



SASKATCHEWAN  
COLLEGE OF  
PHARMACISTS

**Saskatchewan College of Pharmacists**

**Position Statement**

**On**

**Enhanced Authority for the Pharmacist**

**To**

**Prescribe Drugs**

**In**

**Collaborative Practice Environments**

**September 2008**

## **Executive Summary:**

The Saskatchewan College of Pharmacists (SCP) supports interdependent pharmacist prescribing in collaborative practice environments because it makes the best use of the skills and knowledge of the pharmacist, encourages the interdisciplinary approach to health care, and enhances patient care and safety. Enabling authority for pharmacists to prescribe will also legitimize certain current practices.

Enhanced authority to prescribe in Saskatchewan has three important cornerstones:

1. **Collaboration:** Collaboration with other health providers is an important and integral component to pharmacist prescribing and medication management. This includes two-way communication and documentation regarding drug therapy decisions. Prescribing by pharmacists should complement care provided by other health professionals.<sup>1</sup>

Authorities cite the benefits when health care professionals work collaboratively in an integrated health care system that is patient centered.

2. **Public Safety:** Pharmacists can ensure the quality and safety of appropriate medication use and the optimization of drug therapy for the benefit of their patients.
3. **Optimization of Competencies:** Allowing pharmacists to practice to their full scope within a health care team can improve the provision of care. Pharmacists' university training prepares them for a significant role in ensuring positive pharmacotherapy outcomes. The shortage of human health care resources in Saskatchewan creates a demand for optimizing the use of skills of all providers. The benefits to patients and the health care system are well recognized.

SCP has determined that pharmacists be allowed to prescribe under two different levels of authority:

1. **Level I** - recognizes the basic level of knowledge, skills and training that all pharmacists have:
  - a. While pharmacists will be oriented to the process and practice expectations, additional training is not required
  - b. Includes the following range of activities:
    - i. Continuing Therapy – interim supplies and maintenance therapy
    - ii. Drugs in emergency circumstances ( previously prescribed medication)

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<sup>1</sup> CPhA Position Statement on Pharmacist Prescribing, CPhA, August 2007.

- iii. Incomplete or inaccurate prescriptions
  - iv. Refills of medications during physician absence (with limitations)
  - v. Medications for self care
  - vi. Exempted Codeine Products
  - vii. Non-prescription drugs (to obtain 3<sup>rd</sup> party coverage)
  - viii. Seamless care
2. Level II – recognizes that pharmacists are capable of undertaking advanced training:
- a. Pharmacists will be oriented to the process and practice expectations, and additional training to obtain credentials will be required
  - b. Includes the following range of activities:
    - i. Part A – Provision of oral contraception and lifestyle and health promotion
    - ii. Part B – Collaborative prescribing agreements, therapeutic substitution, and altering dosage and/or dosage regimen

## Introduction

Health care for patients should be safe, efficient and effective. The efforts of all health professionals make these goals achievable. The challenge is to find ways to make this happen. Research continues to look for ways to improve health outcomes for patients and examine the role each professional can play in support of this goal. All health care professions continuously evaluate their role and scope of practice within the health care system and consider whether their skills and knowledge are optimized. Health care professionals who work in a collaborative practice, in primary care settings, have indicated this is the way of the future.<sup>1</sup>

Enabling legislation to allow pharmacists to prescribe interdependently within a collaborative practice environment optimizes their skills and knowledge in order to complement the skills of the other members of the health care team. Under the proposed changes, pharmacists will be able to prescribe given a variety of situations categorized under Level I or Level II Authority.

The Saskatchewan College of Pharmacists will regulate orientation and training to ensure standards are met. This new role for pharmacists in the health care system is not a change in their scope of practice but an opportunity to make the most of their education and training. Ultimately patient care and patient safety are improved through the synergy between other prescribers and the pharmacist to ensure the best possible outcomes from pharmacotherapy.

## Definitions

### Clinical Practice Guidelines

This information comes from reputable source(s), which rely upon scientific evidence to assist in the determination of a course of action for disease and medication management. They are “systematically developed statements about appropriate healthcare for specific clinical circumstances.”<sup>2</sup>

### Collaborative Practice Agreement

A written, formal agreement between health care providers in a collaborative practice environment, which outlines the competency based functions performed by each health care provider, and acknowledges shared risk and responsibility for patient outcomes.<sup>3</sup>

### Collaborative Patient-Centered Practice

A positive interaction of two or more health professionals who bring their unique skills and knowledge to assist patients and families with their health decisions.<sup>5</sup> It is designed to promote the active participation of several health care disciplines and enhances patient, family and community centered goals and values, provides mechanisms for continuous communication amongst health care providers, optimizes staff and patient participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all providers.<sup>4</sup>

### Continuum of Care

An integrated and seamless system of settings, services, service providers and service levels to meet the needs of clients or defined populations.<sup>6</sup>

### Evidence Based Medicine

The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.<sup>7,8</sup>

### Health Promotion

Any action that helps promote, encourage, stimulate or enable patients to make life-style changes in order to move toward a state of optimal health. It is a balance of physical, emotional, social, spiritual and intellectual health.

### Interdependent Prescribing

A working relationship between another prescriber and the pharmacist where each professional relies upon one another's skills to manage the pharmacotherapy needs of their patients in a collaborative environment. As an underlying principle, all prescribing decisions performed by the pharmacist are communicated to the other prescriber.

### Interdisciplinary Team

Consists of practitioners from different professions who share a common patient population, common patient care goals, and have responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members, as well as with patients and families, to ensure that integration occurs concerning various aspects of patients' health care.<sup>9</sup>

### Medication Discrepancies

As defined by medication reconciliation processes<sup>15</sup> they can be categorized as:

1. Intentional Discrepancy - where the prescriber has made an intentional choice to add, change or discontinue a medication and this choice is clearly documented. This is considered to be 'best practice' in medication reconciliation.
2. Undocumented Intentional Discrepancy – where the prescriber has made an intentional choice to add, change or discontinue a medication but this choice is not clearly documented.
3. Unintentional discrepancy - occurs when the physician unintentionally changed, added or omitted a medication the patient was taking.

### Pharmaceutical Care

The responsible provision of drug therapy for the purpose of achieving definite outcomes which improve a patient's quality of life.<sup>10</sup>

### Pharmacist Assessment Record (PAR)

A record completed by the pharmacist for the purpose of documenting patient information, drug related problems and action plans, and becomes the clinical record of the pharmacist's drug therapy decisions that can be shared with other health professionals.

### Practitioner

Includes all persons within the definition of "practitioner" under:

- *The Pharmacy Act, 1996;*
- The Drug Schedules Regulations, 1997; and
- The Registered Nurse (Nurse Practitioner) Category, described in Bylaw VI, Section 3 of the Saskatchewan Registered Nurses' Association Bylaws 2006

### Seamless Care

The desirable continuity of care delivered to a patient in the health care system across the spectrum of caregivers and their environments.<sup>11</sup>

### Self Care

Within a broad spectrum of behaviours, includes all health decisions consumers make for themselves and their families to maintain a good level of physical and mental health. These include maintaining physical fitness and good health to

prevent disease or manage conditions, using self-medication to treat and prevent illness, and managing one's health after discharge from tertiary health care.<sup>12</sup>

### Therapeutic Equivalence

Drugs, dosage forms, or formulations, which have acceptably equivalent effects in treating or preventing disease and/or restoring health.<sup>13</sup> Medications frequently differ in chemistry, mechanism of action and pharmacokinetic properties, and may possess different adverse reaction, toxicity and drug interaction profiles.<sup>14</sup>

### Support for Collaborative Practice Model

Collaborative care is highly patient centered and involves the co-ordination and teamwork of a group of primary health care providers, including both medical and non-medical clinicians.<sup>27</sup>

Major reviews of the Canadian health care system outlined in the Romanow Commission, Kirby and Fyke Reports call for changes to the delivery of patient care. While these reports cover many issues, they all support a common recommendation when it comes to the utilization of health care professionals. In general they recommend that if major changes are to occur in the delivery of health care, all pharmacists should play a major role as a member of the team. Specifically the Romanow Commission on the Future of Health Care in Canada states that “pharmacists can play an important role as part of the primary health care team, working with patients to ensure they are using medications appropriately and providing information to both physicians and patients about the effectiveness and appropriateness of certain medications for certain conditions”.<sup>17</sup>

Romanow also recommends that: “Changes in the way health care services are delivered, especially with the growing emphasis on collaborative teams and networks of health providers, means that traditional scopes of practice also need to change. This suggests new roles for nurses, family physicians, pharmacists, case managers and a host of new and emerging health professions”.<sup>17</sup> At the same time the underutilization of pharmacists has also been widely recognized, with several authorities acknowledging the benefits of having the pharmacist as a member of the health care team.<sup>3, 16 and 17</sup>

Patients seeking the services of health professionals have a reasonable expectation that care is provided by the individual within the health care team who is most qualified to address their needs. The American Academy of Family Physicians further underscores the importance of collaborative practices by stating that: “the pharmacy professional and physician can and should work in a collaborative environment where their combined expertise is used to optimize the therapeutic effect of pharmaceutical agents in patient care.”<sup>18</sup> Collaborative

practice, which optimizes the use of the pharmacist, takes full advantage of the skills and knowledge of the pharmacist while at the same time providing increased benefits to the patient.<sup>18</sup>

Collaborative models of practice, as described by the federally funded initiative “Enhanced Interdisciplinary Collaboration in Primary Health Care (EICP)”, demonstrates the benefits of a new approach to patient care.<sup>3</sup> The chair of the initiative, Dr. John Service, offers the following observation: “In the future, Medicare had better be in the hands of health teams. We have heard loud and clear that collaboration by primary health professionals delivers benefits for patients and clients, and health professionals themselves value the support of a team, especially since they are increasingly suffering from burn-out and long work days”.<sup>26</sup> This statement not only supports collaborative care, but also focuses on the benefits of this practice model to the health care system.

Enhanced authority for pharmacists to prescribe medications in collaborative practices has gained recognition both in North America and internationally. To date prescriptive authority has been granted to pharmacists in 42 states and some Canadian provinces. For example, limited authority has been granted in Quebec and Nova Scotia, with more comprehensive authority being most recently granted in Alberta. In England and Scotland, new practice models for delivery of pharmacy services are in place<sup>22</sup> allowing for the prescribing of medicines by competent healthcare professionals such as pharmacists. The development of the primary care model presents the ideal situation for pharmacists to optimize their skills and knowledge to improve patient care using the collaborative care model.

Two major health professional groups, the Canadian Medical Association (CMA) and the Canadian Pharmacists Association (CPhA) both support a new model for delivering enhanced patient care<sup>28</sup>. They have provided leadership to their respective professions by supporting a collaborative practice model. Therefore, it is not surprising that in collaborative practices where pharmacists have been recruited to work, they have demonstrated their value to the team.<sup>3</sup>

The Saskatchewan health care system has seen considerable changes in the past few years. Now more than ever resources are limited and using the right health professional for the right service at the right time is a responsible utilization of health human resources. Patients need pharmacists to use their knowledge and skills to improve safety and outcomes of drug therapy. Providing this knowledge and skills within a collaborative patient-centered practice will benefit the patient and the health care team. Enabling legislation, which authorizes a pharmacist to prescribe medications, would allow the pharmacist to optimize their role and reduce related care gaps in the health care system.

## Working Collaboratively

In a collaborative practice, the patient is an active participant in creating a care plan. With respect to medications, the CPhA has put forward a position statement supporting the collaborative practice philosophy.<sup>29</sup> The position paper states: "All decisions related to medication management, including prescribing, must be collaborative, patient centered and focused on addressing the health care needs of the patient". This concept is a key principle in defining interdependent pharmacist prescribing within collaborative practices.

Characteristics and skills of professionals working in a collaborative practice may include, but are not limited to, consultation, cooperation, flexibility, shared documentation, competency based roles, quality of work life, mutual respect, mutual trust and communication between team members.<sup>11</sup> Various organizational structures can exist to determine how the collaborative operates.<sup>27</sup> As the members of the team become comfortable with each other's practice skills, new working relationships and trust will grow.

Good communication will be the cornerstone of a good collaborative relationship. The availability of new technologies, such as electronic medical records (EMR) and the Pharmaceutical Information Program (PIP) will be helpful tools to enhance communication. Efficiency of service delivery and increased patient safety will improve by all health professionals recognizing and using these advances in technology.

## Pharmacists' Skills and Knowledge

The pharmacist's primary focus is to monitor drug therapy to ensure it is safe and effective. Pharmacist managed drug therapy addresses established goals to improve the patient's care in many different ways. Using the Pharmaceutical Care Model (PCM) pharmacists develop a care plan, assist with medication management and as a result achieve optimum health outcomes for the patient. The PCM is the foundation on which prescriptive authority is built. The PCM proposes to prevent, identify and resolve the following eight drug related problems<sup>8</sup>:

1. Untreated indications: The patient has a medical problem that requires medication therapy (an indication for medication use) but is not receiving a medication for that indication.
2. Improper drug selection: The patient has a medication indication but is taking the wrong medication.
3. Sub-therapeutic dosage: The patient has a medical problem that is being treated with too little of the correct medication.
4. Failure to receive medication: The patient has a medical problem that is the result of not receiving a medication (e.g. for pharmaceutical, psychological, sociological or economic reasons).

5. Over dosage: The patient has a medical problem that is being treated with too much of the correct medication (toxicity).
6. Adverse drug reactions: The patient has a medical problem that is the result of an adverse drug reaction or adverse effect.
7. Drug interactions: The patient has a medical problem that is the result of a drug–drug, drug–food, or drug–laboratory test interaction.
8. Medication use without indication: The patient is taking a medication for no medically valid indication.

The application of the PCM results in additional responsibilities for the pharmacist. These include:

- Utilization of their extensive drug knowledge to ensure medications do no harm to the patient (e.g. pharmacokinetics and pharmacodynamics).
- Communicating with the prescriber to provide feedback or information regarding the pharmacotherapy of the patient, which may include changing, modifying or discontinuing the medication.
- Making therapeutic recommendations based on clinical practice guidelines.
- Providing for continuity of care by communicating with other health care practitioners to ensure all care providers in the patient’s circle of care are informed when necessary.
- Providing drug information to other health care professionals.
- Providing patient counselling, to encourage patient participation in caring for themselves, which may include a discussion around treatment goals and adherence strategies with appropriate expectations.
- Counselling patients to ensure patients understand when to seek medical help and when it is appropriate to self-treat.

As part of the pharmacist-patient interaction, the pharmacist documents the drug related problems, the pharmacy care plan, and the action plan for follow-up. The record will also facilitate pharmacist-physician interaction regarding pharmaceutical decisions.

### Current Patient Experience

The act of visiting a pharmacy to have a prescription filled, or to obtain self-care advice may seem straight-forward. However leaving the pharmacy with the correct medication and the correct information is complex. The pharmacist ensures that when medication is dispensed it is safe, and does not interact with pre-existing prescription and over-the-counter medications, including herbal products. Pharmacists possess a wealth of knowledge about medications and effective utilization of this expertise improves the safety and outcomes of drug therapy.

The following are just a few examples of how the pharmacist's knowledge can improve the delivery of health care:

- The patient presents to the pharmacy with a new prescription and may be unsure of the purpose for the medication. The pharmacist will interview the patient or communicate directly with the physician to determine the patient's medical condition. This aids in directing pertinent information to the patient on proper drug use.
- The patient presents to the pharmacy with a prescription which states "take as directed". The pharmacist ensures the patient understands how the medication should be taken to ensure optimum outcomes. This may also require direct communication with the physician to clarify diagnosis.
- Filling a prescription can be complex when multiple medications are involved. Pharmacists check for interactions, counsel patients on important side effects, and oversee the safety of the distribution system. Patient education and follow-up are other important aspects of the pharmacist's responsibilities.
- The number of refills authorized by a physician has an intended purpose. Patients seeking a refill without authorization can benefit by having the pharmacist either supply them with an interim supply or provide them with a few doses and contact the physician to determine if the patient should make an appointment or continue with the drug therapy.
- When a physician leaves practice temporarily or permanently, the pharmacist can inform the patient of the need for a new prescription. In some of these situations being able to prescribe and extend the refills of certain medications may be critical to a patient's health outcomes.
- Patients making self-care decisions often benefit from a pharmacist assisting them to make appropriate and safe choices. Helping patients prevent interactions with their current medication and informing them when they should be seeking medical attention is an important pharmacist role.

These examples are only a sample of the range of problems pharmacists resolve.

### Patient Benefits to Enhanced Authority to Prescribe

Enhanced interdependent prescriptive authority for the pharmacist will benefit the patient through a more efficient, effective and safer health care system. Allowing the pharmacist to provide medications under specific circumstances will ensure a continuum of care is provided. Optimizing the role of the pharmacist will benefit patients in many different ways. Some of these benefits include:

- The pharmacist ensures the patient continues on medically necessary medications (e.g. insulin, asthma medication, blood pressure medications, anticoagulation medication, oral chemotherapy)
- The pharmacist establishes effective and efficient methods to ensure patients are aware of and have access to the pharmacist's skills and knowledge when choosing self care options
- The pharmacist can be proactive when medications are proven to be of value in order to avoid complications or adverse events (e.g. prescribe laxatives when treating palliative patients on high doses of narcotics or anti-nauseants are required as part of a protocol)

Creation of enabling legislation, granting interdependent prescriptive authority to pharmacists, recognizes the pharmacists' contributions as part of the health care team. New legislation along with new standards of practice will allow pharmacists to practice up to their full scope of competency and will legitimize many current practices. The emphasis is on professionals working together to create a more efficient and effective system that improves patient safety and outcomes of drug therapy.

### Current Pharmacy Practice

As a rule, pharmacists practice in two major sites: approximately 20% institution and 80% community based. The following describes how the majority of pharmacists spend their time:

- Providing drug information
- Reviewing medication profiles and providing recommendations to optimize therapy
- Making evidenced based therapeutic recommendations
- Counselling patients and communicating drug related problems to the physician
- Dispensing or overseeing the medication distribution system to ensure safety
- Performing drug reviews and medication reconciliation activities to optimize patient safety at various intersections within the health care system (e.g. in-patient vs. outpatient)
- Resolving issues regarding insurance coverage for medications

Pharmacists acknowledge their limitations and when needed, meet their professional responsibilities by seeking the advice of other health care professionals or referring the patient to a physician. When pharmacists will prescribe medications to meet the needs of the patient, they will build trust and respect by:

- applying their skills and knowledge to meet their professional obligations to the patient;

- following the pharmacist's Code of Ethics to avoid any conflict of interest;
- demonstrating responsibility and accountability for patient outcomes; and,
- documenting their prescribing activities and communicating this information to other prescribers.

Availability of a patient's health information can vary depending on the practice setting. In order to support optimal medication management, pharmacists require access to the patient's relevant health information, which may include diagnosis, therapeutic intent and diagnostic test results. Access to this information can affect the pharmacist's ability to resolve pharmacotherapy problems.

Currently, pharmacotherapy assessments can be done using the PIP viewer and/or patient interviews. Further assessments may require communication with other pharmacists and/or caregivers. Pharmacists in institutional settings usually have better access to patient's health information. Future changes to the way we share health information will need to focus on improved access to information for all health care professionals in the patient's circle of care.

Pharmacists have expertise about a broad range of medications and health-related issues allowing them to make good pharmacotherapy management decisions on behalf of their patients. Some pharmacists seek specialized skills training to increase their expertise in the pharmacotherapy management of specific diseases or with specific medications. This additional training prepares pharmacists to establish collaborative practice agreements with physicians in specific areas of expertise for example: certification of pharmacists to prescribe in an anticoagulation clinic; as Certified Diabetic Educators to monitor diabetic patients; or as Certified Asthma Educators to monitor and treat asthmatics; and to allow pharmacists to order and adjust medication doses for renal patients.

Prescribing is not new to pharmacists in Saskatchewan. Effective September 1, 2003, legislation allowed qualified pharmacists in Saskatchewan to prescribe emergency contraception. This has provided women with timely access to emergency contraception and we understand that unwanted pregnancies have declined. Pharmacists wishing to become certified are required to take additional training, interview and counsel patients appropriately, document and bill for the service, and with the consent of the patient communicate the pharmacist-patient interaction with her physician. Experience with emergency contraception has proven this additional responsibility for pharmacists to be a successful undertaking and has provided a specific patient population more timely and better access to a needed medication.

## Practice Changes

The pharmacist will be expected to accept responsibility for patient outcomes when exercising prescribing authority. This is consistent with the concept of pharmaceutical care, which expects the pharmacist to be responsible for pharmacotherapy outcomes. When clinical practice guidelines are issued or updated, the pharmacist can identify these opportunities and make evidence based recommendations. Responsible interdependent prescribing will optimize use of the pharmacist's skills and knowledge.

Several factors support expanding the role of the pharmacist in the near future, including:

- An aging population which will result in an increased number of patients needing medications. Drug therapy is still one of the most cost-effective treatments of illness and disease.
- An increasing number of medication choices available to prescribers and their patients.
- An overworked and overstressed health human resources pool. There are increased demands on time of all health care professionals. Working in a collaborative practice with pharmacists could decrease the workload demands for all members of the team.
- A need for policy makers and economists to improve options for an effective and efficient health care system that is sustainable. Optimizing the skills and knowledge of all professionals is supported.
- A need to reduce gaps in the delivery of health care. Some examples are:
  - In the process of dispensing a prescription for a new medication, the pharmacist reviews the medication history, engages the patient in a discussion regarding the treatment and then counsels the patient. When unintended discrepancies occur or when dosage adjustments are required, the pharmacist applies his/her skills and knowledge to ensure the patient receives the correct dose and/or medication and dispenses the corrected medication to the patient.
  - Patients who are on chronic medications often run out of refills before they are able see their physician. In this situation, pharmacists would be able to provide the medication on an interim basis prior to the patient making an appointment.
  - Physicians and pharmacists establish collaborative agreements by having a pharmacist manage the patient's pharmacotherapy once the physician has made the diagnosis. In such agreements, the physician and pharmacist work together to achieve optimum patient outcomes.
  - When prescription refills expire, the pharmacist exercises professional judgment to decide whether to provide medications until a physician is contacted. These decisions are made in the best interest of the patient, but at the same time contravene existing legislation. Many prescriptions have a set number of refills ordered. Under current legislation once a refill authorization expires, the physician must be contacted to verify

whether the prescriptions should continue or be changed. However, in some cases, a quantity of medication may need to be extended to ensure potential harm is minimized before contacting the physician. This is contrary to the law. In other cases, the pharmacist determines that a review is in order and the patient is asked to contact their physician.

### Framework for Enhancing Pharmacist Prescribing Within an Collaborative Practice Environment

The Saskatchewan College of Pharmacists will use the following framework to guide interdependent collaborative prescribing by pharmacists:

1. Legislation
2. Accountability
3. Ethics
4. Communication
5. Consent
6. Defining interdependent prescribing authority in a collaborative practice environment

#### 1. Legislation

*The Drug Schedules Regulations, 1997*, authorize the categorization of drugs into lists according to their condition of sale. For prescription drugs, they further specify those health care professionals authorized to prescribe. Section 9.1 authorizes the pharmacist to prescribe emergency contraception. This section should be amended to broaden its scope to include all drugs subject to the Bylaws of SCP.

Section 14(2)(i.1) of *The Pharmacy Act, 1996* authorizes the SCP Council to make regulatory Bylaws (require Ministerial approval) “governing the prescribing and dispensing of drugs by members”. Thus, Bylaws will be required enabling pharmacists to prescribe, but also describing the limits and any other restrictions or conditions for safe prescribing.

#### 2. Accountability

Scopes of practice should reflect the degree of accountability, responsibility and authority each health care provider assumes for patient outcomes. The Canadian Medical Protective Association (CMPA) believes that “clearly defined scopes of practice are helpful to mitigate accountability risks within collaborative practices of regulated health professionals”.<sup>32</sup> Within the scope of this new authority, pharmacists will practice according to their skills, training and knowledge by:

- Maintaining or improving the patient's quality of life;

- Knowing their limits by referring patients to other health care providers as required;
- Addressing the pharmaceutical care needs of the patient;
- Establishing a good relationship with the patient and other members of the team; and,
- Maintaining competency to prescribe as set out in legislation and relevant professional guidelines.

### 3. Ethics

Section 13 of the Bylaws of the SCP contains the Code of Ethics for pharmacists. The Code describes the ethical obligations of all pharmacists. Most important is “holding the health and safety of the public to be their first consideration, in the practice of their profession”. In fulfilling these obligations, pharmacists will:

- Perform Level I prescribing in situations where patients may be subject to harm.
- Perform Level II prescribing in a collaborative environment after being appropriately trained.
- Ensure the patient’s profile is current, relevant and accessible to health care professionals (i.e. PIP), and reflects all prescribing activities.
- Not prescribe for him/herself, or any family member or relative.
- Will respect the autonomy of the patient to decide whether to accept the prescribing decisions of the pharmacist, and where to obtain their prescription.

### 4. Communication

When pharmacists prescribe interdependently, their actions complement other healthcare professionals. During the prescribing process, the pharmacist will record pertinent clinical information in the PAR. When appropriate, the PAR is forwarded (verbally, electronically or copied) to the other health care providers within the circle of care. Practice guidelines will describe the nature and scope of the assessment. Level I and Level II authority guidelines will specify when and how communications should occur between the pharmacist and other health care professionals. The method of communication should match the urgency of the situation.

### 5. Consent

In all cases, the pharmacist will inform the patient (or caregiver) of his/her actions, allowing the patient to choose which option is most appropriate for them. Further, the pharmacist will ensure that verbal or written consent has been obtained from the patient prior to prescribing. If verbal, the pharmacist will record the information on the PAR. A record of the consent should remain on file, in writing or electronically, for a period of at least 10 years. An important goal is to

maximize the use of PIP under these circumstances to record information that usually is recorded in the PAR. In the future, electronic medical or health records may provide another useful place to record clinical information.

#### 6. Defining Interdependent Prescribing Authority in a Collaborative Practice Environment

The SCP proposes to categorize the framework for pharmacist prescribing as Level I or Level II Authority. The following principles apply to both categories:

- All prescribing functions are deemed to be a pharmacist's responsibility and cannot be delegated to a technician.
- The pharmacist will spend sufficient time counselling the patient to ensure proper guidance is provided.
- Except for Self Care, Exempted Codeine Products and Non-Prescription Drugs to obtain Third Party Coverage, Level I and Level II Authority can occur only on existing prescriptions that are current (less the one (1) year), and where the practitioner is still practising.
- Patient information is shared within the circle of care, as consent is deemed under the *Health Information Protection Act*.
- The PAR can be a manual or an electronic record and is retained for a minimum of 10 years.
- Once a PAR is created the original practitioner is informed of any modifications to the prescription.
- The pharmacist will also record all prescribing decisions in the PIP Medication Profile Viewer.
- The pharmacist is not able to prescribe Controlled Substances (Narcotics, Controlled Drugs, Benzodiazepines or other Targeted Substances) to anyone.
- Prior to performing any or all of the Level I or Level II prescribing, pharmacists must participate in orientation to the process and expectations.
- Level II prescribing will require submission of evidence of advanced skills or credentials.

Under Level I Authority, collaboration occurs when the relationship between the pharmacist and other prescribers involved in the care of the patient is sufficient so that they can rely upon the basic skills of the pharmacist to prescribe in the best interests of the patient, communicate those decisions to them, and refer the patient to them or other health care providers as appropriate.

Under Level II Authority, collaboration occurs as described above, except that other prescribers accept and then rely upon the advanced skills of the pharmacist to prescribe in the best interests of the patient according to an agreement. Recognition of these skills is often formalized through collaborative practice agreements.

In both, the more urgent the situation, the more urgent the communication should be.

### Level I Authority Prescribing

Level I Authority prescribing addresses continuum of care issues, as well as unintended discrepancies during the act of prescribing. The pharmacist will document decisions into the PAR to serve as a clinical record as well as a tool to communicate with other health care providers. Pharmacists will receive orientation training according to the following learning objectives:

- Appropriate written and verbal communications techniques;
- Review of professional obligations under the Code of Ethics and Standards of Practice;
- Review of accountability requirements, including documentation, with respect to all prescribing situations;
- Appropriate PAR and PIP documentation; and,
- Identification of when and how to communicate with other health care professionals.

The Level I Authority describes activities that are within the competency of all pharmacists licensed in the province of Saskatchewan. Other health professionals expect the pharmacist to act in the best interest of the patient and communicate all relevant information to them in a timely manner. Ongoing communication between the pharmacist and the physician is expected.

Pharmacists will have authority to prescribe drugs in the following situations:

1. Continuing therapy – interim supplies and maintenance therapy
2. Drugs in emergency circumstances ( previously prescribed medication)
3. Incomplete or inaccurate prescription
4. Refills of medications during physician absence (with limitations)
5. Medications for self care
6. Exempted Codeine Products
7. Non-prescription drugs (to obtain third party coverage)
8. Seamless care

#### 1. Continuing Therapy – Interim Supplies and Maintenance Therapy

A common scenario is that the patient has a legal prescription with no valid repeats remaining. The pharmacist determines if circumstances warrant the provision of additional quantities of the medication(s) originally prescribed in order to prevent missed doses and reduce the potential for harm. The pharmacist uses the PIP viewer to validate the patient's medication history prior

to providing any medication. If the patient is unable to see a physician and has not had a previous interim supply issued since their last visit to a physician, the patient is eligible to receive an interim supply of up to one month.

In the case of chronic medication without valid repeats remaining, a patient may request refills from any pharmacy on a one-time basis. If refills are remaining, they must be transferred and used first. Alternatively, after reviewing a patient's request for more medication, the pharmacist can refuse and refer the patient to their physician. The pharmacist has a responsibility to notify the original prescriber of the prescription extension.

## 2. Drugs in Emergency Circumstances (Previously Prescribed Medication)

A patient presenting to any pharmacy and who requires medication for acute or extended treatments and where discontinuation or interruption will produce a negative outcome may request additional medication. In these situations, a pharmacist may prescribe and dispense up to a 72-hour supply of medication to a Saskatchewan resident who is not able to see a physician to review their condition. The pharmacist creates a new prescription after reviewing the patient's profile in PIP.

## 3. Incomplete and inaccurate prescription

Amongst other things, the prescription should contain the patient's name, address, date, drug name, strength, dosage form and quantity, directions for use, number and frequency of refills if appropriate, and signature of the prescriber. However, unintended omissions or errors occur. By correcting these errors or omissions the pharmacist increases the efficiency of the health system.

When a prescription is incomplete but the intent of the prescriber can be reasonably deduced, the pharmacist can complete and fill a prescription when the final dose is calculated, based upon patient parameters. For example, the prescription may contain an obvious error that the pharmacist can easily correct and then dispense the medication (e.g. Ampicillin 50 mg for an adult).

When the dose is not indicated, an agreed upon "standard dose" can be used. The pharmacist may use patient assessment information such as weight, age, gender and other relevant parameters to determine the appropriate dose according to clinical guidelines.

If the formulation or dosage form on a prescription needs to be changed, the pharmacist modifies the dosage form, after consultation with the patient or patient's caregiver. The pharmacist must document the change and the reasons for changing the formulation on the original prescription.

#### 4. Refills of Medications During Physician Absence (With Limitations)

During the physician's absence, the patient may require a refill for a chronic medication or extended treatment of a specific medication. This does not apply to short-term treatments, where it was anticipated the condition would resolve itself after a single course of therapy or where the patient regularly sees a physician who reviews their treatment. Or, a physician during his/her absence, may request a pharmacist to refill medications for his/her patients. This applies to chronic disease therapy or any extended therapy where interruption would produce an adverse outcome. Upon the physician's return, the pharmacist provides a list of refills issued during his/her absence. The pharmacist shall also complete a PAR for these situations and include documentation of any situations where there was a refusal to refill a prescription.

#### 5. Medications for Self Care

The pharmacist plays a key role assisting patients to make self-care choices. The pharmacist must assess if the patient requires medical assistance. Self-limiting conditions which fail to respond to one prescription will require the patient to see a physician.

Prescribing is permitted only under established guidelines as set out by the SCP and only when the official product monograph has an approved indication for a prescription drug being considered for a self-care indication. Examples include:

- Schedule F topical corticosteroids for severe insect bites
- Schedule F topical antifungal agents for athlete's foot
- Schedule F antifungal medications for vaginal yeast infections

#### 6. Exempted Codeine Products

Under provincial law, sales of these products can only be captured to appear in the PIP medication profile viewer if they are legally classified as a prescription drug. Therefore, it is increasingly important that pharmacists prescribe Exempted Codeine Products rather than issuing them without a prescription so that sales are recorded in the PIP system to more accurately identify usage patterns. Exempted Codeine Products contain 8 mg or less of codeine per solid dosage form or 20 mg in 30 ml if in the form of a liquid. There must also be a minimum of two (2) other active non-narcotic ingredients in therapeutic proportions. In Saskatchewan, non-prescription quantities are restricted to 50 oral solid dosage units or 100 ml of liquid per occasion. There are no limits on quantities when prescribed.

#### 7. Non-Prescription Drugs (To Obtain Third Party Coverage)

Many insurers require a prescription in order for a non-prescription medication to be covered under their program. Therefore, the pharmacist can write a

prescription if any patient requires a non-prescription medication to augment other prescribed therapies for which the patient may not otherwise purchase the medication. For example, palliative care patients may require a prescription for a laxative before the medication is eligible for coverage by a third party. Third parties include the Saskatchewan Prescription Drug Plan (SPDP), First Nations & Inuit Health, Health Canada, Veteran Affairs Canada, Royal Canadian Mounted Police, Canadian Armed Forces, Workers' Compensation Board, federal penitentiaries, and a variety of insurance carriers.

## 8. Seamless Care - Medication Reconciliation

When a pharmacist identifies that an unintended discrepancy has occurred which could potentially cause harm to the patient, the pharmacist may prescribe a medication to correct the omission and informs the patient's physician. The pharmacist will verify the omission through discussions with the patient, family, the PIP viewer or confirming with professionals who previously provided treatment. The pharmacist is able to prescribe in a case of an unintended discrepancy if:

- After discharge from a hospital it is determined there are medications that should be continued;
- After admission to a facility it is determined the patient should be receiving medication; or,
- There has been no prescription issued or there is no one available to issue a prescription.

## Level II Authority Prescribing

Level II prescribing reflects how collaborative practices can optimize the skills and knowledge of the pharmacist to assist patients who wish to implement lifestyle changes or to achieve specific therapeutic goals. A collaborative environment is a key determinant for the pharmacist to prescribe under Level II. This category recognizes that the pharmacist requires access to clinical information in order to optimize therapy.

Training for Level II Authority prescribing must meet the following criteria:

- Programs which certify pharmacists will require SCP approval. SCP can also approve recognized providers of training and certification (e.g. Canadian Diabetes Association).
- The training for Level II is in addition to Level I orientation and is a prerequisite for Level II prescribing.
- Certification and training focuses on the current standards of practice, evidence based studies and clinical practice guidelines.
- Qualified instructors will certify that the pharmacist meets the requirements to prescribe interdependently.

Level II Authority is divided into Parts A and B. Part A describes when a pharmacist is able to prescribe through credentialing processes (similar to ECP). Part B describes situations where prescribing is performed under a collaborative agreement.

Educational requirements for Part A and Part B are as follows:

- Part A certification will require the pharmacist to participate in accredited educational sessions. This training will include information on collaborative responsibilities, review of ethics and a review of the pharmacology and therapeutics of the agents involved.
- Part B requires proper training. All programs will test competency to ensure that the pharmacist has the knowledge and skills to practice that level of prescribing. Educational requirements will also include the requirements as specified for Part A.
- For both Parts, the pharmacist will be required to submit evidence of proper training.

Specifically:

#### Part A

1. Provision of oral contraception
2. Lifestyle and/or health promotion

#### Part B

1. Collaborative Prescribing Agreements
2. Therapeutic Substitution
3. Altering dosage and /or dosage regimen

#### Level II Authority – Part A

##### 1. Provision of Oral Contraception

After responding to a request for emergency contraception, the pharmacist is able to prescribe up to a two (2) month supply of oral contraception according to accepted practice guidelines. The pharmacist completes the PAR and advises the patient she will have to see her physician for complete assessment to obtain a further supply.

##### 2. Lifestyle and/or Health Promotion

Patients require support when making lifestyle changes. Pharmacists can play an important role in helping patients achieve success. Initially, pharmacists will be able to prescribe medications approved to assist with smoking cessation treatments.

## Level II Authority – Part B

### 1. Collaborative Prescribing Agreements

Once a collaborative prescribing agreement is in place, pharmacists may prescribe medications within the limits specified under such agreements. The physician makes the diagnosis and the pharmacist has authority to prescribe medications, monitor the patient's response to the medication and adjust doses as authorized in the agreement. A pharmacist can order up to a three (3) month supply all the medications covered by the collaborative agreement.

### 2. Therapeutic Substitution

Therapeutic substitution requires that the practitioner is aware of the policies on therapeutic substitution and has endorsed the policy. Therapeutic substitution occurs in consultation with the patient, and takes into consideration many factors including the patient's response to therapy, adverse reactions, allergies and sensitivities and financial needs of the patient.

### 3. Altering Dosage and/or Dosage Regimen

The physician and pharmacist identify which medications require monitoring and adjusting. The physician indicates acceptable guidelines the pharmacist should follow when adjusting doses, including when to refer the patient back to the physician. Prescriptions for the approved list of medications are valid for a period of three (3) months

## Role of the Saskatchewan College of Pharmacists

The Discussion Paper issued by the SCP proposes that the role of the pharmacist is optimized by having the pharmacist prescribe interdependently in a collaborative practice environment. Many stakeholders have provided feedback and an Interdisciplinary Advisory Working Group was formed to allow them and others to submit further input and feedback. SCP believes that enabling legislation establishing Level I Authority and Level II Authority serves to protect the public, and at the same time ensures optimum health outcomes are achieved. The SCP will use the following principles when registering pharmacists to prescribe:

- Practising pharmacists will be able to choose whether they wish to become eligible to prescribe interdependently.
- The SCP, as well as other professional groups, acknowledges that effective communication is critical at all times, especially when working in a collaborative environment. As such, pharmacists will be responsible to communicate information to all health care providers as required.

- The SCP will develop core elements of a Collaborative Prescribing Agreement to ensure consistency and clear understanding of the roles of the pharmacist in the agreement.
- The SCP will define which elements of a collaborative environment needed to be in place in order to meet the needs of the pharmacist (e.g. access to clinical information necessary to monitor therapy). In particular, if pharmacists are to optimize their role, they must have access to information.

The SCP is aware that granting pharmacists with authority to prescribe medications under Level I and Level II Authority will have an impact on the health care system. Collaborative practice environments will allow the pharmacist to be a responsible member of the team, improving patient outcomes, thereby improving the overall health care system. To ensure competency, the SCP will require all pharmacists who wish to prescribe to meet the orientation, education and training requirements.

### **Conclusion**

Authority for pharmacists to prescribe drugs as described herein is consistent with the concept of collaborative practice as an enhanced model for delivering improved patient care. Within this environment, each professional practising to his/her level of skills, training and ability should be the standard. Pharmacists will bring their unique pharmacotherapy knowledge to the team. Working collaboratively, the team will strive to ensure that the patient receives the maximum benefits of drug therapy. Pharmacists optimize their role within the collaborative practice environment by sharing their medication expertise, practising within their competencies, prescribing medications under the regulatory framework described in this document, and recording and communicating their pharmaceutical decisions to the other members of the team.

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#### Core Members

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## **References**

- <sup>1</sup>Enhancing Interdisciplinary Collaboration in Primary Health Care  
[http://www.caslpa.ca/PDF/EICP\\_Fact\\_sheet.pdf](http://www.caslpa.ca/PDF/EICP_Fact_sheet.pdf) (accessed April 17/2008)
- <sup>2</sup>Handbook on clinical practice guidelines <http://mdm.ca/cpgsnew/cpgs/index.asp>
- <sup>3</sup>Enhancing Interdisciplinary Collaboration in Primary Health Care ( [www.eicp.ca](http://www.eicp.ca)) (accessed Jan 8, 2007)
- <sup>4</sup>Health Canada IECPCP <http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index-eng.php>
- <sup>5</sup>Canadian Association of Occupational Therapists (CAOT) 2005 ([www.caot.ca](http://www.caot.ca)) (accessed Jan 9, 2008)
- <sup>6</sup>Canadian Council on Health Services Accreditation (CCHSA)
- <sup>7</sup>Family Practice Management (Feb 2004) Making Evidence-Based Medicine Doable in Everyday Practice Vol 11 No 2 (accessed Jan 13, 2008)
  
- <sup>8</sup>Editorial, British Medical Journal on 13th January 1996 (BMJ 1996; 312: 71-2) (accessed Jan 13, 2008)
- <sup>9</sup>University of North Carolina School of Medicine - The Expert Preceptor Interactive Circular ([www.med.unc.edu/epic/module4/m4to.htm](http://www.med.unc.edu/epic/module4/m4to.htm)) (accessed Jan 9/2008)
- <sup>10</sup>Hepler CD, Strand LM, Opportunities and responsibilities in pharmaceutical care.  
Am J Hosp Pharm 1990; 47:533-43
- <sup>11</sup>Canadian Society of Hospital Pharmacists and Canadian Pharmacists Association. 1998. Proceedings of the Seamless Care Workshop. Ottawa, ON: Canadian Society of Hospital Pharmacists and Canadian Pharmacists Association
- <sup>12</sup>[Self Care Definition //encyclopedia.thefreedictionary.com/self-care](http://encyclopedia.thefreedictionary.com/self-care) (Accessed July 16/08)
- <sup>13</sup>Joint Statement April 2003 (CMA, CNA CPhA) ( [www.pharmacists.ca](http://www.pharmacists.ca)) (accessed Jan 14, 2008)
- <sup>14</sup>American College of Clinical Pharmacists Statement - Pharmacotherapy 1993;3(3):252-256
- <sup>15</sup>Institute for Safe Medications Practices Canada [www.ismp-canada.org](http://www.ismp-canada.org)
- <sup>16</sup>Emmerton, et al "Pharmacists and Prescribing Rights: Review of International Developments"; Journal of Pharmacy and Pharmaceutical Sciences ([www.cspCanada.org](http://www.cspCanada.org)) 8 (2): 217-225, 2005
- <sup>17</sup>The Commission on the Future of Health Care in Canada ([www.hc-sc.gc.ca/english/care/romanow](http://www.hc-sc.gc.ca/english/care/romanow))
- <sup>18</sup>American Academy of Family Physicians  
[www.aafp.org/online/en/home/policy/policies/p/pharmacistspositionpaper.htm](http://www.aafp.org/online/en/home/policy/policies/p/pharmacistspositionpaper.htm)
- <sup>19</sup>Joint Statement on Scope of Practice ([www.cma.ca](http://www.cma.ca)) (accessed Jan 8/2008)
- <sup>20</sup>Saskatchewan Action Plan for Primary Health Care ([www.health.gov.sk.ca/primary-health-care-action-plan](http://www.health.gov.sk.ca/primary-health-care-action-plan)) (accessed Jan 8/2008)
- <sup>21</sup>Pharmacist Prescribing, Glen Pearson, Hospital Pharmacy Practice ov/Dec1998/Vol 6, No5

- <sup>22</sup>The Right Medicine, Strategy for Pharmaceutical Care in Scotland (<http://www.scotland.gov.uk/Publications/2002/02/10633/File-1>) (accessed Jan 8, 2008)
- <sup>23</sup>The Health of Canadians-The Federal Role  
<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repoct02vol6-e.pdf>
- <sup>24</sup>MEDICARE - Commission on Medicare Final Report (AKA Fyke Report)  
<http://www.publications.gov.sk.ca/details.cfm?p=12038&cl=1>
- <sup>25</sup>Pharmacy Coalition on Primary Care May 2003  
(<http://www.napra.ca/pdfs/provinces/sk/PCPC%20Submission-final.pdf>)
- <sup>26</sup>Ottawa, April 25 /CNW Telbec <http://www.physiotherapy.ca/releases/eicp.pdf>
- <sup>27</sup>Health Canada [http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/collabor/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/collabor/index_e.html)
- <sup>28</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) (accessed Jan 14, 2008)
- <sup>29</sup>Pharmacist Prescribing – CPhA Position Statement (Aug 2007)  
([www.pharmacists.ca](http://www.pharmacists.ca))
- <sup>30</sup>Canadian Medical Association [www.cma.ca/index.cfm/ci\\_id/53577/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/53577/la_id/1.htm)
- <sup>31</sup>CPhA [www.pharmacists.ca/content/about\\_cpha/whats\\_happening/cpha\\_in\\_action/emerge\\_contra.cfm](http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/emerge_contra.cfm)
- <sup>32</sup>CMPA Collaborative Care: A medical Liability Perspective (Aug 2006)  
([http://www.cmpa-cpm.ca/cmpapd03/pub\\_index.cfm?FILE=ISSUES\\_MAIN&LANG=E](http://www.cmpa-cpm.ca/cmpapd03/pub_index.cfm?FILE=ISSUES_MAIN&LANG=E))  
(Accessed Jan 8/2008)

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