



**Alberta Health
Services**

Pharmacy Services

**FRAMEWORK FOR IMPLEMENTATION OF
EXPANDED SCOPE OF PRACTICE FOR PHARMACISTS**

A. Background

The Health Professions Act of Alberta has provided opportunities for various health care professionals to use their expertise to streamline delivery of health care services to our patients. If implemented properly, these expansions of practice will improve the efficiencies in delivery of quality of care without compromising the care we provide.

The approval of the new Regulations in 2007 has allowed for the expansion of the pharmacist's scope of practice to include the following practices (some of which are restricted) not previously considered part of a pharmacist's role:

1. to order laboratory tests;
2. to prescribe a Schedule 1 drug or a blood product for the purpose of adapting an existing prescription;
3. to prescribe a Schedule 1 drug or a blood product if it is not reasonably possible for the patient to see another health professional to obtain the prescription, and there is an immediate need for drug therapy;
4. to prescribe a Schedule 1 drug or a blood product;
5. to administer subcutaneous or intramuscular injections;
6. to insert or remove instruments, devices or fingers beyond the anal verge, and beyond the labia majora.

In acute care settings, some, though not all, of these activities will be implemented in the inpatient and ambulatory care settings. In current practice, a pharmacist must consult the physician caring for the patient to get approval for adaptations to patient orders (prescriptions). These adaptations are within the realm of the pharmacist's drug therapy knowledge and expertise. This process slows the completion of the medication order process, and thus delays availability of the appropriate medication to the patient. Creating a system where the health care professional best qualified to make the decision is empowered to do so will ultimately make the system more efficient.

An important concept within the inpatient setting is that while receiving care, each patient has a Most Responsible Practitioner (MRP) which is a physician in most inpatient situations. The phrase refers to the single, designated practitioner who carries the primary responsibility for care of a patient during an episode of illness or care. Ongoing collaboration and consistent communication between the MRP and the rest of the health care team is a key component of AHS inpatient care.

The objective of this document is to illustrate the process of implementation of these full scope of practice activities by pharmacists working within Alberta Health Services (AHS) and will include any restrictions that need consideration given the specialty areas of practice in acute care settings. For detailed information on the new Practice Framework for Pharmacists in Alberta, please refer to: https://pharmacists.ab.ca/Content_Files/Files/HPA_Standards_FINAL.pdf

B. Competency Assurance

All pharmacists registered on the clinical register in Alberta are required to maintain a high standard of competency and commit to lifelong learning through ongoing continuing education. Further, AHS Pharmacy Services has developed clinical expectations documents for acute care, ambulatory care, and for long term care, which outline the expectations of care provided by pharmacists in their various practice settings. To support the standards, AHS Pharmacy Services is currently developing and implementing province-wide clinical orientation and professional development programs to help ensure that all clinical pharmacy staff are prepared to apply their unique practice knowledge in their respective practice settings

C. Full Scope Practices and Quality Assurance Implementation

1. Ordering of Laboratory Tests

Independent ordering of laboratory tests is only permitted by pharmacists with a practitioner identification number (PRAC ID) through Alberta Health and Wellness. If a pharmacist has received a PRAC ID number from Alberta Health authorizing them to order laboratory tests and is in a practice setting where this may be facilitated, the pharmacist must notify their direct supervisor and/or the site pharmacy manager. The Pharmacy Manager (in liaison with the pharmacist) will then notify key programs and stakeholders of this change.

Consistent with the expectations of the Alberta College of Pharmacists (ACP), a pharmacist will order the laboratory test under their own name (PRAC ID) providing that:

- the pharmacist will be able to follow-up directly on the result;
- the pharmacist is ultimately responsible for receiving, evaluating, determining potential courses of action and communicating these actions to other members of the health care team;
- a well-communicated and documented plan is in place for follow-up on test results if the ordering pharmacist is not available to directly receive and take action on the test result (e.g. evenings and weekends); and
- a structure is in place within the ordering pharmacist's practice so that critical test results can be efficiently communicated to the ordering pharmacist or to another member of the health care team as required under laboratory services guidelines.

Pharmacy Services will also impose guidelines based on the pharmacist's practice site as follows:

- a. A clinical pharmacist providing patient care from the dispensary may not be able to fulfill the required criteria for patient assessment. Ordering lab tests from the dispensary should be done in conjunction with other members of the health care team as part of a collaborative practice environment. To maintain clear responsibilities, the person who orders the test is responsible for the review of the results and has the responsibility to respond as required.
- b. A clinical pharmacist providing off-service coverage is able to access more patient information, such as the patient chart, in comparison to the dispensary pharmacist. In some instances, there will be sufficient knowledge of the patient treatment goals to determine if laboratory tests need to be ordered, but not in other cases. When a laboratory test is ordered in this scenario, the clinical pharmacist will document the

assessment, rationale, and plan for this patient in the appropriate section of the patient chart in compliance with the Alberta College of Pharmacists. Guidelines for Pharmacists Ordering Laboratory Tests and Using Laboratory Data. Jan 11, 2010. (e.g. Progress Notes for most inpatient charts)

- c. A clinical pharmacist providing team-based coverage is in an ideal environment to make the required assessments required to order laboratory tests as needed to optimize patient care providing they have completed a thorough patient assessment, have identified an unmet laboratory monitoring need, and have a documented plan for follow-up on results. Additionally, independent ordering of lab tests supports the monitoring and follow-up for medications ordered by pharmacists with additional prescribing authority.

2. Prescription of Schedule 1 drug or blood product for the purposes of adapting a prescription (NB: This does NOT include controlled drugs.)

There are 4 ways in which a new prescription may be adapted:

- i. altering the dosage, formulation or regimen for a Schedule 1 drug that has been prescribed for a patient,
- ii. 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,
- iii. substituting a generic drug for the prescribed drug, or
- iv. renewing a prescription to dispense a Schedule 1 drug or blood product to ensure continuity of care.

Prior to initiation of new restricted activities, pharmacists in AHS have been able to perform therapeutic substitutions, including dosage or formulation changes, as per an approved list of substitutions³. With the regulatory changes and AHS policy in practice, pharmacists are now able to independently make changes in patients' therapies, such as altering a dosage regimen for organ dysfunction. Due to the need to establish an appropriate relationship with the patient to make these changes, AHS Pharmacy Services will impose some guidelines on this practice as outlined below:

- a. A clinical pharmacist providing dispensary coverage in a hospital setting lacks the patient relationship and detailed understanding of their treatment plans to make independent therapeutic changes to a patient's regimen. However, within this practice, upon assessment of new orders a clinical pharmacist in the inpatient dispensary is still able to determine if a regimen requires changes due to impaired organ function based on data available through the electronic health record (Netcare or hospital EMR) Note that the pharmacist in these situations must also ensure the validity of the data before making changes in therapy (e.g. a patient on dialysis – CRRT, IHD, etc. – will not have a reliable SCr value due to the impact of the dialysis) and must also work in collaboration with other healthcare professionals involved with the patient's care.

Additionally, if a patient's medication is going to be discontinued through the automatic stop process in AHS⁴, a pharmacist in this practice is able to determine if the medication should be continued until the care team is able to reassess this

order. The automatic stop order process is a tool to ensure periodic reassessment of therapy. The pharmacist is not to be expected to routinely extend orders; this responsibility rests with the original prescriber.

When adaptations to a prescription are made within this environment, proper communication of this will occur in the patient care record, either electronically or through use of medication order clarification notices (e.g. MOCN) which will be placed in the Patient Care Orders in the chart. These notes will clearly indicate the pharmacist has adapted the prescription (i.e. no co-signature is required), as well as include information that outlines the reason for the adaptation to the original order.

- b. A clinical pharmacist providing off-service coverage has access to more patient information (such as the patient chart and patient) compared to the pharmacist providing dispensary coverage. A pharmacist in this practice is able to make adaptations to *new* prescriptions beyond those outlined for the dispensary pharmacist. Professional discretion in adapting *new* prescriptions must be exercised as the pharmacist is not a regular part of the patient's care team. When such an adaptation occurs, in addition to writing the order, the clinical pharmacist will document the assessment, rationale and plan for this patient in the appropriate section of the patient chart (e.g. Progress Notes for most inpatient charts).
- c. A clinical pharmacist providing team-based coverage will have an established relationship with the patient and the care team. This pharmacist is in an ideal environment to make the needed assessments to adapt *new* prescriptions as needed to optimize patient care. One example of where adaptation in this setting is appropriate is in making changes to a patient's admission order for their blood pressure medication based on a comprehensive medication review that highlights a recent change in their dose missed on the admission orders. In these instances, there is sufficient knowledge of the patient treatment history, current status (including BP) and treatment goals to determine that therapy needs to be adjusted. When such an adaptation occurs, in addition to writing the order, the clinical pharmacist will document the assessment, rationale and plan for this patient in the appropriate section of the patient chart (e.g. Progress Notes for most inpatient charts).

There are specialty care areas within an acute care setting which are considered restricted in terms of any prescriber being authorized to prescribe (i.e. closed units) for the patients receiving care there. Prescribing activities would be restricted only to those pharmacists working collaboratively with the healthcare team in these areas (e.g. critical care). Note this does not include AHS standards which apply throughout the institution (e.g. an approved therapeutic interchange could be authorized by any pharmacist, unless otherwise specified).

The substitution of a brand to a generic product is done through contract tendering at a provincial level. This substitution process generally has no applicability to hospital practice, and therefore there is no need to notify the original prescriber of the change.

3. Prescription of Schedule 1 drug or blood product for emergency access when it is not reasonably possible for the patient to see a physician

Having no reasonable access to a physician in an acute care facility is not anticipated to occur during normal practice. Exceptional situations where this may be utilized would be during a pandemic or disaster situation where access to any other authorized prescriber may not be possible or in an emergency situation (e.g. a patient in cardiac arrest) where specially trained (ACLS certified) pharmacists may perform these tasks.

4. Prescription of Schedule 1 drug or blood product at initial access, or to manage ongoing therapy

Prescribing of a Schedule 1 drug or blood product is only permitted by pharmacists who have met the competencies and been granted additional prescribing authorization by the Alberta College of Pharmacists. This kind of prescribing would only occur by a team-based clinical pharmacist in an institutional or ambulatory care setting where the expansion of the pharmacist's role will facilitate improved patient care.

If a pharmacist has received appropriate authorization from the Alberta College of Pharmacists to perform this activity, and is in a practice setting where this may be facilitated, the pharmacist must notify their direct supervisor and/or the site pharmacy operations manager. The operations manager (in liaison with the pharmacist) will then notify key programs and stakeholders of this change.

AHS Pharmacy Services will also impose guidelines based on the pharmacist's practice site as follows:

- a. A clinical pharmacist working in the inpatient dispensary in most cases would not be in a position to make this level of prescribing decisions for patients as there is no collaborative relationship established with the team or the patient.
- b. A clinical pharmacist providing off-service coverage is able to access more patient information, such as the patient chart, in comparison to the dispensary pharmacist. In some instances, there will be sufficient knowledge of the patient treatment goals to determine if therapy needs to be adjusted, but not in other cases (e.g. aminoglycosides and vancomycin can be adjusted based on drug levels whereas levels of anticonvulsant medications can only be interpreted in context of patient status). When a prescription is written in this scenario, the clinical pharmacist will document the assessment, rationale, and plan for this patient in the appropriate section of the patient chart in compliance with the Alberta College of Pharmacists Standards for Pharmacist Practice (e.g. Progress Notes for most inpatient charts).
- c. A clinical pharmacist providing team-based coverage is in an ideal environment to make the required assessments to prescribe as needed to optimize patient care. When this occurs, in addition to writing the prescription, the clinical pharmacist will document the assessment, rationale and plan for this patient in the appropriate section of the patient chart in compliance with the Alberta College of Pharmacists Standards for Pharmacist Practice (e.g. Progress Notes for most inpatient charts).

5. Administration of subcutaneous or intramuscular injections

Administration of injections is permitted through the Regulations to the Health Professions Act only when the pharmacist has received proper training and authorization to permit this restricted activity. With access in acute care settings to other health care professionals trained in this activity, utilization of this activity in inpatient care is expected to be minimal. A potential role for pharmacists in this activity may be in the ambulatory care setting, home care, long term care, and/or in a pandemic situation where mass vaccinations may warrant the support of pharmacists in this practice. If a pharmacist has received appropriate authorization from the Alberta College of Pharmacists to perform this activity, and is in a practice setting where this may be facilitated, Alberta Health Services Pharmacy Services must be notified by the pharmacist receiving the authorization. The Pharmacy Services operations managers will then notify key programs and stakeholders of this change.

6. Insertion or removal of instruments, devices, or fingers beyond the anal verge or labia majora.

In routine practice in acute care settings, other health care professionals are usually available to fulfill this restricted practice. In a pandemic, disaster or other emergent situation, access to pharmacist-provided services in this area may prove to be of benefit to patient care.

D. Other Considerations:

The regulations to the Health Professions Act of Alberta stipulate other considerations that must be incorporated into practice within AHS. A key stipulation of pharmacist prescribing in the regulations is that the patient must provide informed consent. It has been determined that the consent to treatment provided by patients entering an AHS facility shall be considered implied consent to the accepted professional practices within the institution.

E. Definitions:

Collaborative team* – a team consisting of a variety of health service providers, patients, their families and caregivers, and the community working together for the best interest of the patient

Dispensary pharmacist – indirect, but individualized, clinical pharmacy services provided from the dispensary of the hospital

Key stakeholders – include unit and program managers, program medical directors, physicians and others who may act as the Most Responsible Practitioner for unit or program patients, nursing staff and other members of the health care team to which the pharmacist belongs.

* Adapted from Health Canada Website www.hc-sc.gc.ca/hcs-sss/hhr-rhs/collabor/index-eng.php. Accessed 15/12/2009

Off-service coverage– reactive clinical pharmacist services provided on a limited, problem solving basis (as available) to patients admitted to a service or unit without a team-based pharmacist

Team-based practice – proactive direct patient care is provided to patients admitted to an interdisciplinary team which may include a physician, nurse practitioner and/or other allied health team members

F. References:

1. Alberton D, Gray, M, Druteika D, for Regional Pharmacy Services, Clinical Orientation for Pharmacists, September 2007.
2. Clinical Practice Leader Guideline Committee, Clinical Expectations, Capital Health Regional Pharmacy Services, 2007.
3. Automatic Therapeutic Substitution List, CH Regional Formulary Online, Volume 12(3), Dec 2007. <http://www.intranet2.capitalhealth.ca/pharmacy/formulary/autosubs/autosubcurrent.pdf>
4. Automatic Stop Order Corporate Administrative Directive 2.3.1, Capital Health, last revised May 2004. <http://www.intranet.capitalhealth.ca/policies/s2/2.3.1%20Automatic%20Stop%20Orders.pdf>
5. Alberta College of Pharmacists. Competency Profile for Alberta Pharmacists. September 1, 2005.
6. Alberta College of Pharmacists. RxCel Competence Program: Continuing Professional Development Plan. September 1, 2005.
7. Alberta College of Pharmacists. Guidelines for Pharmacists Ordering Laboratory Tests and Using Laboratory Data. Jan 11, 2010 https://pharmacists.ab.ca/Content_Files/Files/Lab_Guidelines.pdf