4.7 PHARMACIST AUTHORITIES

The College of Pharmacists of BC Professional Practice Policy (PPP) 58 – Medication Management (Adapting a Prescription) became effective April 1, 2009. The intent of this policy is to improve the timeliness, safety and efficiency of meeting patients' drug-related needs by enabling pharmacists to perform select activities independently, within their scope of competence and experience. In all cases, the pharmacist must ensure that:

1. they are practicing within their scope of competence and experience
2. they have adequate information to make appropriate therapeutic decisions
3. the health needs of the patient are being met
4. the effectiveness of drug therapy is maintained or improved
5. the patient is not placed at increased risk
6. the appropriate documentation and communication is completed
7. they continue to manage and monitor the drug regimen, and to ensure there is transfer of care before leaving the service.

Exception: Pharmacists cannot adapt prescriptions for Narcotic or Controlled drugs.

PPP 1. Continuation of a medication to ensure continuity of care

PPP 1A. Authority to continue non-prescription medication taken prior to admission or initiate a non-prescription medication:
Clinical pharmacists may write orders for continuation, initiation or adjustment of non-prescription medications other than ASA/NSAIDs if they are indicated for a symptom/condition other than the patient's admitting diagnosis. Clinical pharmacists may also initiate the pre-printed nicotine replacement therapy (NRT) order form (PPO#638) at any time.

To ensure responsible drug therapy in the best interest of the patient, pharmacists will adopt the following procedure when initiating orders for non-prescription medication(s):

The Pharmacist

1. Identifies:
    - Medical indication for a non-prescription (OTC) medication
    - Too little of the correct OTC medication
    - Too much of the correct OTC medication

2. Reviews patient medication and disease state to rule out contraindication.

3. Consults with the patient explaining the benefits and risk of the OTC medication; patient must be in agreement. The NRT patient teaching sheet(s) are given to and discussed with patient, if indicated.

4. Writes orders for medication or medication modification.

5. Documents in progress notes the change in therapy, and rationale. Documents any follow-up required.

6. Monitors for desired therapeutic outcome and documents in patient's chart.

Eligibility: Unit-based clinical pharmacists who have been in clinical practice at VA for at least 1 year post-residency or PharmD training.

PPP 1B. Authority to continue prescription medication taken prior to admission:
Clinical pharmacists may write orders for continuation of prescription medication taken prior to admission, when confirmed by PharmaNet and verified with the patient or caregiver. The pharmacist must use professional judgment to avoid a situation where prior to admission medications have been purposely avoided due to changes in medical status or suspected adverse effects. The same procedures per non-prescription medication must be followed.

Common situations where this authority could be employed:

- Continuation of inhalers, thyroid medication, glaucoma medications

Eligibility: Unit-based clinical pharmacists who have been in clinical practice at VA for at least 1 year post-residency or PharmD training

PPP 1C. Authority to reorder an in-patient prescription with an automatic stop-date:
Clinical pharmacists may continue drugs that are scheduled to stop due to an automatic stop-order policy. The pharmacist has the authority to:

1. Extend the stop date of any medication that is potentially reaching a discontinuation date based on the VA Automatic Stop Date Policy as long as the pharmacist can be sure that continuation is in the best interest of the patient.

2. Write the order as "Drug Reorder" and sign their name to the order.

3. Document in progress notes the extension of therapy, and rationale. Document any follow-up required.

4. The pharmacists DO NOT assume the responsibility for ensuring that all drug therapy is ordered for the appropriate duration or for reordering medications which the pharmacist views as appropriately ending. Current methods of informing the physician of potential discontinuation dates will be continued.

Eligibility: Unit-based clinical pharmacists at any time point.

PPP 2. Adaptation of ambiguous orders or non-essential orders for non-formulary complementary medicines or vitamins

PPP 2A. Authority to adapt a prescription that is ambiguous:
Pharmacists may use their judgment to adapt a prescription that is ambiguous because of missing or obviously incorrect information.

1. Pharmacists have the authority to modify orders that are:
    - Obviously misstated
    - Clearly indicative of the sustained release formulation when not specified
    - Modify a formulation based on information from PharmaNet (verified with patient)

2. All revised orders require a written clarification/interpretation on the prescriber order form.

Eligibility: All clinical and dispensary pharmacists at any time point.

PPP 2B. Authority to discontinue complementary medicines, and non-formulary vitamins
Pharmacists may discontinue any orders for medications with no legal status in Canada such as herbs or complementary alternative therapies, or non-formulary vitamins that are deemed non-essential during hospital stay. The pharmacist must:

1. Dispensary pharmacist will write a discontinuation order for the specific medication and send to the nursing unit. A copy of this order will be flagged for the clinical pharmacist to follow-up.

2. Clinical pharmacist will consult with the patient to explain discontinuation of therapy.

3. Clinical pharmacist will document in the progress notes the discontinuation of therapy and rationale.

Eligibility: All clinical and dispensary pharmacists at any time point.

PPP 3. Adaptation of unsafe orders

PPP 3A. Modify an unsafe order
Pharmacists may use their judgment to adapt a prescription that has elements that could be unsafe, such an obviously wrong dose or route so that the prescription is corrected as quickly as possible to minimize any risk of administration or delay in provision. An example of such an adaptation is changing from “mg” to “mcg” for a particular medication.

1. A written clarification on the prescriber order form is required.

Eligibility: All clinical and dispensary pharmacists

PPP 3B. Hold interacting drug
Clinical pharmacists may hold one drug if it is involved in a significant drug-drug interaction and the prescriber cannot be contacted (e.g. hold atorvastatin/simvastatin if clarithromycin initiated).

1. The interacting drug that is held is considered non-essential to immediate patient care.

2. The pharmacist must document the interaction in the progress notes, with the action taken.

3. Contact the prescriber as soon as possible.

Eligibility: Unit-based clinical pharmacists who have been in clinical practice at VA for at last 1 year post-residency or PharmD training

PPP 4. Adaptation of dose, regimen or formulation

PPP 4A. Modify dosage of anti-Infective drugs based on renal function
Clinical pharmacists can change the dose and/or frequency of oral or parenteral anti-infective drugs based on renal function to improve the safety and/or effectiveness of a regimen according to the following conditions:

1. The prescribed dose and/or frequency of the anti-infective agent is not appropriate for the patient’s level of renal function.

2. The pharmacist has access to appropriate clinical information to make the regimen change.

3. The pharmacist ensures the modified dose is adequate for the indication.

4. If the patient is being followed by the Infectious Diseases (ID) team, the pharmacist should liaise with the ID pharmacist prior to any dosage adjustments.

5. Recommendations are based on those listed in the VA PDTM, formulary, or Anti-infective Comparison Card.

6. The pharmacist documents this change in the progress notes to indicate the rationale for the change and the follow-up plan.

7. The pharmacist ensures appropriate laboratory tests are ordered for on-going monitoring (i.e. serum creatinine, BUN, drug levels).

Eligibility: Unit-based clinical pharmacists at any time point

PPP 4B. Modify aminoglycoside and vancomycin dosage based on levels
Unit-based clinical pharmacists can write orders to change the dosage for intravenous aminoglycosides and vancomycin based on levels.

1. All patients with aminoglycoside and vancomycin serum drug concentration measurements will be reviewed by a clinical pharmacist from Monday to Friday.

2. When necessary for monitoring or adjusting therapy in an individual patient, the pharmacist will order a serum drug level and/or serum creatinine for aminoglycoside or vancomycin therapy.

3. Dose adjustments for aminoglycoside and vancomycin will be made independently by the pharmacist based on drug level interpretation and other patient considerations, including: diagnosis, goals of therapy, clinical status, pharmacokinetic evaluation, and administration times.

4. The pharmacist documents any dosage changes and level interpretations in the progress notes.

Eligibility: Unit-based clinical pharmacists at any time point

PPP 4C. Modify all medication dosages based on levels
Clinical pharmacists can write orders to change the dosage for any medication based on a drug level as long as the pharmacist is familiar with this medication. The same steps as per aminoglycoside and vancomycin serum level monitoring must be followed.

Eligibility: Unit-based clinical pharmacists who have been in clinical practice at VA for at least 1 year post-residency or PharmD training

PPP 4D. Modify medication dosages based on a target level
Clinical pharmacists can write orders to change the dosage of a medication based on a target level, e.g. INR, blood sugar, blood pressure. The pharmacist will discuss with the attending physician and document in the patient's health record that they will assume responsibility for the designated medication from M-F during working hours. When no further adjustments in drug dosage are required, the pharmacist may return the responsibility of dosing to the patient's physician, and document such transfer in the patient's health record.

Eligibility: Unit-based clinical pharmacists at any time point.

PPP 4E. Pharmacist-managed IV-PO conversion program
Refer to formulary policy 4.6 for IV-PO conversion of antimicrobials, proton pump inhibitors and H2 blockers.

Eligibility: Unit-based clinical pharmacists at any time point.

PPP 4F. Ability to change formulation
Pharmacists may change the formulation of a medication to an equivalent dose per interval as follows:
a) solid to liquid, rectal or vice versa – dispensary or clinical pharmacist
b) nebulized inhalers to MDI, diskus, etc. – clinical pharmacists only
c) IV to PO – antiemetics – clinical pharmacists only

Clinical pharmacist will document in the progress notes the change in therapy and rationale for b) and c)

Eligibility: Dispensary and clinical pharmacist at any time point per above.

PPP 4G. Order serum drug levels and other tests to guide in drug therapy monitoring
Clinical pharmacists may order serum concentrations of all measurable drug levels including (but not limited to) aminoglycosides, carbamazepine, cyclosporine, digoxin, lithium, phenobarbital, phenytoin (with serum albumin), tacrolimus, theophylline, valproic acid, and vancomycin.

Clinical pharmacists may order any test to guide in drug therapy decision making.

Eligibility: Unit-based clinical pharmacists at any time point

PPP Clinical Governance
The appropriate application of all PPPs will be evaluated with each audit of the Pharmacist Clinical services. For those where chart notes are required, copies of each chart note must be given to the resource pharmacist as a quality assurance measure.

Delivery of Care
The pharmacist will attempt to provide the above care to any patient without the need for a specific request from a physician or care team member. However, the provision of this care will be governed by the availability of appropriate staffing levels and in the context of patient priorities.