The Council of the College also supports HPRAC to consider recommending that pharmacists be permitted to dispense without further authorization or prescribe under the conditions identified previously. The College recommends that any terms, conditions and limitations necessary to protect the public be placed in standards of practice rather than in legislation. We would expect to adopt existing practice standards developed and in use in other Canadian jurisdictions where pharmacists are currently able to prescribe and as such are realizing their full role in medication management therapy. Including such conditions and limitations to the practice standard means that a member not practising in accordance with the standard would appropriately face a professional misconduct review.

## Other Legislation Requiring Changes

Managing medication therapy involves knowing which drugs require monitoring through laboratory tests and subsequent dosage adjustment depending on the test results. In existing models involving professional collaboration and care, pharmacists order bloodwork for patients whose medications require ongoing blood monitoring and adjust dosages of chronic medications depending on the results (e.g. INR clinics, renal clinics). The College would strongly support pharmacists in both community and hospital practice settings being able to initiate orders for laboratory testing within the ambit of medication therapy management and collaborative practice.

*The Laboratory Specimen and Collection Centre Licensing Act* and its regulations require changes to Section 9(1) of Regulation 682 and Sections 2(b) and (5) of Regulation 683 to include pharmacists as health professionals who can order laboratory tests. These tests would be for the purpose of medication monitoring and management.

Regulation 965 of the *Public Hospitals Act* needs to permit pharmacists various authorities with respect to treating inpatients, including the recognition of orders for treatment or diagnostic tests given by pharmacists.

Regulation 522 under the *Health Insurance Act* needs changes to recognize pharmacist services to permit payment to employers for services provided to inpatients under the pharmacist's authority and for pharmacists to be included under other services and programs. Without this recognition, services and programs funded under the *Health Insurance Act* may exclude pharmacists due to payment concerns.

### **13. How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?**

The fact that the current legislation restricts certain acts only to certain professions was not an issue twenty years ago but, today, this limits pharmacists from fully realizing their role in medication therapy management. The reality of pharmacy practice today is that some of the controlled acts not previously authorized to pharmacists are now incorporated into the day-to-day practice of pharmacists in both hospital and community practice settings. The need to teach patients how to self-administer drugs through inhalation and injection and to self-monitor their diseases with devices that analyze small amounts of blood obtained through the use of lancets is a commonly accepted practice standard for pharmacy practice across Canada. Pharmacists have the education and training to do this. The need for pharmacists to adapt prescriptions by providing interim supplies and refills, to change dosage formulations to facilitate compliance, or to change the dosage strength or formulation to a product commercially available has increased in tandem with the public's increasing difficulty in accessing a family physician for routine appointments or to seek authorization for the prescription refill or change. Permitting pharmacists to practice within clear legislative authority rather than relying on S.29(1) of the *RHPA* and professional judgment more clearly establishes the pharmacist's direct accountability for his / her safe practice. It also clarifies the pharmacist's direct accountability to members of the public and to other health professionals.

Pharmacists routinely assess patients who come to them in community pharmacies for health advice for minor ailments. Pharmacists recommend medication and non-medication therapy. If the optimal therapy is a Schedule II or III drug, and is a benefit under the

patient's drug plan, the patient must then see an authorized prescriber for a prescription. This also pertains to a patient requiring further supplies of a Schedule II or III drug that the patient has received previously under a prescription from an authorized prescriber. Private and public sector drug plans decide which drugs are benefits. These third party payors also can determine the types of practitioners (e.g. physicians, dentists, nurse practitioners, midwives) that they will accept as prescribers for prescriptions they will reimburse. In Alberta, when pharmacists gained prescribing authority, all drug plans recognized prescriptions written by pharmacists for reimbursement, including prescriptions for Schedule II and III drugs. If changes to the legislation permitted pharmacists to dispense without further authorization, it is anticipated that drug plans in Ontario would be consistent with Alberta in recognizing this dispensing for reimbursement purposes. Hence, the public could obtain their medications in a more timely manner, without further use of the health system by seeing family physicians, using walk-in clinics or emergency departments.

Some pharmacists provide controlled acts under medical directives. While concerns respecting accountability and liability are often barriers, the reality is that when a family physician retires, dies, or re-locates to another community, pharmacists who have competently been performing delegated activities as a part of their practice, are left without the ability to gain an authorization mechanism to provide or continue the care their patients require, except under professional judgment or Section 29(1) of the *RHPA*. This is of special concern in isolated and under-serviced areas where there may not be another health professional to perform the controlled act or delegate to the pharmacist in a timely manner.

In the institutional sector, the need for all physicians to sign medical directives is also very difficult to achieve administratively and in a timely manner. Recognition of these controlled acts for pharmacists would greatly facilitate the integration of pharmacists into health care teams, and provide them with the flexibility to address patient needs in a more timely fashion.

Changes to the *Public Hospitals Act* will allow recognition of orders for treatment and diagnostic tests given by pharmacists, thus facilitating monitoring of therapy and therapy changes in a more timely manner, as currently a practitioner who is recognized under this *Act* must do the ordering or co-sign the pharmacist's order. Changes to the *Health Insurance Act* will permit payment to employers for services provided to inpatients under the pharmacist's authority and for pharmacists to be included in programs and services. Changes to the *Laboratory Specimen and Collection Centre Licensing Act* and its regulations will allow pharmacists to have tests ordered by pharmacists processed by the laboratories and specimen collection centres (e.g. INR tests for anticoagulation monitoring). This recognition will facilitate pharmacists being able to function more fully in medication therapy management and thus facilitating greater integration into health care teams.

Pharmacists can be very reluctant to do more than what is stated in legislation. The public relies on pharmacists to provide health information and access to drugs when they can not access their physician or the health system in a timely manner. This is particularly important in times of emergencies. An analysis of pharmacist practice in Toronto during the severe acute respiratory syndrome (SARS) outbreak in 2003 and the electrical system failure in the Eastern Seaboard of North America in August 2004, found that during times of crisis, pharmacies become frontline health care facilities and there was an increased reliance on pharmacists' experience, expertise and professional judgment. During the SARS outbreak the health care system literally was suspended for many patients. During the blackout, pharmacists did not have access to their computers and the patient's medication records. So they often had to dispense prescriptions without knowing the status of the patient's prescription (i.e. remaining refills) or if the patient had a prescription (e.g. urgent

need for an inhaler for a person who appeared to have breathing difficulties due to asthma). They did so by gathering information from the patients or their agents and by applying their knowledge, skills and judgement in an appropriate way. The researchers found that for many pharmacists, especially younger pharmacists, this created significant coping challenges. The pharmacists were very concerned about rules and the law and were worried that performing acts not traditionally authorized for pharmacy could result in disciplinary proceedings or prosecution.<sup>6</sup>

Consultations and anecdotal reports also reveal that other health professionals are not sure what pharmacists can or can not do and under what circumstances. Many physicians and other prescribers are unaware that pharmacists must dispense a prescription as written and must receive authorization from the prescriber for even minor prescription changes (e.g. substituting tablets or capsules for a patient who has difficulty swallowing) or to provide interim supplies for continuity of therapy, when the patient has difficulty seeing their family physician in a timely manner. Many health professionals think of the stereotype of pharmacists as compounders and dispensers of medications rather than as medication therapy experts with extensive training and expertise. The current scope of practice in the legislation reinforces these limited perceptions of pharmacists, hence contributing to their underutilization in medication therapy management.

## Collaboration

### **14. Do members of your profession practice in a collaborative or team environment where a change in scope of practice and the recognition of existing or new competencies will contribute to multidisciplinary health care delivery? Please describe any consultation process that has occurred with other professions.**

Pharmacists work within inter-professional teams, especially in institutional settings and in primary care teams.<sup>7,8,9,10</sup> In 1996, a joint statement was developed by the Canadian Pharmacists Association and the Canadian Medical Association to include the goal of drug therapy, strategies for collaboration to optimize drug therapy and physicians' and pharmacists' responsibilities in drug therapy. The statement recognizes the importance of patients, pharmacists and physicians working in close collaboration and partnership to achieve optimal outcomes from drug therapy.<sup>11</sup> In 2003, the Canadian Medical Association,

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<sup>6</sup> Austin Z, Martin JC, Gregory PA. Pharmacy practice in times of civil crisis: The experience of SARS and the blackout in Ontario, Canada. *Research in Social & Administrative Pharmacy*: 2007. 3(3):320-35.

<sup>7</sup> Howard M, Trim K, Woodward C, Dolovich L, et al. Collaboration between community pharmacists and family physicians: lessons learned from the Seniors Medication Assessment Research Trial. *Journal of the American Pharmacists Association*: 2003; 43(5):566-72.

<sup>8</sup> Dolovich L, Kaczorowski J, Howard M, et al. for the IMPACT team. Cardiovascular outcomes of a pharmaceutical care program integrated into family practices (abstract). *Can J Clin Pharmacol* 2007; 14(2):e116.

<sup>9</sup> Dolovich L, Kaczorowski J, Sellors C, et al. on behalf of the IMPACT team. Integration of a pharmaceutical care program into family practices: Drug-therapy problems identified and recommendations made by participating pharmacists (abstract). *Can J Clin Pharmacol* 2007; 14(2):e164.

<sup>10</sup> Farrell B, Woodend K, Pottie K, et al. Collaborative working relationships between family physicians and pharmacists: changes over time as pharmacists integrated into family practice. *Can J Clin Pharmacol* 2006; 13(2):e217.

<sup>11</sup> Canadian Medical Association and the Canadian Pharmacists Association Joint Statement. Approaches to Enhancing the Quality of Drug Therapy. 1996. [www.pharmacist.ca](http://www.pharmacist.ca).

the Canadian Nurses Association and the Canadian Pharmacists Association developed the *Joint Statement on Scopes of Practice*.<sup>12</sup> The statement states:

*In order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses and pharmacists engage in collaborative and cooperative practice with other health care providers who are qualified and appropriately trained and who use, wherever possible, an evidence based approach. Good communication is essential to collaboration and cooperation.*

In a 2007 survey of Canadian pharmacists, increasing numbers reported that they would like to formally collaborate with physicians, i.e. 81% of Canadian pharmacists, up from 66% in 2005. Twenty-one per cent of Ontario pharmacists reported that they currently collaborate.<sup>13</sup> All pharmacists collaborate to various degrees with physicians and other health care providers every day in their routine practice. Ontario respondents to a Canadian survey supported the idea of community pharmacists being members of teams.<sup>14</sup> Support for this position was slightly higher among respondents who were already members of teams. Pharmacists on teams were more likely to agree their training and skills were sufficient to participate, and to report good relations with physicians. Pharmacists on teams were more likely to agree there was more opportunity to meet and get to know other health disciplines, and to see teamwork as part of their role. They were also more likely to agree physicians wanted their input, and less likely to see other disciplines as being too protective of their professional turf. Pharmacists on teams did not differ from those not on teams in rating lack of time, bad past experiences with teamwork, financial reimbursement or proximity to other health care workers as barriers to being a member of a community-based primary care team. An enhanced scope of pharmacy practice will contribute to inter-professional health care delivery.

The College developed with the College of Physicians and Surgeons of Ontario and other stakeholders authorizing mechanisms based on delegation and medical directives. The College, the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, and the Ontario Pharmacists Association have agreed to conditions under which a pharmacist may authorize and dispense an extension of a prescription when the prescribing physician is unavailable to provide refill authorization.<sup>15</sup> (See Appendix 2E.)

A consultation session on the Pharmacists Scope of Practice Review was held on May 9, 2008. Representatives from the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Royal College of Dental Surgeons of Ontario, the Ontario College of Family Physicians, the Ontario Dental Association, the Ontario Medical Association, the Nurse Practitioners Association and the Registered Nurses Association of Ontario indicated support for the greater use of the expertise of pharmacists in medication management, especially in collaboration with them. There was no consensus on whether pharmacists should be recognized for additional controlled acts or if pharmacists should continue performing the controlled acts under delegation, medical directives, Section 29(1) of the *RHPA*, and professional judgement.

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<sup>12</sup> Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association. *Joint Statement on Scopes of Practice*. March 2003. [www.cma.ca](http://www.cma.ca).

<sup>13</sup> *2007 Trends and Insights*, prepared for Rogers Media: [www.mckesson.ca/documents/Trends\\_2007.pdf](http://www.mckesson.ca/documents/Trends_2007.pdf).

<sup>14</sup> Dobson RT, Henry CJ, Taylor JG, et al. Interprofessional health care teams: attitudes and environmental factors associated with participation by community pharmacists. *Journal of Interprofessional Care*. 2006; 20(2): 119-32.

<sup>15</sup> Ontario College of Pharmacists, Ontario Pharmacists Association, Ontario Medical Association, College of Physicians and Surgeons of Ontario. Pharmacist Authorization of Prescription Extensions (PAPE) Agreement. Draft. January 2008.

The College of Nurses of Ontario (CNO) wrote a letter to provide the College with CNO's initial feedback to the May 2008 consultation.<sup>16</sup> Extracts from this letter include:

***Additional Controlled Acts***

*We do not believe that the exception provisions listed in section 29 of the Regulated Health Professions Act are meant to be used to provide a regulated health profession with broad and routine access to controlled acts. It is CNO's recommendation that OCP seek legal access to the controlled acts; this approach is transparent, provides clarity to pharmacists and to other health care practitioners and protects the public - as it facilitates role clarity and OCP's ability to govern its members with respect to the performance of these acts.*

***Dispensing Without Authorization - Medication Therapy Management***

*CNO's interpretation of OCP's proposal is that pharmacists would not be initiating prescriptions, but they would alter prescriptions initiated by an authorized prescriber. This could include changes as straightforward as substitutions or, under specific circumstances, authorizing refills or adjusting doses. CNO appreciates that OCP envisions that these activities would occur within a collaborative context and would require enhanced communication between the pharmacist and other health care providers.*

*We understand that there has been some groundwork on the issue of authorizing refills between the medical and pharmacy communities with the PAPE (Pharmacist Authorization of Prescription Extensions) agreement. We recommend that OCP begin this dialogue with other prescribers.*

*OCP proposes that pharmacists be authorized to order and receive laboratory tests to monitor drug therapy and adjust dosages in certain conditions. CNO recommends that OCP develop these conditions in consultation with other providers of the health care team, specifically prescribers. We would also emphasize that our support is contingent upon appropriate two-way communication between the pharmacist and other health providers.*

*Overall, we believe that this type of expanded role for pharmacists would work best in a system that is integrated and would be most appropriate in settings where pharmacists are directly involved as part of the larger health care team. This provides direct access to the client's health record and the other professionals involved in medication therapy. These types of settings include hospitals, Family Health Teams and Community Health Centres. We view the absence of an integrated electronic health record as a key barrier to implementing these initiatives in the community (i.e. retail) pharmacy sector.*

***Minor Ailment Management***

*CNO understands this to be a role that in many ways pharmacists are already filling in Ontario. It is CNO's interpretation that the pharmacist in this situation would not be dispensing prescription drugs, but rather would recommend and dispense either schedule II or III drugs.*

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16 Campbell HM, Director, Practice & Policy, Ontario College of Nurses. May 27, 2008. Letter to Anne Resnick, Director, Professional Practice, Ontario College of Pharmacists.

*We are supportive of such an initiative that would make better use of pharmacists' competencies and understand that OCP's position is that this initiative would require pharmacists to communicate their interventions to the client's physician. CNO requests that this concept be expanded to require pharmacists to also communicate with other primary care providers, specifically nurse practitioners. There are currently over 700 nurse practitioners providing primary care services to people across the province - and this number is growing. Increasingly, pharmacists are going to come across clients who receive their primary health care from a nurse practitioner.*

*Should OCP be proposing that this initiative involve pharmacists dispensing prescription drugs, CNO would interpret the activity as initiating a prescription and would therefore suggest the need for additional consultation.*

## Public Interest

### **15. Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider and describe the influence of any of the following factors:**

The proposed change in scope of practice will reflect what pharmacists are doing. Permitting pharmacists to do so, in a legislatively recognized manner, will enable all pharmacists to fully realize their role as experts in medication therapy management. No other profession possesses the unique body of knowledge that pharmacists have or the extensive education and training respecting drugs and how they work. While all pharmacists possess the necessary knowledge, skills and ability to work in this expanded role, there are many who as noted, are reluctant to do anything outside of the current authorized acts, whether through delegation, medical directives, or through the use of professional judgement. There is little question that optimizing the role of the pharmacist can help fill the current gaps in our health care system with respect to access. Enabling the pharmacist to be the primary care provider for minor ailments for example would increase patient access to necessary care and also help alleviate the burden of family practitioners who cannot now accommodate all of the patients seeking consultations for prescription authorizations or complaints of a minor nature.

The proposed changes to the scope of practice of pharmacy will benefit the public by:

- Reducing patient's disruption in drug therapy and improving continuity of patient care (e.g. extensions for ongoing drug therapy, correction of minor prescription problems)
- Improving safety through pharmacist reconciling medication and providing seamless care as patients receive care in different health care sectors<sup>17</sup>
- Optimizing patient health outcomes by pharmacists identifying, resolving, and preventing actual and potential medication-related problems; initiating or modifying drug therapy; and monitoring and evaluating response to drug therapy, in a collaborative framework with physicians and other health care providers, especially in collaborative health teams in hospitals, long term care facilities, family health teams, community health centres, and home care

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<sup>17</sup> Nickerson A. MacKinnon NJ. Roberts N. Saulnier L. Drug-therapy problems, inconsistencies and omissions identified during a medication reconciliation and seamless care service. *Healthcare Quarterly*. 8 Spec No: 65-72, 2005.

- Increasing the public's convenient access to necessary health care services (e.g. family physicians, walk-in clinics, emergency departments) as the pharmacist will be reducing the workload of other health care professionals related to refills, minor ailments, and medication therapy management
- Increasing the public's access to home care services and long term care facilities as pharmacists will be proactively involved in optimizing medication therapy thus proactively reducing the drug-related problems that often result in the public needing home care services or being institutionalized
- Facilitating the management of chronic and recurrent diseases and conditions
- Improving the effectiveness of drug therapy (e.g. improved therapeutic and health outcomes) primarily due to improved accessibility to the pharmacist's expertise
- Increasing the public's safety by minimizing risks and reducing drug errors and other drug-related problems) due to a more proactive pharmacist role (e.g. helping ensure drugs prescribed appropriately initially) rather than a reactive role (e.g. resolving the drug related problem after it has occurred); decreased adverse drug reactions and drug-drug interactions
- Facilitating the education and training of patients to use their drugs properly (e.g. demonstration of injecting and inhaling drugs) and to self-monitor (e.g. blood glucose monitoring)
- Facilitating and supporting patient self-care by assessing symptoms, providing advice on the management of minor ailments and the use of medications, and referring patients to other health care providers, where appropriate
- Providing education and interventions to prevent disease and disability, thereby promoting healthy lifestyles.
- Facilitating the identification of Ontarians with significant risk factors for conditions or diseases (e.g. through screening clinics, health promotion programs) and then referring them to physicians and other health care professionals<sup>18</sup>

The medical and pharmaceutical literature contains thousands of articles documenting the effectiveness of pharmacists at optimizing drug therapy, improving health outcomes, and developing innovative and collaborative programs with other health care providers.<sup>19</sup> McLean<sup>20</sup> reviewed over 500 articles that demonstrated the pharmacist's value in achieving health outcomes (i.e. better disease control; decreased drug-related problems, including decreased adverse drug reactions, decreased administration problems, increased compliance, better dosing, decreased inappropriate consumption of drugs; increased quality of life; decreased use/need of health services, including decreased hospital admissions and length of stay; decreased mortality); humanistic outcomes (i.e. increased quality of life, increased patient satisfaction) or economic outcomes (i.e. decreased drug costs, decreased use of health services; decreased cost of morbidity / complications).

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<sup>18</sup> Tsuyuki RT, Olson KL, Dubyk AM, et al. Effect of community pharmacist intervention on cholesterol levels in patients with high risk of cardiovascular events: The second Study of Cardiovascular Risk Intervention by Pharmacists (SCRIP-plus). *Am J Med* 2004; 116: 130-3.

<sup>19</sup> Bacovsky RA. Pharmacists Prescribing in Alberta: An Examination of the Literature and Pharmacist Practices. Prepared for the Alberta College of Pharmacists. June 2003: [www.pharmacists.ab.ca](http://www.pharmacists.ab.ca).

<sup>20</sup> McLean W. Pharmaceutical care evaluated: the value of your services. *Canadian Pharmaceutical Journal* 1998; 131(4): 34-40.

### **a. Gaps in professional services**

Studies have repeatedly shown that Canadians receive less than optimal drug therapy and disease management, resulting in poor health outcomes and preventable hospitalizations. These may be attributed to poor access to health professionals and may be improved by interdisciplinary health care teams and closer monitoring of patients, especially those with chronic conditions. Pharmacists, because of their expertise, accessibility, and frequent contact with patients getting prescriptions dispensed, can facilitate improved patient care.

Some of these gaps in service were identified in the report of the Ontario Health Quality Council.<sup>21</sup> The Council found in surveys, that 92 percent of people in Ontario said they have a family physician, but only 86 percent of immigrants who have lived here less than five years have a family physician. Only 10 percent of Ontario family physicians are taking new patients, down from 40 percent seven years ago. Only 39 percent of Ontarians who need to see their doctor can do so that day or the day after.

The Council estimated that about 8,000 lives could be saved annually, and the quality of life improved for many more people, if there was better delivery of regular care and monitoring that prevents people with chronic disease from becoming more severely ill.

The Council also reported that people with coronary artery disease are only getting two-thirds of the right drugs and tests — and women get much less care than men. The Council found that three-quarters of patients were recommended aspirin; about two-thirds were recommended beta-blockers and a similar proportion, statins. In theory, all patients with coronary artery disease should at least be considered for each of these three treatments. But just one in three is considered for all three drugs.

The Council recommended that people get a second opinion on their prescriptions through the MedsCheck program in which all Ontarians who take three or more prescription medications for chronic conditions can receive a free one-on-one review of their medications from a pharmacist, once per year. A follow-up MedsCheck is also covered if the person has been recently discharged from hospital and needs to have medication changes double-checked.<sup>22</sup>

With the expanded scope of practice, pharmacists will be able to facilitate better medication therapy management, including more regular care and monitoring, especially when patients come to pharmacies to get their refills of chronic medications.

### **b. Epidemiological trends in illness and disease**

Canadians are living longer. One in three people in Ontario has a chronic disease, such as heart disease, emphysema, diabetes and arthritis. Eighty percent of Canadians who are older than 65 have some form of chronic disease and of those, about 70 percent suffer two or more.<sup>23</sup> According to the World Health Organization, an estimated 89 percent of all deaths in Canada are caused by chronic disease.<sup>24</sup> WHO research puts the cost of medical

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<sup>21</sup> Ontario Health Quality Council. *2008 Report on Ontario's Health System*. 2008:www.ohqc.ca.

<sup>22</sup> Medchecks website: www.medchecks.ca.

<sup>23</sup> Gilmour H & Park J. Dependency, chronic conditions, and pain in seniors. Health Reports. 2005; supplement1: 21-31: www.statcan.ca/english/freepub/82-003-SIE/2005000/pdf/82-003-SIE20050007443.pdf.

<sup>24</sup> World Health Organization. *Innovative Care for Chronic Conditions: Building Blocks for Action*. Geneva 2002.

treatment for chronic diseases, and the lost productivity they cause, at \$80 billion annually in Canada.<sup>25</sup> The 33% of Canadians with one or more of seven chronic health conditions uses approximately 51% of general practitioner consultations, 55% of specialist consultations, 67% of nursing consultations, and 72% of nights spent in a hospital.<sup>26</sup>

The expanded scope of practice will enable pharmacists to focus on medication therapy management for these chronic diseases.<sup>27, 28</sup> By permitting pharmacists to change dosages and order laboratory tests, pharmacists can provide anticoagulation services and monitor patients on drugs such as warfarin.<sup>29,30</sup> Pharmacists will also be involved in more screening programs to identify people with increased risk factors to develop chronic diseases and then provide information on how to prevent or manage the diseases. The screening programs can also help detect these diseases sooner, hence facilitating earlier treatment and management, thus improving health outcomes.<sup>31</sup> Pharmacist-directed care has been found to significantly reduce the risk of all-cause hospitalizations and hospitalizations for heart failure, but was associated with a non-significant reduction in mortality. Pharmacist collaborative care resulted in greater reductions in heart failure hospitalization rates compared to pharmacist-directed care.<sup>32</sup>

### **c. Changing public need for services and increased public awareness of available services**

A study of the supply and utilization of general practitioner and family physician (GP/FP) services in Ontario, found the use of their services, as measured by the per capita visit rate, declined from 1993/94 to 2001/02.<sup>33</sup> Most of this decline was the result of a large drop in utilization among children and young adults. There was a slight shift in care to pediatricians, but this accounted for only 6% of the decrease in GP/FP visits. Visits to the emergency department by children and young adults also fell during the 1990s. It appeared that young Ontarians were simply visiting GP/FPs less. One possibility is that decreased physician supply may lead to increased wait times such that an otherwise healthy adult or child with a minor acute self-limiting condition may be less likely to seek care. The proportion of the population with no GP/FP visits in a year rose from 21.4% to 24.6%. One possible explanation for this trend is that an increasing number of Ontarians cannot find a family doctor, but the 2001 Statistics Canada Health Services Access Survey suggests that only

<sup>25</sup> World Health Organization. Primary Health Care: A Framework for Future Strategic Directions. 2003.

<sup>26</sup> Health Council of Canada. 2007. Population Patterns of Chronic Health Conditions in Canada: A Data Supplement to *Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions*. Toronto: Health Council. [www.healthcouncilcanada.ca](http://www.healthcouncilcanada.ca).

<sup>27</sup> Diamond SA, Chapman KR. The Impact of a nationally coordinated pharmacy-based asthma education intervention. *Can Respir J*. 2001, Jul-Aug; 8(4):261-5.

<sup>28</sup> McLean W, Gillis J, Waller R. The BC Community Pharmacy Asthma Study: A study of clinical, economic and holistic outcomes influenced by an asthma care protocol provided by specially trained community pharmacists in British Columbia. *Can Respiratory J*. 2003; 10:195-202.

<sup>29</sup> Bungard TJ, Archer SL, Hamilton P, et al. Bringing the benefits of anticoagulation management services to the community. *Can Pharm J* 2006; 139(2):58-64.

<sup>30</sup> Lalonde L, Martineau J, Blais N, et al. Is long-term pharmacist-managed anticoagulation service efficient? A pragmatic randomized controlled trial. Submitted Thrombosis Research (August 2007).

<sup>31</sup> Chambers LW, Kaczorowski J, Dolovich L, et al. A community-based program for cardiovascular health awareness. *Canadian Journal of Public Health*. 2005;96(4):294-8.

<sup>32</sup> Koshman SL, Charrois TL, Simpson SH, et al. Pharmacist care of patients with heart failure: a systematic review of randomized trials. *Arch Intern Med* 2008; 168:687-94.

<sup>33</sup> Chan BTB, Schultz SE. *Supply and Utilization of General Practitioner and Family Physician Services in Ontario*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences. 2005.

5.7% of Ontarians report not having a family physician, and only one-half of these individuals stated that it was because they could not contact one. One explanation was that more patients are engaging in self-care for minor conditions.

This study also found that one-third to one-quarter of all GP/FP visits were of probable low acuity. This indicated opportunities for delegation to other health professionals and to increase patient education on how to self-manage some of these low acuity conditions. A very slight decrease in probable low acuity visits was observed, possibly due to patients who are more knowledgeable than before and thus visit GP/FPs less often for minor complaints. Another possibility is that because physician supply is decreasing, such patients may elect not to see their physician if there are longer queues.

The public is more interested in self-care and taking an active role in the management of their health. They actively research through computer websites to find information about their illnesses and treatment options. They question their physicians and other health care professionals about their findings.

Pharmacists, with their new scope of practice, can help patients by managing their minor ailments and help them with self-treatment and increasing self-management of their chronic diseases.

#### **d. Waiting times for health care services**

The Ontario Health Quality Council reported that only 39 percent of Ontarians who need to see their doctor can do so that day or the day after.<sup>34</sup> Having pharmacists be able to treat minor ailments, renew prescriptions, and adjust dosages will provide continuing care for many patients until they are able to see their physician.

The concern about waiting times in emergency departments have resulted in the Ontario government taking numerous coordinated steps to reduce wait times and improve patient satisfaction.<sup>35</sup> A major factor causing long emergency room wait times is the high number of alternate level of care (ALC) patients occupying acute care hospital beds, making it difficult to admit patients from the emergency room to the hospital. More than 18 per cent of patients who are currently in a hospital bed in Ontario are in need of an alternate level of care. A study at Vancouver General Hospital found that more than 1 in 9 emergency department visits are due to drug-related adverse events. Of these, 68 per cent were considered to be preventable. The most common reasons for drug-related visits were adverse drug reactions (39.3%), nonadherence (27.9%) and use of the wrong or suboptimal drug (11.5%). The probability of admission was significantly higher among patients who had a drug related visit than among those whose visit was not drug-related. Among those admitted, the median length of stay was longer – 8 v. 5.5 days. The findings suggested that the highest rate of drug-related visits occurred during the night (midnight to 0759h). This may reflect differences in the patient population that visits the emergency department overnight and lack of access to other health care resources at that time of day.<sup>36</sup> Pharmacists' interventions can reduce medication errors by 66 per cent in an

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<sup>34</sup> Ontario Health Quality Council. 2008 Report on Ontario's Health System. 2008:www.ohqc.ca.

<sup>35</sup> Government of Ontario. News Release. Ontario Tackles ER Waits With \$109 Million Investment. May 30, 2008

<sup>36</sup> Zed PJ, Abu-Laban RB, Balen RM, et al. Incidence, severity and preventability of medication-related visits to the emergency department: a prospective study. CMAJ 2008;178 1563-1569.

emergency department.<sup>37</sup> With an expanded scope of practice, pharmacists can assist by proactively intervening to facilitate better medication therapy and hence help avoid emergency visits and hospitalizations. There are some pharmacists who work in emergency departments, but their potential contributions are not readily recognized by other health professionals.<sup>38</sup>

Access to other health services, such as long term care beds, also can be facilitated by the expanded scope of practice of pharmacists. Pharmacists will help improve the health outcomes of patients, especially through better medication management of chronic conditions, thus helping maintain Ontario residents in their homes longer.

#### **e. Geographic variation in availability and diversity of health care providers across the province**

The availability of physicians varies greatly across the province, in both primary care and specialists. A study of physician services in rural and northern Ontario found that there is significant variation in physicians among rural communities at both the individual community and District Health Council (DHC) area levels. There are also variations in physician type, number and demographics, with communities in the southern DHC areas showing increasing turnover, decreasing physician to population ratios and an aging workforce.<sup>39</sup> International medical graduates (IMGs) are an important source of specialists in rural areas, but not so for family physicians.

There are over 11,000 pharmacists accessible to the public throughout the province, through all hospitals and in 3,600 pharmacies. Pharmacies are located in communities in which there is limited access to physicians and other health care services. Therefore pharmacists can increase the public's access to health services by managing minor ailments and other medication therapists. This would allow physicians to focus on their diagnostic skills and more complex cases.

#### **f. Changing technology**

Advances in drug formulation design have resulted in increasing numbers of drugs being administered through injection or inhalation. Advances in parenteral therapy administration devices and techniques and changes in health care delivery have resulted in more patients finishing their drug therapy infusions at home. The new scope of practice will facilitate pharmacists in educating patients about these therapies and how to administer them properly.

Advances in technology for self-monitoring of diseases and conditions often require small amounts of blood obtained by using a lancet. In addition to blood glucose monitoring, other home devices are being developed, such as INR for patients on warfarin. The new scope of practice will facilitate pharmacists in educating patients about using these devices accurately.

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<sup>37</sup> Brown JN, Barnes CL, Beasley B, et al. Effect of pharmacists on medication errors in an emergency department. *Am J Health Syst Pharm* 2008;65(4):330-3.

<sup>38</sup> Rowland M. A day in the life of an emergency department pharmacist. May 2008.

<sup>39</sup> Tepper JD, Schultz SE, Rothwell DM, et al. Physician Services in Rural and Northern Ontario. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences. 2005.

Advances in technology allow more types of disease screening in a pharmacy setting (e.g. osteoporosis) thus helping Ontarians detect these diseases earlier, change lifestyles to improve their health outcomes, and obtain treatment earlier.

Biomonitoring and genomic forecasting will help health professionals, including pharmacists to identify Ontarians at risk for disease and tailor therapies accordingly.

Electronic health records, under development in Ontario, will enable pharmacists, especially those in community practice, to access health information of their patients and thus provide better medication management. Pharmacists will be able to order tests to monitor patients' response to medication therapy, and receive the results in a timely manner. Patient portals to electronic health records will allow patients to see their records and support self-management initiatives. Electronic health records will also facilitate electronic prescribing, thus improving patient safety by reducing drug errors due to misreading of hand written prescriptions.

### **g. Demographic trends**

The population of Ontario is projected to grow by 30 per cent, or 3.8 million, from an estimated 12.69 million on July 1, 2006, to 16.49 million on July 1, 2031. Over this period, net migration is estimated to account for 74 per cent of total population growth, primarily through immigration. The median age of Ontario's population is projected to rise to 43 years in 2031 from 38 years in 2006. The median age for women climbs from 39 to 43 years, and the median age for men increases from 37 to 42 years. The population age 65 and over more than doubles from 1.6 million, or 12.9 per cent of the population, in 2006 to 3.5 million, or 21.4 per cent, in 2031. The population aged 75 and over will also more than double, increasing from 776,000, or 6.1 per cent of the population, in 2006 to 1.6 million, or 9.7 per cent, in 2031. The growth in seniors' share of the population will accelerate after 2011 as baby boomers begin to turn age 65. The life expectancies at birth for 2031 remain at 82.6 years for males and 85.0 years for females.<sup>40</sup>

An older population has more chronic health conditions and uses more health services. Pharmacists will be able to provide medication therapy management for these chronic conditions. With pharmacists helping treat minor ailments, the time of physicians can be reallocated to serving this older population.

### **h. Promotion of collaborative scopes of practice**

Pharmacists have always worked in collaboration with other health professionals, in both the community and institutional settings. Pharmacists provide a safety net for the public on medication issues by providing prescription checks on dosage amounts and choices of drug therapy. Pharmacists working in hospitals, long term care and other institutional settings work in collaborative health teams environment where their expertise in medication management directly impacts on the patients. Pharmacists routinely review the patient's health history and medications, access laboratory and other diagnostic information in order to make recommendations to physicians on the best medication therapy option for the patient.

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<sup>40</sup> Ontario Ministry of Finance. (2007). *Ontario Population Projections Update: 2006-2031*. Available at: <http://www.fin.gov.on.ca/english/economy/demographics/projections/2007>.

Documenting and record keeping are key parts of the pharmacist's current scope. With the expanded scope, pharmacists will communicate, in a timely manner, their medication management activities and other pertinent information to physicians, nurse practitioners and other health care professionals involved with their patients.

### **i. Patient safety**

Medications have been a key concern in patient safety, not only from the perspective of adverse events and interactions with other drugs, but also in accurate communication among health professionals about a patient's medication therapy as they receive services in different health sectors.

In comparing patterns of potentially inappropriate drug therapy prescribing in community-dwelling older adults and nursing home residents in Ontario in 2001, researchers found that nursing home residents were close to half as likely to be dispensed a potentially inappropriate drug therapy as community-dwelling older adults. Clinical pharmacist services, which are mandated in the nursing home setting, were thought to be responsible for these differences.<sup>41</sup>

In long term care facilities, research found that the overall rate of adverse drug events was 9.8 per 100 resident-months; 42% of these adverse events were preventable.<sup>42</sup> Errors associated with preventable events occurred most often at the stages of ordering and monitoring. Residents taking antipsychotic agents, anticoagulants, diuretics, and antiepileptics were at increased risk of a preventable adverse event.

Recognition of the expertise of the pharmacist in medication management and their role in promoting health, preventing and treating diseases, dysfunctions and disorders introduces little or no new risk to patients because, in many cases, pharmacists already perform these duties. Patient safety will increase as more proactive involvement of pharmacists in medication therapy management and other medication-related activities have been found to reduce medication-related problems.

### **j. Wellness and health promotion**

Pharmacists are very active in wellness and health promotion. Studies have found that trained community pharmacists, providing a counselling and record keeping support program for their customers, may have a positive effect on smoking cessation rates.<sup>43</sup> Pharmacists have assisted in government-lead initiatives to increase flu immunizations by hosting flu vaccine clinics, to provide education on smoking cessation,<sup>44</sup> and have distributed testing kits to detect colorectal cancers.

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<sup>41</sup> Lane CJ, Bronskill SE, Sykora K. et al. Potentially inappropriate prescribing in Ontario community-dwelling older adults and nursing home residents. *Journal of the American Geriatrics Society*. 2004;52(6):861-6.

<sup>42</sup> Gurwitz J, Field T, Judge J, et al. The incidence of adverse drug events in two large academic long-term care facilities. *Am J Med* 2005;118(3):251-258.

<sup>43</sup> Sinclair HK, Bond CM, Stead LF. Community pharmacy personnel interventions for smoking cessation. *Cochrane Database of Systematic Reviews*. 1, 2008.

<sup>44</sup> Ontario Ministry of Health Promotion. News Release. April 5, 2007. Ontario Pharmacists' Association and the Centre for Addiction and Mental Health announce new phase of the STOP Study – offering 5,000 Ontarians free medication to quit smoking.

Pharmacies often host clinics that involve providing information and may involve consultation appointments. These clinics may include other health care professionals such as nurses, dietitians, and personal trainers.<sup>45</sup> Some examples are:

- Heart Health -- cholesterol screening / management; lipid panel screen; blood pressure reading; Framingham Risk Assessment; assessment of current medications; body mass index calculation; nutritional assessment; physical activity assessment; discussion about risk factors (modifiable and non-modifiable) and suggestions to reduce risks; recommendations on pharmacotherapy and lifestyle modifications.
- Osteoporosis -- bone density scan; review of risk factors (modifiable and non-modifiable); customize individual plan for lifestyle (i.e., calcium intake and suggestion for implementing weight bearing exercises).
- Asthma -- puffer instruction; peak flow meter training; recommendations for actions patient may need to take (i.e., discussing with physician medication changes, identification of potential triggers and how to avoid and decrease the likelihood of an asthma attack)
- Diabetes -- blood glucose monitoring; lifestyle assessment; medication assessment.
- Men's Health -- discussion of erectile dysfunction and treatment options
- Smoking Cessation -- assessment of smoking habits, lifestyle changes, and treatment options
- Women's Health -- hormonal replacement therapy counseling; menopausal symptom reduction – lifestyle modifications and natural remedies.
- Influenza Vaccination Clinic
- Pain Management -- discussion of symptoms and disease state (e.g. arthritis, chronic back pain), assessment of current medications.
- Weight Loss and Nutrition Consultations
- Anticoagulation Management Clinics
- Travel Clinic -- discussion about destination and potential problems; travel safety precautions, needed vaccines

The expanded scope of practice will empower pharmacists to provide more of these wellness and health promotion initiatives. The public will benefit from more access to these services, including education, being identified earlier with risk factors or the disease or condition being screened, and hence earlier treatment.

#### **k. Health human resources issues**

There are shortages of many health professionals, including physicians, nurses, nurse practitioners and pharmacists. Having pharmacists more involved in medication therapy management and in treating minor ailments, will relieve the workload of these other health professionals, allowing them to focus on their unique areas of expertise. This will make them more accessible to the public.

In addition, pharmacy technicians will soon be regulated and assuming responsibility for the technical elements of dispensing, thereby freeing up the pharmacist to provide more patient focussed care.

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<sup>45</sup> Pharmacists Association of Alberta. Fact Sheet on Pharmacist Clinical Services. 2003.

## **I. Professional competencies not currently recognized**

The public and other health professionals often do not recognize the many services pharmacists can provide. Official recognition of these in the expanded scope of practice will facilitate integration of pharmacists into more programs, services and initiatives.

Physicians often think that pharmacists can already adapt prescriptions by changing formulations (e.g. changing tablets/capsules to oral liquid for patients who have difficulties swallowing; changing the dosage strength / formulation if prescribed one not commercially available or not covered by patient's drug plan) and that pharmacists can provide interim supplies. Physicians become frustrated when contacted by pharmacists to obtain authorization to do the above. This confusion can delay the patient getting their prescription filled quickly when physicians aren't able to return, in a timely manner, phone calls from pharmacists requesting prescription changes.

The publicity surrounding the expanded scope of practice will help educate the public about the many services they can expect to receive from pharmacists.

### **m. Access to services in remote, rural or under serviced areas**

The public can experience difficulty in accessing health services in all areas of the province, including cities. In more remote or rural areas, pharmacies may be readily accessible while physicians may only be accessible on certain days. In all circumstances, pharmacists provide required services to their patients as necessary, often through delegation and frequently through the use of their professional judgement.

The expanded scope will improve access to the pharmacist services and hence to other health professionals in these areas, who can reallocate their time to patients and more complex cases as the pharmacists provide medication therapy management and treat minor ailments.

## **16. How would this proposed change in scope of practice affect the public's access to health professions of choice?**

This proposed change in scope of practice will increase the public's access to the medication therapy expertise of pharmacists in institutions and in the community sector. Since pharmacists will be able to assess and treat more minor illnesses and conditions, provide refills, and provide medication therapy management, other health professions will be more accessible.

## **17. How would the proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public? Describe the effect the proposed change in scope of practice might have on:**

### **a. Practitioner availability;**

#### **Pharmacists**

Significant time is required by pharmacists and technicians to ensure prior authorization is obtained for prescription changes and obtaining refills. Anecdotal reports from Alberta, where pharmacists have been able to independently adapt prescriptions and prescribe in emergencies since April 2007, indicate that their expanded scope of practice has

significantly decreased time involved in trying to contact physicians to change prescriptions and to obtain refills, thus offsetting the additional time required for increased documentation and communicating prescribing decisions to the patient's family physician and other health professionals.

The appropriate management of the pharmacist as a high priority health human resource is undergoing significant studies. In 2005, eight leading national pharmacy organizations partnered together to carry out a human resources study of pharmacists and pharmacy technicians, now known as *Moving Forward: Pharmacy Human Resources for the Future*. This study was funded by the Foreign Credential Recognition Program of Human Resources and Social Development Canada and managed by the Canadian Pharmacists Association. The multi-pronged research program examined factors contributing to pharmacy human resources challenges in Canada, and has developed a series of pharmacy human resources planning recommendations to ensure a strong pharmacy workforce prepared to meet the future health care needs of Canadians.<sup>46</sup> This initiative complements another collaborative initiative known as the *Blueprint for Pharmacy*.<sup>47</sup> The *Blueprint* has developed a vision, mission, and strategic action plan for the pharmacy profession in Canada to strengthen its alignment with the health care needs of Canadians and to respond to the stresses on the health care system. It is based on the enhanced roles pharmacists and pharmacy technicians including drug therapy management, public health outreach, prescribing and monitoring authority, self-care patient support and dispensing leadership.

Hence, pharmacists throughout Canada are working to ensure the availability of pharmacists for expanded scopes of practice.

## Physicians

Many physicians have found the interventions of pharmacists useful and are accustomed to working with pharmacists, especially in hospitals and long term care facilities. Studies have found physicians develop a very positive attitude to pharmacist interventions after working with pharmacists in primary care models. Physicians will benefit from pharmacists being integrated more fully into the health system and as members of collaborative health teams. They will get increased support from pharmacists in helping to manage medication therapy by

- improving communication among health care providers
- providing information on the review and modification of all medication therapies a patient is taking (prescription, non-prescription, herbals, etc.) for patients receiving medication therapy management
- improving continuity of care/seamless care as patients move between health sectors.

Physicians' workload will be reduced related to pharmacists

- authorizing dosage / formulation changes and refills
- treating minor injuries, illnesses, and self-limiting conditions
- extending prescriptions
- managing of chronic and recurrent diseases and conditions
- decreasing interruptions outside of physician regular practice hours, associated with requests for authorization of prescriptions.

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<sup>46</sup> Ascentum Inc. Integrated Key Findings from the Moving Forward: Pharmacy Human Resources for the Future Research Program. Synthesis Report. May 2008. [www.pharmacyhr.ca](http://www.pharmacyhr.ca).

<sup>47</sup> Task Force on a Blueprint for Pharmacy. *Blueprint for pharmacy: the vision for pharmacy*. Ottawa (ON): Canadian Pharmacists Association; 2008. [www.pharmacists.ca](http://www.pharmacists.ca).

Physicians will also be able to reallocate their time to see new patients and other patients who require their expertise

### **Nurses / Nurse Practitioners**

Nurses and nurse practitioners also are accustomed to working with pharmacists, especially in hospitals and long term care facilities. They rely on the pharmacist's expertise on medications and medication therapies and will benefit from pharmacists being integrated more fully into the health system and as members of collaborative health teams. They will get increased support from pharmacists in helping to manage medication therapy by

- improving communication among health care providers
- providing information on the review and modification of all medication therapies a patient is taking (prescription, non-prescription, herbals, etc.) for patients receiving medication therapy management
- improving continuity of care / seamless care as patients move between health sectors.
- managing of chronic and recurrent diseases and conditions

### **Other Health Care Professionals**

Other health care professionals (e.g. dietitians, physiotherapists, and respiratory therapists) will benefit from greater access to pharmacists as members of inter-professional teams and their expertise in medication therapy management.

### **Public**

The public impact and benefits of the expanded scope of practice for pharmacists has been discussed in Question 15.

#### **b. Education and training programs, including continuing education;**

The proposed change in scope would have a minimal impact on education and training programs as pharmacists are educated to perform these activities, except for injecting drugs. Education and training programs will be revised to include the expanded scopes of practice. More will be offered on medication therapy management and training in injecting drugs.

In a 2007 survey of Canadian pharmacists, 49% of Ontario pharmacists reported that they were most likely to provide special pharmaceutical care services, beyond the day-to-day counseling about prescriptions. This was the highest percentage in Canada. These services include medication management, drug utilization review, diabetes-related care, and drug therapy management for seniors, smoking cessation and hypertension management.<sup>48</sup>

#### **c. Enhancement of quality of services;**

By allowing pharmacists to manage medication therapies and order laboratory tests, there will be decreased delays in needed changes to medication dosages and hence better

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<sup>48</sup> 2007 Trends and Insights, prepared for Rogers Media:  
[www.mckesson.ca/documents/Trends\\_2007.pdf](http://www.mckesson.ca/documents/Trends_2007.pdf).

monitoring. By allowing pharmacists to adapt prescriptions and provide supplies to continue therapy, delays or disruptions in therapy will be reduced.

Proactive involvement of pharmacists will help reduce preventable drug-related problems and adverse events.

#### **d. Costs to patients or clients;**

Patients will save time, transportation costs, and time away from work due to fewer visits to the physician or emergency department for refills and the treatment of minor illnesses. They will also benefit from improved medication therapy and better health outcomes.

Pharmacists will start providing and charging for more comprehensive consultations on medication therapy management. There may be additional charges to the public for these depending upon whether the government and private sector drug plans cover these fees.

#### **e. [Cost Effective] Access to Services;**

The expanded scope of practice would provide increased access to the pharmacist's expertise by the public and to other health care professionals. It would also increase the public's access to health and wellness programs and to other health professionals and services who would have time freed up by pharmacists more integrated into the health system. We believe that using pharmacists to the full extent of their scope of practice, especially in assessing and treating minor ailments can both improve public access to necessary health care services and decrease overall costs to the health care system.

### **Treatment of Minor Ailments**

One significant area involves the assessment and treatment of minor ailments. As noted earlier, a study of the supply and utilization of GP/FP services in Ontario, found that one-third to one-quarter of all GP/FP visits were of probable low acuity.<sup>49</sup> The public routinely seek out pharmacists as their primary source of advice and care for numerous minor ailments and because pharmacists are easily seen without appointments they have long been recognized as the most accessible health care professionals. Through the expanded scope of practice and government recognition and support, more patients can be encouraged to use their pharmacist as the first line health professional for the assessment and treatment of minor ailments.

Such programs have existed in the United Kingdom since the early 2000s, first as pilots and then as core services. These minor ailments schemes enable patients who are exempt from prescription charges to receive treatment for common illnesses free of charge direct from a community pharmacy. The minor ailments and drug benefits vary with the jurisdiction. The ailments can include acne, allergies, athlete's foot, back pain, bites, burns, colds, simple viral infections (e.g. cold sores), colic, conjunctivitis, constipation, contact dermatitis, cough, cystitis, diaper rash, diarrhea, dyspepsia, earache, ear wax, eczema, fever, hemorrhoids, hayfever, headaches, head lice, indigestion, mouth ulcers, nasal congestion, oral thrush, scabies, sore throat, strains, teething, threadworms, urinary tract infections, vaginal thrust, and warts. While the products prescribed under this scheme generally are not prescription-requiring by law, they may require a prescription in order for the patient to obtain drug coverage by the NHS. It relieves pressure in primary care by discouraging

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<sup>49</sup> Chan BTB, Schultz SE. *Supply and Utilization of General Practitioner and Family Physician Services in Ontario*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences. 2005.

patients from seeing physicians for minor ailments. In April 2006, minor ailments schemes became one of the four core services in the community pharmacy contract, meaning that it would be offered by every community pharmacy in Scotland.<sup>50</sup> In England, the government recently proposed that minor ailments schemes be commissioned from community pharmacies in every primary care trust.<sup>51</sup> As of March 2007, only 24% of all pharmacies held such contracts. (See Appendix 1.)

Preliminary data, included in the appendices, demonstrates increased access by the public to necessary health services for minor ailments, increased access to physicians by patients who are more seriously ill, and overall cost savings to the NHS. IMS Health analysed anonymized patient records from its database of 210 general practices across the UK, covering four million patient records and 190 million prescriptions.<sup>52</sup> Data from 500,000 UK patients who had consulted their GP about a minor ailment suggested that, in 2006–07, 51.4 million GP consultations a year were solely for minor ailments.

Estimated at eight minutes per consultation, this represents 18 per cent of GPs' workload or an hour a day for each GP. The total cost to the NHS of these consultations is £1.8bn and 80 per cent of this (£1.5bn) is attributable to the cost of GPs' time. In addition, 10 minor ailments are responsible for 75 per cent of the cost of minor ailments consultations and 85 per cent of the cost of prescriptions for minor ailments. These are:

- back pain
- indigestion
- dermatitis
- nasal congestion
- constipation
- migraine
- acne
- cough
- sprains and strains
- headache

A minor ailments program was used by the Canadian Forces.<sup>53</sup> If their members did not have access to a base pharmacy, the member had to consult a physician to get a prescription to get an over-the-counter drug covered. The pilot project was tested in several Canadian locations, including London, Ontario. The Canadian Forces member could get the over-the-counter drug directly from these pharmacies and the pharmacy would bill the Canadian Forces. The researchers found the provision of these drugs by pharmacists to be cost-effective and convenient. They found that the members interacted with the pharmacists to obtain optimal treatment of the ailments and that few members required follow-up with a physician to treat the ailments.

Implementation of such a scheme in Ontario would more fully utilize the training and expertise of the pharmacist, but could also be expected to increase the public's access to health services involving minor ailments and free up family physicians to see more seriously ill patients. The overall costs to the health care system would decrease proportionately with

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<sup>50</sup> Bellingham C. How to manage a minor ailment service. *Pharmaceutical Journal* 2005; 275: 694.

<sup>51</sup> Department of Health. *Pharmacy in England: Building on strengths – delivering the future*, April 2008.

<sup>52</sup> Moberly, T. Making the case for a pharmacy-based minor ailments scheme for England. *Pharmaceutical Journal* 2008; 280: 111.

<sup>53</sup> Vaillancourt R, Trottier M, Gervais A, et al. Provision of non-prescription medications to Canadian Forces members through civilian pharmacies: interim results of a pilot project *Canadian Pharmaceutical Journal* 2002; 135(9): 36-37.

decreased “first line” visits to physician offices, walk-in clinics and emergency rooms for minor ailments.

#### **f. Service efficiency;**

The health system will be able to more effectively use health care providers and resources and provide residents of Ontario with better access to medication therapy management, such as:

- provide more flexibility in designing programs to make better use of health care providers according to their qualifications, skills and training
- facilitate the greater use of pharmacists to manage medication therapy in hospitals, long term care facilities, family health teams, primary care, community health centres, home care, outpatient, outreach, and community based programs
- reduce the workload of physicians, nurses, and other health professionals related to medication therapy permitting reallocation of their time to patients who require their expertise
- improving continuity of care / seamless care as patient moves between health sectors
- facilitate the incorporation of pharmacists into primary care treatment groups and disease management programs

#### **g. Inter-professional care delivery;**

Pharmacists work within inter-professional teams, especially in institutional settings and in primary care teams.<sup>54,55,56,57</sup> The majority of the 150 family health teams in Ontario include pharmacists. In a 2207 survey, increasing numbers of Canadian pharmacists reported that they would like to formally collaborate with physicians, i.e. 81% up from 66% in 2005. Twenty-one per cent of Ontario pharmacists reported that they currently collaborate.<sup>58</sup>

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<sup>54</sup> Howard M, Trim K, Woodward C, Dolovich L, et al. Collaboration between community pharmacists and family physicians: lessons learned from the Seniors Medication Assessment Research Trial. *Journal of the American Pharmacists Association*: 2003;43(5):566-72.

<sup>55</sup> Dolovich L, Kaczorowski J, Howard M, et al. for the IMPACT team. Cardiovascular outcomes of a pharmaceutical care program integrated into family practices (abstract). *Can J Clin Pharmacol* 2007; 14(2):e116.

<sup>56</sup> Dolovich L, Kaczorowski J, Sellors C, et al. on behalf of the IMPACT team. Integration of a pharmaceutical care program into family practices: Drug-therapy problems identified and recommendations made by participating pharmacists (abstract). *Can J Clin Pharmacol* 2007; 14(2):e164.

<sup>57</sup> Farrell B, Woodend K, Pottie K, et al. Collaborative working relationships between family physicians and pharmacists: changes over time as pharmacists integrated into family practice. *Can J Clin Pharmacol* 2006; 13(2):e217.

<sup>58</sup> 2007 Trends and Insights, prepared for Rogers Media: [www.mckesson.ca/documents/Trends\\_2007.pdf](http://www.mckesson.ca/documents/Trends_2007.pdf).

## **h. Economic issues; and**

Total drug spending in Canada is estimated to have reached \$26.9 billion in 2007.<sup>59</sup> For the last decade, drugs have represented the second-largest component of health spending, after hospitals. This represents an estimated annual growth rate of 7.2%, an increase of approximately \$2 billion over 2006. Spending on prescribed drugs continues to grow faster than spending on non-prescribed drugs and is estimated to have reached 84% of the total drug bill in 2007. Total drug spending in Ontario is estimated to have reached \$11.3 billion in 2007. This represents 17.6% of total health expenditure, above the Canadian average of 16.8%. The per capita spending on drugs by the public sector is forecast to have been \$341 in Ontario, above the Canadian average of \$327. Prescribed drug expenditure per capita financed by the private sector is expected to have been \$391, again higher than the Canadian average of \$356.

In addition to their beneficial therapeutic effects, drugs are a significant cause of illness, disability and death. Inappropriate prescribing is estimated to cause at least 1.1% to 3.1% of hospitalizations, and at least 1.1% to 4% of physician visits. In 1997, a conservative estimate of these costs was \$0.84 billion to \$2.56 billion in Canada each year.<sup>60</sup> The estimated cost of misuse, underuse, and overuse of medications ranges from \$2 billion to \$9 billion per year.<sup>61</sup> Between 1995 and 2000, costs associated with adverse drug-related events rose from US\$76.6 billion to over US\$177.4 billion.<sup>62, 63</sup>

In a recent Canadian study, 24% of patients were admitted to a hospital's internal medicine service for medication-related causes, and over 70% of these admissions were deemed preventable.<sup>64</sup> A study at Vancouver General Hospital found that more than 1 in 9 emergency department visits are due to drug-related adverse events. Of these, 68% were considered to be preventable. The most common reasons for drug-related visits were adverse drug reactions (39.3%), nonadherence (27.9%) and use of the wrong or suboptimal drug (11.5%). The probability of admission was significantly higher among patients who had a drug-related visit than among those whose visit was not drug-related. Among those admitted, the median length of stay was longer – 8 v. 5.5 days. The findings suggested that the highest rate of drug-related visits occurred during the night (midnight to 0759h). This may reflect differences in the patient population that visits the emergency department overnight and lack of access to other health care resources at that time of day.<sup>65</sup>

Adverse events after hospital discharge have been reported as 23% of patients experiencing an adverse event within 30 days; 50% of these adverse events were deemed preventable

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<sup>59</sup> Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985 to 2007* (Ottawa: CIHI, 2008).

<sup>60</sup> Coombs RB, Jensen P, et al. A Preliminary Review of the Causes of Inappropriate Prescribing and its Costs in Canada. Toronto: Health Promotion Research. February 1997.

<sup>61</sup> Romanow RJ, chair. Building on values: the future of health care in Canada — final report. Saskatoon (SK): Commission on the Future of Health Care in Canada; 2002:194.

<sup>62</sup> Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost of illness model. *Arch Intern Med* 1995;155:1949-56.

<sup>63</sup> Ernst FR, Grizzle AJ. Drug-related morbidity and mortality: updating the cost-of illness model. *J Am Pharm Assoc* 2001;41:192-9.

<sup>64</sup> Samoy LJ, Zed OH, Wilbur K, et al. Drug-related hospitalizations in a tertiary care internal medicine service of a Canadian hospital: a prospective study. *Pharmacotherapy* 2006;6:1578-86.

<sup>65</sup> Zed PJ, Abu-Laban RB, Balen RM, et al. Incidence, severity and preventability of medication-related visits to the emergency department: a prospective study. *CMAJ* 2008;178:1563-1569.

and 72% were due to medications.<sup>66</sup> Preventable drug related morbidity in Canadians aged 65 or older has been estimated at \$11.9 billion in 2000, with admissions to long-term care facilities being the largest component of costs (61.3%) and hospital admissions being second.<sup>67</sup> This model captured only costs to a public payer, and did not include costs (direct or indirect) to private sector payers, including the seniors and their families.

Expanding the scope of pharmacists will empower them to become more proactively involved throughout the health system and help reduce these preventable adverse events and help optimize medication therapy.

#### **i. Other impacts.**

By expanding their scope, pharmacists will be better prepared to act in times of emergencies to help patients with their medication issues and to inject immunizations as they will be more familiar with injecting drugs when they educate patients on how to do so.

### **18. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved.**

Yes, the members are in favor of this change in scope of practice. Many pharmacists have developed their practices over the years and have participated in medical directives to include this proposed scope of practice thus indicating their support for legislative recognition.

In concert with our consultations over the past ten years respecting the regulation of pharmacy technicians, the College has consulted widely with the membership regarding the scope of practice for pharmacists to gain solid understanding of what pharmacists are currently doing in their day-to-day practice and what the comfort level is among members respecting their scope. The consultations mainly have taken place during the College's bi-annual face to face district meetings and through informal surveys. The long standing position of this College to not actively pursue prescribing rights for pharmacists was taken based on feedback from the majority of pharmacists who were concerned that prescribing traditionally follows the process of conducting a differential diagnosis and the acknowledgement that they were not trained to diagnose. We learned however, that members feel on the whole extremely comfortable in medication therapy management and embrace the ability to adapt or alter existing prescriptions to ensure patient compliance, to extend authorizations of prescriptions for continuing care, to adjust dosages based on laboratory results, to administer substances by injection or inhalation in the course of educating their patients about their therapy, etc. This is consistent with what is considered pharmacist prescribing in other Canadian jurisdictions. We believe that pharmacists in Ontario support and embrace being able to "dispense a prescription without authorization of a prescriber" subject to the above conditions and as well as the autonomy to perform other controlled acts so that they can provide the necessary patient education within their scope of practice.

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<sup>66</sup> Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. *CMAJ* 2004; 170:345-9.

<sup>67</sup> MacKinnon NJ, Kidney T. Preventable Drug-Related Morbidity in Older Adults: a Canadian Cost-of-Illness Model. Presentation. Canadian Pharmacists Association Annual Conference. Winnipeg, Manitoba May 14, 2002.

Ontario pharmacists have participated in the consultations on the Pharmacy Human Resources for the Future Research Program and on the Blueprint for Pharmacy.<sup>68</sup> (See Appendix 3.) Both of these initiatives support expanded scopes for pharmacists. These include:<sup>69</sup>

- Drug Therapy Management: Pharmacists will spend more time managing drug therapy in collaboration with patients, physicians, and other health providers
- Public Health Outreach: Pharmacists will play a more prominent role in health promotion, disease prevention, and chronic disease management
- Prescribing and Monitoring Authority: Pharmacists will have greater responsibility and authority for making prescribing decisions (including initiating and modifying drug therapy) and monitoring drug therapy outcomes (including ordering and performing tests) in collaboration with other health providers
- Self-Care Patient Support: Pharmacists will continue to be accessible and available to support patient self-care.

Pharmacists responding to the consultations expressed broad support for these expanded roles. They recognized the increased workload and liability and noted there would also be an increase in job satisfaction.

**19. Describe any consultative process with other professions that might be impacted by these proposed changes.**

The most recent consultative process respecting the scope for pharmacy occurred in the fall of 2007 resulting in the joint development and approval of the PAPE agreement which would permit pharmacists to extend the authorization of prescriptions for continuing care. On May 9, 2008, consultation focus groups were held at the College respecting this submission and while no representatives of other professions opposed the notion of pharmacists fully realizing their role as experts with a unique body of knowledge in medication therapy, there was less support from the medical profession representatives for pharmacists initiating a prescription. The notion of pharmacists dispensing without further authorization subject to terms and conditions seemed less problematic, perhaps because of the recent process involving PAPE. Other professions in attendance, nurses, nurse practitioners appeared supportive.

As mentioned in Question 14, the College of Nurses of Ontario has indicated its support for the College's pursuit of an expanded scope.

**Risk of Harm**

**20. How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?**

Medications have been a key concern in patient safety, not only from the perspective of adverse events and interactions with other drugs, but also in accurate communication among health professionals about a patient's medication therapy as they receive services in

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<sup>68</sup> Task Force on a Blueprint for Pharmacy. Blueprint for pharmacy: the vision for pharmacy. Ottawa (ON): Canadian Pharmacists Association; 2008. [www.pharmacists.ca](http://www.pharmacists.ca).

<sup>69</sup> Ascentum Inc. Integrated Key Findings from the Moving Forward: Pharmacy Human Resources for the Future Research Program. Synthesis Report. May 2008. [www.pharmacyhr.ca](http://www.pharmacyhr.ca).

different health sectors. As discussed in Question 15(i), the recognition of the expertise of the pharmacist in medication management and their role in promoting health, preventing and treating diseases, dysfunctions and disorders introduces little or no new risk to patients because, in many cases, pharmacists already perform these duties. Patient safety will increase as more proactive involvement of pharmacists in medication therapy management and other medication-related activities have been found to reduce medication-related problems.<sup>70,71</sup>

**21. What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they performing it? (under delegation, supervision or on their own initiative?)**

Physicians, dentists, nurses with extended practice can perform all of these additional activities on their own initiative. Medical radiation technologists, midwifery (within scope), registered nurses (general class), registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics can administer substances by injection or inhalation if authorized under order or regulation.<sup>72</sup>

**22. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.**

Pharmacists routinely assess and triage each patient as required, especially in the community setting and refer patients to a physician or another appropriate health care professional (e.g. dietitian, physiotherapist). If the pharmacist has the competencies and appropriate information to recommend drug therapy for minor self-limiting or self diagnosed conditions, he or she may recommend the therapy to the patient or to their primary care provider. Alternatively, if a Schedule I drug is a better choice, the pharmacist will suggest the patient see their family physician. If the pharmacist suspects there is an urgent need for medical advice, the pharmacist will suggest the patient seek medical advice as soon as possible.

**23. If this proposal is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession's need for independence/ autonomy in practice.**

When a family physician retires, dies, or re-locates to another community, pharmacists who have competently been performing delegated activities as a part of their practice, are left without the ability to gain an authorization mechanism to provide or continue the care their patients require, except under professional judgment or Section 29(1) of the RHPA. This is of special concern in isolated and under-serviced areas where there may not be another health professional to perform the controlled act or delegate to the pharmacist in a timely manner.

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<sup>70</sup> Lane CJ, Bronskill SE, Sykora K. et al. Potentially inappropriate prescribing in Ontario community-dwelling older adults and nursing home residents. *Journal of the American Geriatrics Society*. 2004; 52(6): 861-6.

<sup>71</sup> Gurwitz J, Field T, Judge J, et al. The incidence of adverse drug events in two large academic long-term care facilities. *Am J Med* 2005; 118(3): 251-258.

<sup>72</sup> Ontario Health Plan for an Influenza Pandemic. July 2007.

In the institutional sector, the need for all physicians to sign medical directives is also very difficult to achieve administratively. Recognition of these controlled acts for pharmacists would greatly facilitate the integration of pharmacists into health care teams.

**24. Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?**

The College strongly supports pharmacists being able to perform the new controlled acts of administering a substance by injection or inhalation and performing a procedure on tissue below the dermis. This would require a change to Section 4 of the Pharmacy Act.

Changes are needed to extend the conditions under which a pharmacist can dispense without further authorization.

**25. If the proposed change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act.**

Pharmacists should perform the controlled acts of administering a substance by injection or inhalation and performing a procedure on tissue below the dermis subject to terms and conditions limiting these activities to the pharmacist's role in patient education and medication therapy management.

The pharmacist should be permitted to delegate these acts to an employee who is not a regulated health professional, such as pharmacy technician, who may be involved in patient education and in training patients to use self-monitoring devices. The College has developed a policy, with six principles regarding the use of medical directives and delegation by pharmacists.<sup>73</sup> In order to delegate or to accept delegation, pharmacists must ensure that:

1. The procedure being directed or delegated is clinically appropriate and in the patient's best interest;
2. The delegator (authorizer) and the delegate (implementer) have the competency (knowledge, skills and judgment) to perform the acts or tasks;
3. Patients have consented to receive care by the delegate, under the directive or delegation;
4. There is a process for documentation of the care provided and for communication of the care to the authorizer;
5. Re-delegation of the delegated act(s) is not permitted;
6. The above considerations are documented in a readily retrievable format which also includes:
  - a) A process for regular review of the directive or delegation;
  - b) The signatures of all authorizers and implementers on the directive or delegation.

A consultation session on the Pharmacists Scope of Practice Review was held on May 9, 2008. Representatives from the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Royal College of Dental Surgeons of Ontario, the Ontario College of Family Physicians, the Ontario Dental Association, the Ontario Medical Association, the

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<sup>73</sup> Ontario College of Pharmacists. Policy on Directives and Delegation Approved. Pharmacy Connection. May/June 2007:8.

Nurse Practitioners Association and the Registered Nurses Association of Ontario indicated support for the greater use of the expertise of pharmacists in medication management, especially in collaboration with them. There was no consensus on whether pharmacists should be recognized for additional controlled acts or if pharmacists should continue performing the controlled acts under delegation, medical directives, Section 29(1) of the RHPA, and professional judgement.

The College of Nurses of Ontario (CNO) wrote a letter to provide the College with CNO's initial feedback to the May 2008 consultation.<sup>74</sup> (See Question 14.) Extracts from this letter include:

***Additional Controlled Acts***

*We do not believe that the exception provisions listed in section 29 of the Regulated Health Professions Act are meant to be used to provide a regulated health profession with broad and routine access to controlled acts. It is CNO's recommendation that OCP seek legal access to the controlled acts; this approach is transparent, provides clarity to pharmacists and to other health care practitioners and protects the public - as it facilitates role clarity and OCP's ability to govern its members with respect to the performance of these acts.*

**Competencies / Educational requirements for practice**

**26. Are the entry-to-practise (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?**

The proposed changes to the scope of practice apply to pharmacists on Part A of the register. These are pharmacists who are engaging in direct patient care and maintaining the minimum practice requirements (600 hours of practice within Canada every three years).

Pharmacists in their university programs are trained to assess prescriptions for appropriateness so have the competency to adapt prescriptions and provide refills. They are trained to educate patients on their medications, including how to administer them by injection and inhalation. Pharmacists are trained how to use and interpret patient self-monitoring devices such as blood glucose monitors.

Question 28 provides details about the College's measures to ensure competency of its members.

**27. Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession?**

All pharmacists have the competency to adapt prescriptions and provide refills, to educate patients on administering their drugs through injection and inhalation, to prick the skin for obtaining a blood sample for monitoring blood glucose, as pharmacists routinely do these activities.

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74 Campbell HM, Director, Practice & Policy, Ontario College of Nurses. May 27, 2008. Letter to Anne Resnick, Director, Professional Practice, Ontario College of Pharmacists.

**28. What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope?**

Pharmacists across Ontario welcomed the recent announcement that the Minister of Health and Long Term Care may recognize prescribing by pharmacists.

The proposed change in scope recognizes activities that pharmacists have already been doing, currently through delegation, medical directives, S29 (1) of the RHPA, and professional judgement.

The College will develop a communication and education plan for members respecting the change in the scope of practice and the conditions.

Pharmacists are currently assessed both through the College's inspection process which examines operational and cognitive aspects of the practice setting, and through the Quality Assurance program. Both of these have evolved in concert with the evolving standards of practice for pharmacists and operational standards for pharmacies.

The College provides two primary tools to assist pharmacists with their continuing professional development. The Self-Assessment Survey assists in identifying strengths and learning needs. The Learning Portfolio assists in developing learning goals, education action plans and documenting learning activities. All pharmacists in Part A of the Register are subject to random selection for the College's Practice Review process. Part A refers to pharmacists who are engaging in direct patient care, and maintaining the minimum practice requirements (600 hours of practice within Canada every three years). The Quality Assurance Practice Review consists of two phases. Every year, 20% of members in Part A of the Register will be selected to take part in Phase I of the practice review process. This means that approximately 2000 pharmacists will be selected to participate each year, and every pharmacist in Part A will be selected to participate in Phase I once every five years. Candidates who are selected for Phase I are required to complete the *Self-Assessment Survey and Summary of Continuing Education Activities* and submit them to the College within eight weeks. Approximately 240 pharmacists per year are selected for Phase II of the Practice Review, which is the Peer Review, a clinical knowledge and practice-based assessment lasting approximately six hours. Peer Reviews are held quarterly in Toronto at the Ontario College of Pharmacists. Phase II of the Practice Review is an assessment based on a national model competency document developed by the National Association of Pharmacy Regulatory Authorities (NAPRA). This competency document was reviewed and updated in 2007.

Pharmacists must maintain their competency through ongoing professional development activities. There are numerous continuing education programs available through Continuing Education at the University of Toronto, the Ontario Pharmacists Association and other educational providers (e.g. certified diabetic educators, asthma). These will be revised to include the expanded scope of practice including medication counselling and medication therapy management.

**29. How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?**

The College expects all pharmacists to maintain an acceptable level of competence and further that pharmacists will not practice to a level where they lack the ability or confidence to safely do so. Only practicing pharmacists who are in Part A of the College's register may provide direct patient care and accordingly are subject to the provisions and expectations respecting continuing competence. Pharmacists who are not practicing are not subject to provisions of the Quality Assurance program and as such, elect into Part B of the Register.

As pharmacy technicians become regulated in 2010, and are permitted to take on more independent technical roles within the drug distribution system, pharmacists will be better positioned to focus on the cognitive aspects of medication therapy management included within the scope.

**30. Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?**

The change in scope of practice will bring Ontario in line with pharmacy practice in other provinces. The legal acknowledgement and recognition of the pharmacists role in medication therapy management is in keeping with what pharmacists across Canada are already doing in many instances and working towards in others. As all pharmacists are able to do all of the proposed actions, it is not expected that the proposed scope of practice change will in any way affect the mutual recognition agreement for Pharmacy in Canada.

**Public education**

**31. How do you propose to educate or advise the public of this change in scope of practice?**

The public members on the College's Council were very supportive of the proposed changes. Many of the public already think pharmacists already do these activities because they have experienced them when pharmacist's exercised professional judgment. The College will develop a communication and education plan for the public to help them understand what pharmacists can do, what pharmacists can not do, and what the public should expect from their pharmacist.

## Other jurisdictions

### **32. What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations.**

The scope of practice of pharmacy varies significantly among the provinces, reflecting the differences in health professional legislation, i.e. exclusive scope of practice vs. controlled acts. At minimum, it includes compounding, preparing, dispensing, and selling drugs. Activities that may be controlled or restricted in one jurisdiction may not be addressed in others. For example, diagnosis is not a restricted activity in Alberta. In some provinces, the practice of pharmacy is defined or described outside of the main *Act* governing pharmacy. Tables 1 and 2 summarize decision-making authority regarding prescriptions and Table 3, other aspects of the scope of practice, excluding compounding, preparing, dispensing, and selling drugs. Appendix 2 contains the sections of relevant provincial legislation and agreements.

There are various definitions or interpretations of the term prescribe. Some provinces limit its use to ordering prescription status drugs while other provinces consider pharmacists to prescribe if they provide Schedule II and III drugs to a patient without a prescription from a regulated prescriber. There are different interpretations as to whether prescribing activity includes diagnosis or if it can be performed separately from the person who makes the diagnosis. For example, in Alberta diagnosis is not a restricted activity. So pharmacists may assess patients when they prescribe for minor ailments while they use a diagnosis from a physician or other diagnostician for chronic diseases and more complex situations. For the purpose of this section, the terminology "decision-making authority regarding prescriptions" will be used.

### **Pharmacists Prescribing / Decision-Making Authority Regarding Prescriptions in Canada**

Pharmacists have been dependently making decisions regarding prescriptions in Canada for decades, especially those pharmacists in institutional practice where they have worked under delegation and protocols to therapeutically substitute and change doses and drugs according to patient's responses and laboratory and other diagnostic test results.

The *Controlled Drugs and Substances Act* restricts the prescribing of specified drugs (e.g. narcotics, controlled drugs, barbiturates, anabolic steroids, benzodiazepines) to physicians, dentists and veterinarians.<sup>75,76</sup> This federal *Act* takes precedence over provincial legislation.

Legislatively, in the community, pharmacy prescribing began with emergency contraceptives. British Columbia, Quebec and Saskatchewan enacted legislative changes in 2000, 2001 and 2003, respectively.<sup>77</sup> Manitoba implemented continued care prescriptions in July 2002. Alberta pharmacists started independently prescribing in April 2007.

In all provinces, pharmacists must limit their prescribing to areas in which they are competent, must have enough information about the patient, and must communicate to

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<sup>75</sup> The *Controlled Drugs and Substances Act* permits the development of regulations to recognize other prescribers. The *New Classes of Practitioners Regulation* has been developed to permit midwives, nurse practitioners, and doctors of podiatric medicine as practitioners under this *Act*, if they are recognized as prescribers under provincial legislation.

<sup>76</sup> Podiatrists with prescribing authority under provincial legislation can prescribe benzodiazepines.

<sup>77</sup> In May 2008, Plan B for emergency contraception was changed to a Schedule III drug.

physicians and other health professionals their prescribing decision within a timely manner. Pharmacists are not obliged to prescribe, they have the choice to do so, depending on the circumstances.

As shown in Tables 1 and 2, all provinces have, or are pursuing, decision-making authority regarding prescriptions for pharmacists. All provinces are pursuing renewals or continuity of care. Most provinces are pursuing dependent authority, in which delegation or collaboration is required from a physician or another authorized prescriber. The information was obtained from a survey of provincial regulatory bodies in June 2008. The regulatory bodies were asked if they had plans to pursue other types of prescribing and controlled acts. Their responses are as follows:

- BC:** pharmacist initiated prescriptions under parameters similar to Alberta's existing framework; injecting vaccines
- AB:** will work with other provincial regulatory bodies to seek changes to federal legislation that will permit pharmacists to prescribe narcotics and controlled substances. A precursor to such discussion will be to define the necessary accountability and security measures as they relate to the pharmacists role in prescribing and dispensing.
- Will pursue ordering of laboratory tests; however this should not require a change in legislation.
- NB:** will pursue some program type initiatives such as smoking cessation and some additional prescribing authority similar to Alberta.
- NS:** are currently working with the College of Physicians and Surgeons on Agreements that would allow pharmacists to adjust doses of various types of drugs based upon point-of-care test results (e.g. warfarin based upon INRs, insulin based upon glucose and certain medications based upon creatinine levels).
- will pursue administering vaccines and emergency prescribing.

**Table 1: Summary of Pharmacist Prescribing / Decision-Making Authority Regarding Prescriptions in Canada**

Prov	Summary
<b>BC</b>	<p>In 2000, legislation permitted pharmacists to prescribe emergency contraception. In Fall, 2008, pharmacists who have completed a two hour orientation to the College's Medication Management Protocol will be able to adapt existing prescriptions to optimize the therapeutic outcome of treatment for patient (e.g., changing dose, formulation or regimen of a new prescription; renewal of a prescription for continuity of care, including an emergency supply; making a therapeutic drug substitution within the same therapeutic class for a new prescription). Pharmacist is required to address seven fundamental elements.</p>
<b>AB</b>	<p>In April 2007, pharmacists could independently prescribe Schedule 1 drugs. All pharmacists who have completed an orientation to new practice standards can adapt existing prescriptions and prescribe in emergency situations, when immediate treatment is required, but another prescriber is not accessible. The orientation is mandatory for pharmacists by July 1, 2008. Adapting a prescription includes changing the formulation, dosage, regimen; therapeutic substitutions, and providing extensions of the prescription. About 7,000 prescriptions are written monthly by pharmacists for beneficiaries of the government drug programs, representing about 0.6% of the prescriptions. These were primarily for chronic diseases, e.g. thyroid, statins, insulins, oral diabetic therapies, antihypertensives, anticoagulants, and asthma drugs.<sup>78</sup></p> <p>Pharmacists who have been evaluated and granted additional prescribing authorization may initiate, modify, and manage drug therapy for acute and chronic conditions. After a pilot to test the application and review process, 15 pharmacists were so recognized in December 2007. The application process was opened to all pharmacists and the next group of applicants is being assessed.</p>
<b>SK</b>	<p>A policy statement and supporting guidelines are under development to establish the regulatory framework that would permit pharmacist prescribing interdependently. This involves mutual recognition of competencies by the health care team but is not synonymous with delegation or transfer of function. The proposed implementation is Fall 2008.</p>
<b>MB</b>	<p>In July 2002, Manitoba implemented continued care prescriptions. The new <i>Pharmaceutical Act</i> was passed in December 2006, but will not be proclaimed until regulations are developed, approved by pharmacists and government. The <i>Act</i> allows pharmacists to prescribe and administer drugs, order tests and interpret patient administered automated tests. Prescribing authority in the draft regulations allows for adapting prescriptions, continued care prescriptions, prescribing for third party coverage and in declared emergencies. Other activities, like dosage adjustments, will be permitted through Council approved practice directions. Pharmacists with Extended Practice qualifications would have enhanced prescribing authority within their scope of practice.</p>
<b>ON</b>	<p>Pharmacists may perform certain authorized acts through the use of delegation or medical directives, permitted under the Regulated Health Professions Act, and under professional judgement.</p>

<sup>78</sup> Bacovsky RA. Prescribing Pharmacists in Alberta: Understanding the Conditions and Implications of Their Expanded Role in Drug Therapy. IMS Health Canada White Paper. November 2007.

<b>Prov</b>	<b>Summary</b>
<b>QC</b>	In 2001, pharmacists could independently prescribe emergency contraceptives. The <i>Pharmacy Act</i> allows pharmacists to initiate or adjust medication therapy, according to direction/prescription from a physician, making use, where applicable, of appropriate laboratory analyses. For example, a physician may write a prescription to allow one or many pharmacists to initiate a medication therapy, or to adjust a medication therapy, to an individual patient, or a group of patients. When the prescription targets only one patient, it is referred to as an individual prescription; when it targets a group of patients and/or pharmacists, it is referred to as a collective prescription.
<b>NB</b>	Pharmacists can renew an existing prescription for 30 days (except for narcotic/controlled substances). On October 30, 2008, pending the approval of regulations, pharmacists will be able to adapt prescriptions, prescribe in emergencies and initiate prescriptions for minor ailments.
<b>NS</b>	Pharmacists can extend prescription for up to 30 days (continued care). Discussions are ongoing for optimizing a pharmacist's authority through collaboration utilizing the <i>Pharmacy Act's</i> "Conditional Authority" enabling regulation.
<b>PE</b>	On May 22, 2008, the <i>Pharmacy Act</i> was amended to change the definition of "practise of pharmacy" to include the prescription of drugs. Regulations are to be drafted to further define scope of prescribing activities.
<b>NL</b>	Parameters around "continuing care" prescriptions (similar to that NB and NS) have been agreed to in principle by representatives of the NL Pharmacy Board, College of Physicians and Surgeons, Medical Association and Association of Registered Nurses. Discussions are underway on how to implement (e.g., may be through a change in the <i>Pharmacy Act</i> , a change in Regulations, or agreed upon protocol).

Sources: Canadian Pharmacists Association. Summary: Provincial Pharmacy Status regarding Pharmacist Prescribing Authority. May 2008.  
 Responses from pharmacy regulatory bodies to survey. June 2008.

**Table 2: Pharmacist Decision-Making Authority Regarding Prescriptions in Canada**  
(As of June 17, 2008, responses had not been received from PE and NL)

	BC*	AB*	SK*	MB*	ON* C	ON * P	QC*	NB	NS
<b>Adapting a prescription written by a prescriber</b>									
-- altering the formulation	P-I	I	P-D	P	PJ	P-I	D	I	P
-- altering the dosage / regimen	P-I	I*	P-D-R	P	PJ/D	P-I	D	I	P
-- therapeutic substitution	P-I	I	P-D-R	P-D-R	D*	D*	D	I	D*
-- continuing therapy interim supply	I	I	P-D	PJ	PJ	P-I	D	I	I
-- continuing therapy maintenance	P-I	I*	P-D	P-D	D	P-I	D	I	I
<b>Pharmacist initiates prescription (Schedule I drugs; excluding narcotics and controlled drugs)</b>									
-- drugs in emergency situations	I	I	P-D I -EC	PJ P-I	No	No	I - EC	I	P
-- minor ailments	No	I-R	P-D	P-I-R	No	No	D	I	No
-- drugs for lifestyle / health promotion	No	I-R	P-D-R	P-I-R	No	No	D	No	No
-- chronic diseases / conditions	No	I-R	P-D	P-I-R	D	D	D	No	No
<b>Pharmacist prescription for Schedule II/III drugs recognized for reimbursement#</b>									
Extends existing prescription	P-I	I	P-D	P	No	P-I	D	I	I
Initiates prescription	No	I	P-D	P	No	P-I	D	I	I

Note: For Ontario, the current status (ON C) and the proposed scope (ON P) are provided  
 \* See additional information section for each province/territory (starts on following page)  
 # Public and private sector drug plans decide what they will reimburse for their beneficiaries, including the drug products and what type of prescriber has written the prescriptions

- D: Pharmacists can dependently make decisions regarding prescriptions, i.e. authority delegated from physician or other independent prescriber or authority from agreement between pharmacy and regulatory body for physicians or other independent prescribers
- EC Emergency contraception
- I: Pharmacists can independently make decisions regarding prescriptions
- I-R: Independent prescribing restricted to designated pharmacists (e.g. Alberta model)
- No No activity permitted or proposed
- P: Proposed: regulations / standards / policies under development
- P-D: Proposed: regulations / standards / policies under development for pharmacists to dependently make decisions regarding prescriptions
- P-D-R: Proposed: regulations / standards / policies under development for certain pharmacists to dependently make decisions regarding prescriptions (i.e. activity restricted to designated pharmacists or to certain directives)
- P-I-R: Proposed: regulations / standards / policies under development for certain pharmacists to independently make decisions regarding prescriptions; activity will be restricted to designated pharmacists
- PJ: Permitted under professional judgment

### Additional Information

- BC:** Proposed implementation Fall 2008.
- All active / practising pharmacists will be required to complete a two hour orientation prior to being able to prescribe.
- AB:** Some pharmacists have additional prescribing authorization. Unless a pharmacist has additional prescribing authorization, the pharmacist can only alter a dosage for a new prescription, not a renewed prescription, and the adjustment must be needed because of the patient's age, weight, or organ function or that the prescribed dosage is not commercially available. A pharmacist with additional prescribing authorization can only provide ongoing continuing maintenance therapy, while the regular pharmacist can only provide interim supplies or a refill based on the circumstances.
- SK:** Proposed implementation Fall 2008. The Saskatchewan College of Pharmacists is proposing "Interdependent Prescriptive Authority in Collaborative Practice Environments" where all members of the health care team rely upon one another's expertise to maximize the benefits of drug therapy. This requires mutual recognition of competencies and allows the pharmacist to prescribe according to those competencies. Where all pharmacists have these competencies, they may prescribe without further training, other than orientation to the prescribing process. Mutual recognition will arise from agreements between the respective professional organizations. Where some pharmacists possess added competencies due to advanced training, such as certification as a disease state educator, they may prescribe under a collaborative practice agreement. This is a different form of mutual recognition that arises from agreements at the individual practitioner level. Thus, for the comparison chart, the response has been categorized as "dependant", because it depends upon mutual recognition. This should not be interpreted in any way as being synonymous with delegation, or transfer of function, or other related process.
- MB:** The *Pharmaceutical Act* was passed on December 4, 2006, permitting pharmacists to prescribe certain drugs and to order diagnostic tests. Regulations are being developed.
- ON:** Ontario permits pharmacists to make decisions regarding a prescription under a medical directive by physicians to pharmacists within a collaborative practice model. The model templates are at [www.medicaldirectives-delegation.com](http://www.medicaldirectives-delegation.com).
- Pharmacists in institutions can therapeutically substitute drugs in accordance with hospital / facility policies
- QC:** Other than emergency contraceptives, all other activities related to prescribing involve action related to an individual or collective prescription. The word "prescription" in this context, means a direction given to a professional by a physician, a dentist or another professional authorized by law, specifying the medications, treatments, examinations or other forms of care to be provided to a person or a group of persons, the circumstances in which they may be provided and the possible contraindications. In practice, a prescription of this type:
- Can be written by a single physician or a group of physicians;
  - May target one patient or a group of patients;
  - May target one or a number of professionals, from one or more than one group of professionals
  - May target or a number or clinical situations
- The terms individual or collective prescriptions refer to the following:

- if a prescription is written by one physician, targets one patient, and will only be entrusted to one pharmacist, it is an individual prescription.
- if a prescription is written by a number of physicians and/or targets a group of patients and/or targets more than one professional, it is deemed a collective prescription

The collective prescription contains information on:

- A name or title: ex. collective script for the adjustment of warfarin therapy;
- The professional (s) targeted, for example: pharmacists practising in the city of X ;
- The group of patients targeted , for example: patients under treatment for atrial fibrillation with warfarin and under the care of doctors at the heart clinic of x hospital;
- The circumstances under which the use of this prescription is allowed for the targeted professionals ( could be a duration of use before a visit to the physician);
- The circumstances under which the use of this prescription would not be allowed (contra-indications related to other diseases, age, etc...);
- A description of what the targeted professional is expected to do in accordance with the collective script;
- Treatment guidelines (medication adjustment for example) when appropriate;
- Communications guidelines between the prescriber and the targeted professionals.

**NB:** Responses based on approved legislation, effective October 30, 2008, pending approval of the Regulations

**NS:** Continuing care prescriptions are permitted through an agreement between the NS College of Pharmacists and the College of Physicians and Surgeons of NS. It authorizes pharmacists to prescribe continued therapy independently from the original prescriber. The pharmacist's name goes on the prescription and label as the prescriber and the pharmacist is 100% accountable for the extension of therapy.

- Pharmacists in institutions can therapeutically substitute drugs in accordance with hospital / facility policies

**Table 3: Provincial Comparison of Scopes of Practice for Pharmacy**  
 (Excluding compounding, preparing, dispensing and selling drugs;  
 decision-making authority regarding prescriptions described in Table 1)

Activity	BC	AB	SK	MB	ON	QC	NB *	NS #	PE #	NL #
Diagnosing / communicating a diagnosis	No	NA	No	No	No	No				
Administering a substance/drug by injection	No	Yes R*	No	Yes R	P	No	Yes			
Administering a substance/drug by inhalation	Yes	Yes	No	P	P	No				
Performing a procedure on tissue below the dermis (e.g. pricking the skin)	No	Yes	Yes *	P	P	Yes *	Yes			
Ordering a laboratory or diagnostic test	Yes	Yes *	No	P-D	P	Yes *	Yes			
Interpreting a laboratory or diagnostic test	Yes	Yes	Yes *	P-D	P	Yes *	Yes			
Using or interpreting point-of-care monitoring / testing devices or self-monitoring devices	Yes *	Yes	Yes *	P	P	Yes *	Yes			
Using or interpreting screening tests	Yes	Yes	Yes *	P-D	P	Yes *	Yes			

#Note: As of June 17, 2008, responses had not been received from PE and NL  
 NS does not have health profession legislation that defines controlled or restricted activities.

NA: Not applicable; not a controlled activity

Yes: Pharmacists can perform activity

Yes-R: Pharmacists can perform activity, but restricted to pharmacists being certified

No: Controlled / restricted activity; pharmacists can not perform activity

P: Proposed

\* See additional information below

**Additional Information:**

**BC:** When interpreting tests (e.g. screening; laboratory/diagnostic; patient self-monitoring), a pharmacist cannot convey a diagnosis.

**AB:** Pharmacists must complete a training program that is approved by the council of the Alberta College of Pharmacists prior to administering drugs by injection. Pharmacists may inject drugs subcutaneously and intramuscularly. They cannot administer drugs intravenously or intrathecally.

- Ordering a laboratory or diagnostic test is not an activity that is regulated in Alberta. Provincial laboratories are accredited by the College of Physicians and Surgeons of Alberta, and laboratories are operated by regional health authorities. Once there is greater experience with pharmacists using laboratory information, the Alberta College of Pharmacists will proceed to address the ordering of laboratory information.

**SK:** The "\*" activities are limited to the practice of pharmaceutical care

**QC:** Pharmacists can order a laboratory or diagnostic test under an individual or collective prescription. Pharmacists can interpret tests and use point-of-care or screening tests within their scope of practice, i.e. when adjusting medication therapy but not for diagnosis purposes

**NB:** Does not have health profession legislation that defines controlled or restricted activities. The *Pharmacy Act* will allow ordering and interpreting tests and administration, however, this piece will not be enabled until a later date.

### **33. What is the experience in other International jurisdictions?**

The scope of practice of pharmacy varies significantly around the world, reflecting the differences in health professional legislation, i.e. exclusive scope of practice vs. controlled acts. At minimum, it includes compounding, preparing, dispensing, and selling drugs. Administering, including injecting drugs may not be restricted activities in many jurisdictions. The discussion here will focus on prescribing drugs.

There are many types of prescribing models for pharmacists internationally. They vary from independent models to dependent models based on protocols, adherence to formularies, and collaboration with physicians.<sup>79</sup> Many countries have long permitted pharmacists in institutional settings to prescribe in these dependent models. Many countries, such as Canada and the United Kingdom, restrict some non-prescription drugs to distribution after consultation with a pharmacist. These are Schedule II drugs in Canada. The United States is currently considering implementing such a schedule.

The United Kingdom has recognized both dependent and independent prescribing models for pharmacists. Collaborative prescribing models started in the US in the 1970s. Most states in the US now recognize collaborative prescribing and permit their pharmacists to administer drugs and immunizations. These two jurisdictions are described below.

#### **United Kingdom**

The United Kingdom has recognized pharmacists as supplementary (i.e. dependent) prescribers and independent prescribers. The first supplementary pharmacist registered in 2005. Pharmacists as independent prescribers were recognized in May 2006, with the first pharmacist being registered in January 2007. The registration of its pharmacists in these categories is limited. Of about 40,000 practising pharmacists registered with the Royal Pharmaceutical Society of Great Britain, but only 1,417 were registered supplementary prescribers and 534 were registered independent prescribers.<sup>80</sup> One area that is increasingly utilizing the expanded scope of pharmacists is in the treatment of minor ailments.

#### **Independent Prescribers<sup>81</sup>**

While a pharmacist independent prescriber can prescribe any medicine (excluding Controlled Drugs at present) for any condition, it is not anticipated that pharmacists will be consulted by and prescribe for all patients who need treatment with medicines. Some pharmacist independent prescribers will have a role in prescribing for patients who present with minor ailments or a defined range of self-limiting conditions. Other pharmacist independent prescribers will specialise in the management of patients with identified clinical conditions. As independent prescribers they will be able to work as autonomous practitioners making prescribing decisions based on their assessment of the patient's condition and their judgement of the most appropriate medication regime. In addition to the management of the presenting condition, the pharmacist can respond to the signs and symptoms of an additional clinical problem and make a professional decision on whether to treat the patient or refer to another practitioner.

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<sup>79</sup> Emmerton L, Marriott J, Bessell T, et al. Pharmacists and Prescribing Rights: Review of International Developments. *J Pharm Pharmaceut Sci* 2005;8(2):217-225.

<sup>80</sup> Registration, Royal Pharmaceutical Society of Great Britain. June 6, 2008.

<sup>81</sup> Royal Pharmaceutical Society of Great Britain. Pharmacist Prescribing. [www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html](http://www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html)

All pharmacist independent prescribers, whether prescribing for self-limiting conditions or managing a specified disease, will be providing a professional service that is within their professional competence and agreed with a health organisation that has responsibility for the health services provided to the patient. In return the health service organisation will provide the funding for the service. It is the arrangement with the health service organisation that defines the scope of the pharmacist's prescribing practice.

Pharmacist independent prescribing is different from pharmacist supplementary prescribing in the degree of autonomy and clinical responsibility exercised by the pharmacist in their prescribing practice. If circumstances dictate or if the pharmacist chooses, a pharmacist independent prescriber can work as a supplementary prescriber.

### **Supplementary Prescribers**

Supplementary prescribing is a voluntary prescribing partnership between a medical practitioner (*independent prescriber*) who establishes the diagnosis and initiates treatment, a pharmacist (*supplementary prescriber*) who monitors the patient and prescribes further supplies of medication and the patient who agrees to the supplementary prescribing arrangement. For each patient, the framework for supplementary prescribing is set out in an individual clinical management plan which contains details of the patient, their condition, treatment with medicines and when the patient should be referred back to the independent prescriber. Unlike pharmacist independent prescribing, a supplementary prescriber can only prescribe within the limitations of the clinical management plan and cannot prescribe for conditions that are not included in the clinical management plan.<sup>82</sup>

A recent review of supplementary prescribing found that pharmacists were positive about supplementary prescribing but the medical profession were more critical and lacked awareness/ understanding. Supplementary prescribing was identified in many clinical settings but implementation barriers included funding problems, delays in practicing and obtaining prescription pads, encumbering clinical management plans and access to records. It was found that the development of independent prescribing and the apathy of the medical profession represented significant threats to the success of this the supplementary prescribing initiative.<sup>83</sup>

### **Use of Pharmacists - Minor Ailments Schemes**

Minor Ailments Schemes were piloted in the United Kingdom in the early 2000s. These minor ailments schemes enable patients who are exempt from prescription charges to receive treatment for common illnesses free of charge direct from a community pharmacy. The minor ailments and drug benefits vary with the jurisdiction. The ailments can include acne, allergies, athlete's foot, back pain, bites, burns, colds, simple viral infections (e.g. cold sores), colic, conjunctivitis, constipation, contact dermatitis, cough, cystitis, diaper rash, diarrhea, dyspepsia, earache, ear wax, eczema, fever, hemorrhoids, hayfever, headaches, head lice, indigestion, mouth ulcers, nasal congestion, oral thrush, scabies, sore throat, strains, teething, threadworms, urinary tract infections, vaginal thrust, and warts. While the products prescribed under this scheme generally are not prescription-requiring by law, they may require a prescription in order for the patient to obtain drug coverage by the

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<sup>82</sup> Royal Pharmaceutical Society of Great Britain. Pharmacist Prescribing.

[www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html](http://www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html)

<sup>83</sup> Cooper RJ, Anderson C, Avery T, et al. Nurse and pharmacist supplementary prescribing in the UK— A thematic review of the literature. *Health Policy* 2008(85): 277–292.

NHS. It relieves pressure in primary care by discouraging patients from seeing physicians for minor ailments. In April 2006, minor ailments schemes became one of the four core services in the community pharmacy contract, meaning that it would be offered by every community pharmacy in Scotland.<sup>84</sup> In England, the government recently proposed that minor ailments schemes be commissioned from community pharmacies in every primary care trust.<sup>85</sup> As of March 2007, only 24% of all pharmacies held such contracts. (See Appendix 1.)

Preliminary data, included in the appendices, demonstrates increased access by the public to necessary health services for minor ailments, increased access to physicians by patients who are more seriously ill, and overall cost savings to the NHS. IMS Health analysed anonymized patient records from its database of 210 general practices across the UK, covering four million patient records and 190 million prescriptions.<sup>86</sup> Data from 500,000 UK patients who had consulted their GP about a minor ailment suggested that, in 2006–07, 51.4 million GP consultations a year were solely for minor ailments.

Estimated at eight minutes per consultation, this represents 18 per cent of GPs' workload or an hour a day for each GP. The total cost to the NHS of these consultations is £1.8bn and 80 per cent of this (£1.5bn) is attributable to the cost of GPs' time. In addition, 10 minor ailments are responsible for 75 per cent of the cost of minor ailments consultations and 85 per cent of the cost of prescriptions for minor ailments. These are:

- back pain
- indigestion
- dermatitis
- nasal congestion
- constipation
- migraine
- acne
- cough
- sprains and strains
- headache

Therefore, such a service could help reduce pressures on surgeries and free up time for GPs and their staff to treat people with more complex needs. Analysis so far indicates that the cost of medicines supplied by pharmacies for minor ailments may be less than the cost of medicines prescribed by GPs, and that introduction of such a scheme can both meet people's requirements and be cost-efficient.

The Department of Health released a White Paper that describes future NHS pharmaceutical services:

- become 'healthy living' centres – promoting health and helping more people to take care of themselves;
- offer NHS treatment for many minor ailments (e.g. coughs, colds, stomach problems) for people who do not need to go to their local GP;
- provide specific support for people who are starting out on a new course of treatment for long term conditions such as high blood pressure or high cholesterol;
- offer screening for those at risk of vascular disease;

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<sup>84</sup> Bellingham C. How to manage a minor ailment service. *Pharmaceutical Journal* 2005;275:694.

<sup>85</sup> Department of Health. *Pharmacy in England: Building on strengths – delivering the future*, April 2008.

<sup>86</sup> Moberly, T. Making the case for a pharmacy-based minor ailments scheme for England. *Pharmaceutical Journal* 2008;280:111.

- use new technologies to expand choice and improve care in hospitals and the community, with a greater focus on research; and
- be commissioned based on the range and quality of services they deliver.<sup>87</sup>

The White Paper outlines roles for pharmacists at three levels:

- supported self care – where people monitor their own conditions with periodic support and advice;
- disease management – supporting people on multiple, complex medicines regimes; and
- case management – working alongside other primary care providers supporting high risk patients.

### United States

Collaborative prescribing models started in the US in the 1970s. Most states (42 of 50) now recognize collaborative prescribing. Forty-two states do permit their pharmacists to administer drugs and forty-three permit pharmacists to administer immunizations. In the majority of states, many restrictions apply, including training requirements, limitations to practice environment (e.g. hospitals only), restricted to designated patient groups, and to designated drugs or vaccines.

Table 3: US State Pharmacy Laws on Collaborative Practice and Administering Drugs and Immunizations<sup>88</sup>

State	Change Drug Therapy under Collaborative Practice	Pharmacists May Administer Drugs	Pharmacists May Administer Immunizations
Alabama	No	Yes	Yes
Alaska	Yes	Yes	Yes *
Arizona	Yes	Yes *	Yes *
Arkansas	Yes	Yes *	Yes *
California	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes *	Yes *	Yes *
Delaware	No	Yes	Yes
D.C.	No	No	No
Florida	Yes *	No	No
Georgia	Yes	Yes	Yes
Hawaii	Yes	Yes *	Yes *
Idaho	Yes	Yes	Yes
Illinois	No	No	Yes *
Indiana	Yes *	Yes *	Yes *
Iowa	Yes	Yes *	Yes *
Kansas	Yes *	Yes *	Yes *
Kentucky	Yes	Yes *	Yes
Louisiana	Yes	Yes	Yes
Maine	Yes *	No	No
Maryland	Yes	No *	Yes *
Massachusetts	No	Yes *	Yes *
Michigan	Yes	Yes	Yes *

<sup>87</sup> Department of Health. *Pharmacy in England: Building on strengths – delivering the future*, April 2008.

<sup>88</sup> National Association of Boards of Pharmacy. *Survey of Pharmacy Law*. 2008.

State	Change Drug Therapy under Collaborative Practice	Pharmacists May Administer Drugs	Pharmacists May Administer Immunizations
Minnesota	Yes	Yes *	Yes *
Mississippi	Yes	Yes	Yes
Missouri	Yes	Yes	Yes
Montana	Yes	Yes	Yes *
Nebraska	Yes	Yes	Yes
Nevada	Yes *	Yes *	Yes
New Hampshire	Yes *	No	No
New Jersey	Yes	Yes	Yes
New Mexico	Yes *	Yes	Yes
New York	No	No	No
North Carolina	Yes	Yes *	Yes
North Dakota	Yes	Yes	Yes *
Ohio	Yes *	Yes *	Yes *
Oklahoma	Yes *	Yes	Yes *
Oregon	Yes *	Yes *	Yes
Pennsylvania	Yes *	Yes	Yes
Rhode Island	Yes *	Yes	Yes *
South Carolina	No	Yes	Yes
South Dakota	Yes	Yes	Yes
Tennessee	Yes	Yes	Yes
Texas	Yes	Yes *	Yes
Utah	Yes	Yes *	Yes *
Vermont	Yes	Yes	Yes
Virginia	Yes	Yes *	Yes
Washington	Yes	Yes	Yes *
West Virginia	No *	No	Not addressed
Wisconsin	Yes *	Yes *	Yes *
Wyoming	Yes	Yes *	Yes *

\* Restrictions apply (e.g. special training, certain drugs / vaccines; patient groups)

**Costs/Benefits**

**34. What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:**

**1. Direct patient benefits/costs;**

Patients will save time, transportation costs, and time away from work due to fewer visits to the physician or emergency department for refills and the treatment of minor illnesses. They will also benefit from improved medication therapy and better health outcomes. The costs to patients and third party payors could decrease, especially when pharmacists use less expensive drugs as first line therapies. Pharmacists will start providing and charging for more comprehensive consultations on medication therapy management. There may be additional charges to the public for these depending upon whether the government and private sector drug plans cover these fees.

## **2. Benefits and costs to the broader health care service delivery system;**

The Ministry of Health and Long Term Care has identified Ontario's two most important health care priorities over the next four years as reducing wait times with a special focus on emergency departments and improving access to quality family health care. The expanded scope of practice for pharmacists is consistent with and complementary to these priorities. The high number of drug-related visits to emergency departments can be reduced through proactive involvement of pharmacists in medication therapy management and by managing minor illnesses.

The health system will be able to more effectively use health care providers and resources and provide residents of Ontario with better access to medication therapy management, such as:

- provide more flexibility in designing programs to make better use of health care providers according to their qualifications, skills and training
- facilitate the greater use of pharmacists to manage medication therapy in hospitals, long term care facilities, family health teams, primary care, community health centres, home care, outpatient, outreach, and community based programs
- reduce the workload of physicians, nurses, and other health professionals workload related to medication therapy permitting reallocation of their time to patients who require their expertise
- improving continuity of care / seamless care as patient moves between health sectors
- facilitate the incorporation of pharmacists into primary care treatment groups and disease management programs

There also will be increased efficiencies in the health system resulting from pharmacists participating in screening clinics to identify patients with illnesses and conditions and significant risk factors.

Studies have shown that when pharmacists have a more active role in drug therapy, the health care system saves money. Studies have shown that preventable drug-related problems are a significant expense to the system, financially and in inefficient use of resources.

## **3. Benefits and costs associated with wait times;**

The potential impact of pharmacists improving access to physicians, nurse practitioners, other health care practitioners, emergency departments, other health services and long term care beds has been discussed in Question 15(d). This has been shown in the literature to result from their proactive role in medication therapy management and preventing preventable drug-related problems.

## **4. Workload, training and development costs;**

There are no substantial costs estimated for workload, training and development. Continuing education programs are constantly being revised to reflect current therapies and evolving practice standards.

## 5. Costs associated with educational and regulatory sector involvement.

There are no substantial costs estimated for educational and regulatory sector involvement.

### 35. Is there any other relevant information that HPRAC should consider when reviewing your proposal for a change in scope of practice?

Pharmacists have been working toward the recognition of an expanded scope of practice through their evolving practice and through initiatives at the provincial level (e.g. the College, the Ontario Pharmacists Association, Ontario Branch of the Canadian Society of Hospital Pharmacists) and nationally (e.g. the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists) and the two national collaborative initiatives (i.e. Moving Forward: Pharmacy Human Resources for the Future Research Program, the Blueprint for Pharmacy). The regulation of pharmacy technicians is also underway, which will provide pharmacists with the time to devote their expertise into these expanded roles.

As mentioned earlier, in all other provinces, *once a diagnosis has been made* pharmacists are or will be permitted to prescribe or adapt prescriptions, and to provide refills of medications already prescribed. This College has not pursued the controlled act of *prescribing* for pharmacists and within the timeframe allocated for this submission, was not able to undertake the extensive consultation with members and other stakeholders required to change this position. Permitting pharmacists to legally dispense a prescription without further authorization from a prescriber under specific conditions as set out above would bring Ontario into line with what prescribing pharmacists are able to do in other Canadian jurisdictions and falls squarely within the pharmacists scope and abilities as experts in medication management. Without doubt, pharmacists possess the knowledge, skills, ability and judgement required to safely adapt a dosage form, dosing regimen, or dose strength to facilitate drug coverage and to authorize prescription extensions for continuing therapy. College Council acknowledged that these activities are called *prescribing* in other jurisdictions such as Alberta, Saskatchewan, Manitoba and the Atlantic provinces. The College further acknowledges the need for all stakeholders to clearly understand that those pharmacists permitted to "prescribe" in other jurisdictions only do so once a diagnosis has already been made by another health care professional authorized to diagnose. This College is recommending "dispensing without further authorization from a prescriber subject to terms and conditions" over "prescribing" on the basis that these activities fall within the cognitive aspects of the controlled act of dispensing and are already thus within the realm of the pharmacists scope of practice. The College is aware that while the terminology of prescribing is used in other jurisdictions to describe activities that fall within a pharmacist's scope, the perception exists amongst the public and other health professions that prescribing must follow differential diagnosis- an activity that currently does not fall within the realm of pharmacy training and practice. Should HPRAC consider that granting pharmacists in Ontario the ability to adapt or alter a dosage form, dosing regimen or dose strength and to authorize prescription extensions for continuation of care is more appropriately done through *prescribing* than *dispensing*-subject to the terms and conditions cited above, the Council of the Ontario College of Pharmacists would support such a recommendation as long as it is clear that such activity would occur within the pharmacists medication therapy management role and only after a diagnosis has been made.

**Appendices:**

**1.0 International Pharmacy Experience**

**2.0 Provincial Pharmacy Legislation**

Appendix 2A: British Columbia

Appendix 2B: Alberta

Appendix 2C: Saskatchewan

Appendix 2D: Manitoba

Appendix 2E: Ontario

Appendix 2F: Quebec

Appendix 2G: New Brunswick

Appendix 2H: Nova Scotia

Appendix 2I: Prince Edward Island

Appendix 2J: Newfoundland and Labrador

**3.0 Blueprint for Pharmacy**

**Appendix 1: Information on Pharmacy Practice in the UK**

Better Management of Minor Ailments: Using the Pharmacist, June 2003.  
<http://www.rpsgb.org/pdfs/bettmanminail.pdf>

NHS Lothian. Minor Ailments Formulary 2006. For use in community pharmacy. October 2006: [www.ljf.scot.nhs.uk/maf/MAF\\_Oct2006.pdf](http://www.ljf.scot.nhs.uk/maf/MAF_Oct2006.pdf)

## **APPENDIX 2: Provincial Inter-jurisdictional Review: Scope of Practice of Pharmacy**

### **APPENDIX 2A: British Columbia**

The scope of practice of pharmacy is defined in the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* and further described in the Framework of Professional Practice.

Professional Policy Practice - 58 permits pharmacists to prescribe.

#### ***Pharmacists, Pharmacy Operations and Drug Scheduling Act***

##### **Definitions**

"dispense" includes the preparation and sale of a drug or device referred to in a prescription and taking steps to ensure the pharmaceutical and therapeutic suitability of a drug or device for its intended use and taking steps to ensure its proper use;

"practice of pharmacy" includes the practice of and responsibility for

- (a) interpretation and evaluation of prescriptions,
- (b) compounding, dispensing and added labelling of drugs and devices,
- (c) monitoring drug therapy,
- (d) identification, assessment and recommendations necessary to resolve or prevent drug related problems in patients,
- (e) advising persons of the therapeutic values, content and hazards of drugs and devices,
- (f) safe storage of drugs and devices,
- (g) maintenance of proper records, including patient records, for drugs and devices,
- (h) services, duties and transactions necessary to the management, operation and control of a pharmacy or to provide pharmacy services in a hospital, facility or care centre, and
- (i) sale of drugs by pharmacists;

## **Framework of Professional Practice (March 2006)**

### **Components**

#### **Purpose**

**"The primary purpose of the profession of pharmacy is to help people achieve their desired health outcomes. Pharmacists do this by providing current, rational, safe and cost-effective pharmaceutical services, information, and products, in collaboration with clients and others in the health care community."**

Pharmacists who contributed to a functional analysis process that describes why the profession of pharmacy exists, developed this purpose statement. Much like a mission statement, the purpose statement is fundamental to understanding the Framework of Professional Practice. It is the starting point for each component and it relates to everyone who contributes to the profession.

#### **Roles**

The work of today's pharmacists goes far beyond the public's general notion of 'dispensing' drugs. It is both more complex and more related to promoting health and wellness than most people realize. As health care professionals, we are key members of our clients' health care teams.

To maintain good standards of pharmacy practice, and meet the standards described in this Framework of Professional Practice, B.C. pharmacists identified five key roles that require direct pharmacist involvement or supervision.

1. Provide pharmaceutical care
2. Produce and distribute drug preparations and products
3. Contribute to the effective operation of the pharmacy
4. Maintain professional development and contribute to the professional development of others
5. Contribute to the effectiveness of the health care system

#### **Functions**

In order to fulfill the five Roles of the Framework of Professional Practice, pharmacists are responsible for a wide range of Functions in their daily practice. No one pharmacist is responsible for all of the Roles and Functions described in the Framework of Professional Practice. Some Functions are more relevant to pharmacists actively involved in direct patient care, while others are more relevant to pharmacists engaged in research, management, education or consulting.

Each Function describes a broad area for which pharmacists have responsibility. Making sure these Functions are performed well and consistently within each practice setting is essential to the fulfillment of each Role.

**Activities and Indicators of good practice**

Each Activity describes a component of a Function. Activities describe the day-to-day work pharmacists (or their colleagues) do to achieve each Function. Following each Activity is a list of Indicators of good practice. Each Indicator is a description of good pharmacy practice. The Indicators for any one Activity may not be the only possible ones. They are the ones that B.C. pharmacists say are most critical to good performance. These indicators answer the question, "How do I know an activity is being performed well?"

**Knowledge and skills specifications**

The final section of the Framework of Professional Practice specifies Knowledge and Skills Specifications. It is the fundamental knowledge and skills that pharmacists possess that enable them to perform the Roles, Functions and Activities described in the Framework of Professional Practice. To do this, pharmacists draw on their expertise, usually in the form of knowledge, skills and abilities unique to each pharmacist.

## **Roles**

### **Role 1 Provide pharmaceutical care**

Pharmaceutical care is a primary responsibility of the pharmacist, although shared with physicians and other health care providers. Pharmacists may provide this service directly to patients or their caregivers; or they may manage/supervise or teach/train others to provide this care. Thus the 'client' may vary depending on the specific responsibility pharmacists have in this role.

### **Role 2 Produce and distribute drug preparations and products**

Drug distribution is a primary technical responsibility, often performed by pharmacy technicians under direction or supervision of the pharmacist. The pharmacist is legally responsible for all functions in this role, so they must be able to perform these functions in order to train or supervise others, even if they do not perform the functions directly.

### **Role 3 Contribute to the effective operation of the pharmacy**

All pharmacists, regardless of their responsibility, contribute directly or indirectly to this role. For example: they contribute by helping to maintain the effectiveness and efficiency of the workplace; supervising others; ensuring adequate staffing; and/or ensuring quality products and services are provided to meet client needs.

### **Role 4 Maintain professional development and contribute to the professional development of others**

Professional development is a continuous process in the changing profession of pharmacy. As pharmacy practice evolves, pharmacists need to keep current and knowledgeable, and support others. They can do this through professional development, continuing education; workplace interaction and problem-solving.

### **Role 5 Contribute to the effectiveness of the health care system**

As members of the health care community, pharmacists contribute to the health care team by identifying ways to improve overall health outcomes. Pharmacists do this by promoting health and wellness in the community; improving working relationships; investigating emerging therapies; and sharing new information to benefit their clients.

**College of Pharmacists of British Columbia  
Professional Practice Policy: Medication Management PPP-58**

**Protocol for medication management (adapting a prescription)**

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

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

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

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

In addition to the FPP, PPP#58 outlines that a pharmacist may dispense a drug contrary to the terms of a prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets all of the following elements of a protocol to adapt a prescription:

**1. Individual competence**

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

**2. Appropriate information**

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

**3. Prescription**

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

**4. Appropriateness**

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

**5. Informed consent**

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

**6. Documentation**

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

**7. Notification of other health professionals**

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

**Benefits of professional practice policy**

The benefits to clients are to:

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

Note: PPP#58 is not a stand-alone document and must be read with the orientation manual currently under development. For a pharmacist to use PPP#58 they will be required to complete an orientation to PPP#58, details of which are also under development.

## Appendix 2B: Alberta

The scope of practice of pharmacy is described in Schedule 19 of the *Health Professions Act* and section 16 of the Pharmacists Profession Regulation.

### ***Health Professions Act Schedule 19 Profession of Pharmacists***

#### **Practice**

3 In their practice, pharmacists promote health and prevent and treat diseases, dysfunction and disorders through proper drug therapy and non-drug decisions and, in relation to that, do one or more of the following:

- (a) assist and advise clients, patients and other health care providers by contributing unique drug and non drug therapy knowledge on drug and non drug selection and use,
- (b) monitor responses and outcomes to drug therapy,
- (c) compound, prepare and dispense drugs,
- (d) provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices,
- (e) supervise and manage drug distribution systems to maintain public safety and drug system security,
- (f) educate clients, patients and regulated members of the Alberta College of Pharmacists and of other colleges in matters described in this section,
- (g) conduct or collaborate in drug-related research,
- (h) conduct or administer drug and other health-related programs, and
- (i) provide restricted activities authorized by the regulations.

#### **Pharmacists Profession Regulation**

##### **Restricted Activities**

##### **Clinical pharmacists**

**16(1)** A clinical pharmacist is authorized to perform, within the practice of pharmacy and in accordance with the Pharmacists' Standards of Practice, the following restricted activities:

- (a) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug;
- (b) to administer a vaccine or parenteral nutrition;
- (c) to compound blood products;
- (d) to insert or remove instruments, devices or fingers
  - (i) beyond the anal verge, and
  - (ii) beyond the labia majora;
- (e) to prescribe a Schedule 1 drug for the purpose of adapting an existing prescription;
- (f) to prescribe blood products for the purpose of adapting an existing prescription;
- (g) to prescribe a Schedule 1 drug if
  - (i) it is not reasonably possible for the patient to see a health professional to obtain the prescription, and
  - (ii) there is an immediate need for drug therapy;
- (h) to prescribe blood products if
  - (i) it is not reasonably possible for the patient to see a health professional to obtain the prescription, and
  - (ii) there is an immediate need for blood products.

- (2) In subsection (1), "adapting an existing prescription" means
- (a) altering the dosage, formulation or regimen for a Schedule 1 drug that has been prescribed for a patient;
  - (b) substituting another drug for a prescribed Schedule 1 drug if the substituted drug is expected to deliver a therapeutic effect that is similar to the therapeutic effect of the prescribed drug;
  - (c) substituting a generic drug for the prescribed drug;
  - (d) renewing a prescription to dispense a Schedule 1 drug or blood product to ensure continuity of care.
- (3) Subject to subsection (4), a clinical pharmacist is authorized to perform, within the practice of pharmacy and in accordance with the Pharmacists' Standards of Practice, the restricted activities of prescribing a Schedule 1 drug and prescribing blood products if the clinical pharmacist
- (a) has provided evidence satisfactory to the Registrar of having successfully completed the Council requirements to prescribe Schedule 1 drugs and blood products, and
  - (b) has received notification from the Registrar that the authorization is indicated on the clinical register.
- (4) A clinical pharmacist authorized under subsection (3) may prescribe a Schedule 1 drug or blood products only if the clinical pharmacist
- (a) has determined that a Schedule 1 drug or blood products are appropriate for the patient through an assessment of the patient,
  - (b) has received a recommendation that the patient receive drug therapy from a health professional who is authorized to prescribe a Schedule 1 drug or blood products, or
  - (c) has determined in consultation with or has determined in conjunction with a health professional that a Schedule 1 drug or blood products are appropriate for the patient.
- (5) A clinical pharmacist is authorized to perform, within the practice of pharmacy and in accordance with the Pharmacists' Standards of Practice, the restricted activity of administering anything by an invasive procedure on body tissue below the dermis or the mucous membrane for the purpose of administering subcutaneous or intramuscular injections if the clinical pharmacist
- (a) has provided evidence satisfactory to the Registrar of having successfully completed the Council requirements for the administration of injections, and
  - (b) has received notification from the Registrar that the authorization is indicated on the clinical register.

**Additional Information**

All pharmacists who have completed an orientation program developed and delivered by the Alberta College of Pharmacists can prescribe for the purpose of “adapting prescriptions” and for the purpose of meeting emergency needs (defined in standards).

Pharmacists wishing “additional prescribing privileges” as contemplated in s16(3&4) of the Pharmacists Profession Regulation, must make application to the registrar, and demonstrate their competency to prescribe for the purposes outlined in the section. Candidates must submit a portfolio that provides documentation capable of demonstrating their competence to prescribe. The portfolio requires three types of information:

- Personal information outlining education, training, experience, practice relationships, and how the candidate intends to incorporate prescribing privileges within their practice.
- Three comprehensive care plans for three patients that the pharmacist has co-managed the drug therapy needs of.
- Two letters of collaboration from other regulated health professionals, one of whom must have prescribing authority.

## Appendix 2C: Saskatchewan

The scope of practice of pharmacy is provided under an exclusive scope description in section 23(1) of the *Saskatchewan Pharmacy Act*. It is further described in the Standards of Practice.

The following permits pharmacists to prescribe:

Section 14(2)(i.1) of the Saskatchewan Pharmacy Act.  
Section 9.1 of the Drug Schedules Regulations at  
[http://www.napra.ca/pdfs/provinces/sk/the\\_drug\\_schedules\\_regs\\_1997-2006.pdf](http://www.napra.ca/pdfs/provinces/sk/the_drug_schedules_regs_1997-2006.pdf)  
Section 14.13.10.2 of the bylaws at  
[http://www.napra.ca/pdfs/provinces/sk/Bylaws-Drug-Schedules-I-II-III-March2008\\_v2.pdf](http://www.napra.ca/pdfs/provinces/sk/Bylaws-Drug-Schedules-I-II-III-March2008_v2.pdf)  
supplemented by the guidelines at  
<http://www.napra.org/docs/0/203/262/269.asp>

### The *Saskatchewan Pharmacy Act 1966*

23(1) No person other than a licensed pharmacist or intern practising under the supervision of a licensed pharmacist, may prepare, compound, dispense or sell drugs in Saskatchewan.

14(2) Subject to this *Act*, regulatory bylaws may be made pursuant to section 13 for the following purposes:

(i.1) governing the prescribing and dispensing of drugs by members;

### Drug Schedules Regulations

Prescription privileges – pharmacists

9.1 A licensed pharmacist may, subject to the terms, conditions and restrictions in his or her licence, prescribe any drug listed in Schedule I that is an oral contraceptive if, in the circumstances, the provision of a sufficient quantity of the drug for emergency contraception is required to meet the patient's needs.

### Bylaws

14.13.10.2 Upon having received training as approved by Council, a pharmacist may prescribe and sell a Schedule I drug to a member of the public, in the absence of a prescription from a medical practitioner, when under emergency or urgent circumstances the pharmacist deems it to be in the best interests of the patient to provide a reasonable quantity of an oral contraceptive sufficient to meet the patient's needs and a diagnosis or assessment by a practitioner for emergency contraception is not required, as the pharmacist is able to assess the patient's needs for emergency contraception.

**Standards of Practice****THE ROLE OF THE PHARMACIST**

The contemporary role of the pharmacist is defined as drug use control. To fulfil this role, the pharmacist must perform three major functions.

**Control Function**

Ensuring prescription drugs and non-prescription drugs are correctly stored and distributed to minimize drug misuse and drug abuse. This function includes the pharmacist's traditional activities of compounding and dispensing which ensures the provision of the correct drug. However, it also requires that appropriate nonprescribed drug(s) be provided for the condition(s) being treated.

**Education Function**

Ensuring the patient gets maximum benefit from prescription and non-prescription drugs by providing the appropriate information for the patient to understand the use, precautions, common side effects, and storage requirements of the medication.

**Consultant Function**

Providing information on drug products and therapy to the physician and other members of the health care team.

**Appendix 2D: Manitoba**

The definition of the practice of pharmacy is contained in the *Pharmaceutical Act*. The *Act* was passed December 4, 2006, and will be enacted once the regulations have been approved by the membership of the Manitoba Pharmaceutical Association. The draft regulations contain information on prescribing, administering drugs, and ordering and interpreting diagnostic tests.

***The Pharmaceutical Act*****PRACTICE OF PHARMACY**

Practice of pharmacy

2(1) The practice of pharmacy consists of the following practices:

- (a) the compounding, dispensing, and retail sale of drugs;
- (b) monitoring drug therapy and advising on the contents, therapeutic values and hazards of drugs;
- (c) advising on the use, calibration, effectiveness and hazards of devices used in connection with drugs or to monitor health status;
- (d) identifying and assessing drug-related problems, and making recommendations to prevent or resolve them;
- (e) the practices set out in subsection (2), when performed by a member who meets the qualifications and any restrictions or conditions set out in the regulations.

Included practices

2(2) A member who meets the qualifications set out in the regulations may, subject to any restrictions or conditions set out in the regulations, engage in any of the following practices in the course of practising pharmacy:

- (a) prescribe drugs that are designated in the regulations for the purpose of this clause;
- (b) administer drugs that are designated in the regulations for the purpose of this clause;
- (c) interpret patient-administered automated tests that are designated in the regulations;
- (d) order and receive reports of screening and diagnostic tests that are designated in the regulations.

Drug to be dispensed only by prescription

2(3) A member may dispense a drug only pursuant to a prescription and in accordance with this Act, the standards of practice, the code of ethics, and any relevant practice direction.

Exclusive right to practise

3(1) Subject to subsection (2), no person other than a member shall engage in the practice of pharmacy.

**Draft Regulations (December 7, 2007)****Practice of Pharmacy**

**13(1)** The practice of pharmacy includes:

- (a) the supervision of monitoring drug therapy and advising on the contents, therapeutic values and hazards of drugs;
- (b) the provision of information and training to identify and assess drug related problems and making recommendations to prevent or resolve them; or,
- (c) the responsibility that the practice of pharmacy by other members is done in compliance with the Act.

**PART 12 – PRESCRIBING BY MEMBERS****Prescribing by members**

**86(1)** Subject to this part, any member may prescribe the following:

- (a) a drug listed on schedule 2 of the manual;
- (b) a drug listed on schedule 3 of the manual;
- (c) a drug which is not listed in the manual, but has been issued a drug identification number or natural health product number under the *Food and Drugs Act* (Canada); and
- (d) a medical device approved by Health Canada.

**Prescribing by extended practice pharmacists**

**86(2)** Subject to this part, a member who is an extended practice pharmacist may prescribe a drug listed on schedule 1 of the manual, within the scope of his or her specialty.

**Prescribing by clinical assistant specialist**

**86(3)** In addition to the requirements of this part, a member who qualifies as a clinical assistant specialist must prescribe a drug only in accordance with the requirements of *The Medical Act* and regulations applicable to clinical assistants.

**Prescribing in emergency**

**86(4)** Notwithstanding subsection (2), where the minister gives council written notice that a public health emergency exists in all or part of the province, council may approve members to prescribe drugs listed on schedule 1 of the manual, under any conditions deemed appropriate by council, until the state of emergency is lifted.

**Criteria for prescribing**

**87** A member may only prescribe where:

- (a) the member has made a reasonable inquiry to assess whether the drug will be safe and effective in the circumstances of the patient, including:
  - (i) the patient's symptoms;
  - (ii) the patient's medical history or information;
  - (iii) the patient's allergies;
  - (iv) other medications the patient may be taking; and
  - (v) any other inquires reasonably necessary in the circumstances.
- (b) the member has assessed the patient in person, in compliance with the standards of practice or practice directions;
- (c) the drug is prescribed in a circumstance which is within the member's usual scope of practice or specialty;
- (d) the member has complied with any policies or rules related to prescribing at the pharmacy at which the member practices;
- (e) the member has complied with any applicable practice directions;
- (f) the member has determined that the prescription is reasonably necessary or desirable to treat the patient;

- (g) except where the prescription is being issued for an in-patient of a facility under the Health Services Insurance Act, the member has discussed with the patient, or his or her agent, reasonable and available therapeutic options and costs.
- (h) the device is needed to meet the care needs of the patient.

**Controlled substances**

**88** This Part is subject to the restrictions set out in the *Controlled Drugs and Substances Act* (Canada) and the regulations thereunder.

**Continued care prescriptions**

**90(1)** Subject to this section, a member may authorize an additional refill of a prescription, beyond those authorized by the original practitioner issuing the prescription, where:

- (a) the patient has a continuing need or chronic condition;
- (b) the prescribing practitioner or extended practice pharmacist has died or retired within the previous six months or has not responded to an inquiry for refill authorization and it would be onerous or impossible for the patient to contact or attend with the original practitioner issuing the prescription in a timely manner;
- (c) the history of the patient with the subject drug has not changed;
- (d) the patient advises that they have not recently experienced any adverse drug reactions to the subject drug;
- (e) the prescription was previously filled at the same pharmacy; and
- (f) the member complies with any applicable practice directions.

**Requirements for continued care prescriptions**

**90(2)** Where a member authorizes a refill under subsection (1), the member must

- (a) promptly notify the original practitioner who issued the prescription, subject to their death or retirement described in section 90(1)b;
- (b) enter the refill into DPIN; and
- (c) keep the records required by part 8 of this regulation.

**Restrictions on continued care prescriptions**

**90(3)** A member must not authorize a refill under subsection (1):

- (a) where the refill quantity is in excess of the original prescribed refill amount;
- (b) where the drug falls under the *Controlled Drugs and Substances Act* (Canada) unless it is issued in compliance with sections 88 and 90(1) of the regulations;
- (c) where the drug is a benzodiazepine, unless:
  - (i) the drug is used to manage a convulsive disorder; or
  - (ii) there is a serious risk of seizure due to sudden withdrawal;
- (d) where the patient appears to be using continuing care refills to avoid obtaining ongoing medical care.

**PART 13 – ADMINISTRATION OF DRUGS**

**Administration of drugs by members**

**91(1)** Any member or intern may administer a drug listed in the manual or has been issued a drug identification number or natural health product number under the *Food and Drugs Act* (Canada) to a patient:

- (a) orally, including sublingual and buccal;
- (b) topically, including ophthalmic, otic and intranasal; or
- (c) via inhalation.

**Certification in drug administration**

**91(2)** Council may establish a training program to certify members in other methods of drug administration that includes enhanced safety measures and emergency resuscitation, and specify the frequency by which the certification must be renewed.

**Use of titles**

**91(3)** No person may represent that they are certified in drug administration unless they hold current certification under subsection (2).

**Advanced drug administration**

**91(4)** A member who has current certification in drug administration, or under training and direct supervision as described in section 91(2), may administer a drug:

- (a) through intradermal injection;
- (b) through subcutaneous injection;
- (c) through intramuscular injection; or
- (d) intravenously through an established central or peripheral venous access device.

**Administration by clinical assistant specialist**

**91(5)** Notwithstanding anything in this section, a member who is a clinical assistant specialist may administer a drug in accordance with the requirements of *The Medical Act* and regulations applicable to clinical assistants.

**PART 14 – TEST INTERPRETATION****Interpretation of tests by members**

**93** Any member may interpret and advise the patient of the results and implications of any patient administered automated tests.

**Test interpretation record**

**94(1)** A member who interprets and makes a recommendation to a patient regarding a patient administered test must make and retain a record in the pharmacy of:

- (a) the name of the patient;
- (b) the address of the patient;
- (c) the nature of the test interpreted;
- (d) the results of the test;
- (e) the nature of the advice given to the patient;
- (f) the name of the member interpreting the test; and
- (g) the date of the test.

**PART 15 – ORDERING AND RECEIPT OF TEST REPORTS****Ordering tests by members**

**95(1)** Any member may, upon approval from the patient's practitioner, order and receive copies of a screening or diagnostic test.

**Ordering tests by members in hospital**

**95(2)** Any member in a pharmacy with a hospital pharmacy licence, may, in accordance with hospital policy, order and receive a screening or diagnostic test for a person who is an in-patient of a hospital designated under *The Health Services Insurance Act*.

**Ordering tests by extended practice pharmacist**

**95(3)** In addition to the tests referred to in subsections (1) and (2), a member who is an extended practice pharmacist may order and receive the results of screening and diagnostic tests which are within the scope of the member's specialty.

**Results to be made available**

**95(4)** A member who orders and receives the results of a screening or diagnostic test, under this section, that;

(a) reveals medical issues requiring attention, or,

(b) the member is not able to interpret must promptly forward the results to a health professional responsible for the patient's care for the interpretation of the results after which the member may advise the patient when delegated the authority to do so.

## **Appendix 2E: Ontario**

The scope of practice for pharmacy is set out in the Pharmacy Act. Pharmacists can extend prescriptions in accordance to the PAPE agreement.

### **Pharmacy Act S3:**

*The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.*

The authorized acts for Pharmacy under S.4 are:

*In the course of engaging in the practice of pharmacy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug or supervise the part of a pharmacy where drugs are kept.*

## **PHARMACIST AUTHORIZATION OF PRESCRIPTION EXTENSIONS (PAPE) AGREEMENT**

Draft: January 2008

The following agreement provides conditions under which a pharmacist may provide authorization of a prescription extension to a patient where an urgent need for patient drug therapy management exists and the prescribing physician is unavailable to provide refill authorization.

This Agreement assumes the following principles:

1. Pharmacist authorization of prescription extensions cannot and does not take the place of ongoing medical care.
2. Each request for a pharmacist authorization of prescription extensions must be judged on the individual nature of the patient's need/history and professional judgment exercised accordingly.
3. The pharmacist assumes the responsibility for the extended refill.

A pharmacist may authorize a prescription extension where the following conditions are met:

1. The pharmacist must be reasonably satisfied that the prescriber, if available, would in all likelihood, provide the authorization.
2. The medication to be extended has been prescribed to the patient for a chronic or long term condition (generally for at least a year or longer).
3. The patient shall have an established, stable history (no recent changes to dosages or drug therapy) with that medication.
4. The prescription to be extended shall be with that particular pharmacy and the patient shall be within the care of the pharmacy.
5. Narcotic or controlled substances shall NOT be authorized for extension within the confines of this agreement.

6. The pharmacist may authorize a prescription extension once only. Further requests for extensions must be handled by the patient's physician or original prescriber or an on-call physician.
7. The amount of medication provided must not exceed the previous amount filled, or three months, whichever is lesser.
8. The pharmacist shall assign a new prescription number to the prescription extended under this agreement (PAPE) and shall record on the prescription the Rx number of the original prescription. The original prescriber shall be listed as the prescriber on the extended prescription. The pharmacist shall be recorded as authorizing the extension.
9. The PAPE shall be documented on the patient record in such a manner as to ensure the prescription will not be "extended" a second time.
10. The PAPE shall be reported in written format within one week to the original prescriber and to the patient's primary care physician (if different from the prescriber). A copy is to be kept in the pharmacy.
11. A prescriber retains the right to indicate "no extension" on a prescription; however this does not preclude the pharmacist from exercising professional judgment in an emergency situation.

Support/endorsement for this policy is being actively sought from the Council of the Ontario College of Pharmacists, as well as from:

The Ontario Pharmacists Association,  
 The Ontario Medical Association, and  
 The College of Physicians and Surgeons of Ontario

**Appendix 2F: Quebec**

The practice of pharmacy is defined in section 17 of the Pharmacy Act.

***Pharmacy Act*****PRACTICE OF PHARMACY****Pharmacy practice.**

**17.** The practice of pharmacy consists in determining and ensuring the proper use of medications, particularly to identify and prevent pharmacotherapeutic problems, and in preparing, storing and delivering medications in order to maintain or restore health.

Reserved activities.

The following activities in the practice of pharmacy are reserved to pharmacists:

- 1) Issuing a pharmaceutical opinion;
- 2) Preparing medications;
- 3) Selling medications, in accordance with the regulation under section 37.1;
- 4) Supervising medication therapy;
- 5) Initiating or adjusting medication therapy, according to a prescription, making use, where applicable, of appropriate laboratory analyses;
- 6) Prescribing and personally dispensing emergency oral contraception medication provided a training certificate has been issued to the pharmacist by the Order pursuant to a regulation under paragraph *o* of section 94 of the Professional Code (chapter C-26).

1973, c. 51, s. 17; 1990, c. 75, s. 4; 2002, c. 33, s. 22.

**Appendix 2G: New Brunswick**

The practice of pharmacy is defined in the Pharmacy Act.

**Pharmacy Act****PRACTICE OF PHARMACY**

**5.1(1)** The practice of pharmacy promotes health, the prevention and treatment of diseases, dysfunction and disorders through proper drug therapy and non-drug therapy, including, but not limited to, the following actions:

- (a)* assist and advise clients, and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use;
- (b)* monitor responses and outcomes to drug therapy;
- (c)* compound, prepare, dispense and administer drugs;
- (d)* provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices;
- (e)* supervise and manage drug distribution systems to maintain public safety and drug system security;
- (f)* educate clients, and members of the Society in matters described in this section;
- (g)* conduct or collaborate in drug-related research;
- (h)* conduct or administer drug and other health related programs;
- (i)* advise and support other pharmacists in the provision of pharmacy services;
- (j)* direct the client to consult with other health care providers when appropriate;
- (k)* the practices set out in subsection (2), when performed by a member who meets the qualifications and any restrictions or conditions set out in the regulations.

**5.1(2)** A member who meets the qualifications set out in the regulations may, subject to any restrictions or conditions set out in the regulations, engage in any of the following practices in the course of practicing pharmacy:

- (a)* prescribe drugs and treatments that are designated in the regulations for the purpose of this section;
- (b)* administer drugs that are designated in the regulations for the purpose of this section;
- (c)* interpret client-administered automated tests that are designated in the regulations;
- (d)* order and receive reports of screening and diagnostic tests that are designated in the regulations.

## Appendix 2H: Nova Scotia

The practice of pharmacy is defined in the *Pharmacy Act*. S.80(2)d of the *Pharmacy Act* permits the Governor in Council to make regulations respecting the circumstances under which a licensed pharmacist may prescribe drugs.

### *Pharmacy Act*

(r) "practice of pharmacy" means the practice of pharmacy as described in this *Act* and includes professional services provided by a pharmacist related to the use, dispensing, compounding or distribution of drugs to or for the public and the responsibility for taking all reasonable steps to ensure pharmaceutical and therapeutic appropriateness of the therapy;

- (2) The practice of pharmacy includes the practice of and responsibility for
- (a) the interpretation and evaluation of prescriptions;
  - (b) the provision of information respecting drug and non-drug therapy;
  - (c) the compounding, dispensing and added labeling of drugs and devices;
  - (d) taking all reasonable steps to ensure pharmaceutical and therapeutic appropriateness of a drug therapy;
  - (e) monitoring drug therapy;
  - (f) the identification, assessment and recommendations necessary to resolve or prevent problems in patients related to drugs;
  - (g) counselling persons respecting the therapeutic values, content, hazards, side effects and proper use and storage of drugs and devices;
  - (h) the safe storage of drugs and devices;
  - (i) the maintenance of proper records for drugs and devices, including patient records;
  - (j) services, duties and transactions necessary to the management, operation and control of pharmacies;
  - (k) the sale of drugs and devices; and
  - (l) other professional services authorized by law.

### PROFESSIONAL RESPONSIBILITY

**25 (1)** The primary responsibility of a pharmacist is the provision of optimal patient care.

- (2) The practice of pharmacy includes the practice of and responsibility for
- (a) the interpretation and evaluation of prescriptions;
  - (b) the provision of information respecting drug and non-drug therapy;
  - (c) the compounding, dispensing and added labeling of drugs and devices;
  - (d) taking all reasonable steps to ensure pharmaceutical and therapeutic appropriateness of a drug therapy;
  - (e) monitoring drug therapy;
  - (f) the identification, assessment and recommendations necessary to resolve or prevent problems in patients related to drugs;
  - (g) counselling persons respecting the therapeutic values, content, hazards, side effects and proper use and storage of drugs and devices;
  - (h) the safe storage of drugs and devices;
  - (i) the maintenance of proper records for drugs and devices, including patient records;
  - (j) services, duties and transactions necessary to the management, operation and control of pharmacies;
  - (k) the sale of drugs and devices; and
  - (l) other professional services authorized by law.

(3) Every pharmacist shall ensure that each patient has sufficient information and advice for the proper use of the drug or device dispensed.

- 80(2)** The Governor in Council may make regulations respecting
- (a) those provisions of this *Act* that apply to hospital pharmacies;
  - (b) the regulation of hospital pharmacies;
  - (c) the regulation of the practice of pharmacy in a hospital;
  - (d) the circumstances under which a licensed pharmacist may prescribe drugs.

**(3)** In any regulation passed pursuant to this Section, the Council or the Governor in Council may adopt by reference, in whole or in part, any schedule, code, specification, examination, standard or formulary, and may also provide that it is adopted as amended from time to time, except such amendments as are expressly disallowed by the Council or the Governor in Council, as the case may be.

Regulation 24 of the Regulations Respecting Qualifications and Professional Accountability, provides the following:

**Conditional authority**

**24 (1)** In this Section, "conditional authority" means the authority for a pharmacist to lawfully carry out medical activities, services or functions under the conditions set out in a written agreement between the College and the College of Physicians and Surgeons of Nova Scotia.

**(2)** The College may enter into a written agreement with the College of Physicians and Surgeons of Nova Scotia that authorizes a pharmacist to carry out medical services, activities or functions and that has as its underlying objectives, improved access to health care by the public and achieving the best health care results for the public.

**(3)** An agreement entered into under this Section must

**(a)** prescribe the conditions under which the conditional authority may be exercised, including any education or certification that may be advisable or required by a pharmacist before a pharmacist can perform any medical activities, services or functions under the conditional authority;

**(b)** confirm the professional responsibility and accountability of a pharmacist who performs any medical activities, services or functions under the conditional authority; and

**(c)** be filed with the Minister of Health.

**(4)** An agreement entered into under subsection (2) must not authorize a pharmacist to prescribe narcotic or controlled drugs and a pharmacist is prohibited from prescribing narcotic or controlled drugs under a conditional authority.

**(5)** A medical activity, service or function that a pharmacist carries out under a conditional authority is deemed to be practising pharmacy in accordance with the *Act* and the regulations made under the *Act*.

**(6)** For the purposes of Section 44 of the *Medical Act*, a medical activity, service or function that a pharmacist carries out under a conditional authority is deemed to not be a violation of the *Medical Act* or the regulations made under the *Medical Act*.

## **Appendix 2I: Prince Edward Island**

The practice of pharmacy is defined in the Pharmacy Act.

**Pharmacy Act** (including amendments May 22, 2008)

(o.1) "practice of pharmacy" means

- (i) manufacturing, compounding or otherwise preparing a drug, including packaging, repackaging or labelling,
- (ii) dispensing a drug,
- (iii) giving expert instruction or advice on the use of or appropriateness of a drug, the performance of which skill, in the opinion of the Board, requires specialist knowledge and judgment concerning the properties of drugs; or
- (iv) giving a prescription for a drug.

(p) "prescription" means a direction for the preparation and dispensing of a drug that is given by

- (i) a person authorized by the law of any province or territory to practise as a physician, dentist or veterinarian,
- (ii) a person authorized to do so by the Minister under section 14.1; or
- (iii) a pharmacist.

7(2) The functions of the Board are to

...

(g) prescribe conditions and restrictions on the authority of pharmacists to give prescriptions.

## **Appendix 2J: Newfoundland and Labrador**

The practice of pharmacy is defined in the Pharmacy Act.

### **Pharmacy Act**

practice of pharmacy means

- (i) having responsibility for preparing, distributing and controlling drugs in a pharmacy,
- (ii) compounding a prescription,
- (iii) dispensing a drug,
- (iv) selling a drug by retail,
- (v) disseminating information on the safe and effective use of a drug when dispensing or selling a drug, or
- (vi) subdividing or breaking up a manufacturer's original package of a drug for the purpose of repackaging the drug in larger or smaller quantities for redistribution, and includes teaching, consulting or advising in the areas of pharmaceutical services, education, policy or research by a person registered under this Act;

### **Appendix 3: Blueprint for Pharmacy**

Task Force on a Blueprint for Pharmacy. Blueprint for pharmacy: the vision for pharmacy. Ottawa (ON): Canadian Pharmacists Association; 2008. [www.pharmacists.ca](http://www.pharmacists.ca).

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