Standard of Practice

Prescribing Requirements

DRAFT

Initial Approval: **Effective Date:**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

PREAMBLE

Medicine and Pharmacy are two professions that are often jointly involved in the management of the same patient. Unfortunately, the pharmacist and physician often have very little direct contact with each other in this matter, as all contact is usually through the written prescription or by verbal order from the physician. The two individuals may never have met each other and may not totally understand each other's responsibilities. This Standard of Practice attempts to improve this liaison and ensure better access to quality safe prescribing for Manitobans.

1. Application and Definitions

1.1. Prescribe[1] and Prescription[2] includes both prescriptions in the community and what are commonly called "orders" in hospital and residential healthcare institutions. Only the requirements in Part B apply to prescribing for hospital in-patients and residential health care institutions.

1.1.1 Hospitals include healthcare facilities owned and operated by the Government or a Health Authority (including PCH and other Government-run residential care facilities).

1.1.2 Residential healthcare institutions are defined as privately-owned residential care settings.

[1] Prescribe is defined as, "to issue a prescription for a dental appliance, drug, vaccine, vision appliance, or wearable hearing instrument." *RHPA,* s. 3

[2] Prescription is defined as, "in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction of the individual named in the direction." RHPA, s. 3

Part A – Prescribing in the Community

2. Before Prescribing

2.1 Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

2.2 Before prescribing a drug, prescribers **must**:

- 2.2.1 complete an appropriate clinical assessment of the patient;[3]
- 2.2.2 document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information;
- 2.2.3 consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and
- 2.2.4 obtain informed consent.

3. Content of Prescriptions

3.1. Prescribers **must** ensure the following information is included on every written or electronic prescription:

- 3.1.1. the prescriber's printed name, signature[4], practice address, and CPSM registration number;
- 3.1.2. the patient's name and either date of birth or Personal Health Identification Number (PHIN) (for M3P drugs, also include patient's address and date of birth);
- 3.1.3. the name of the drug;
- 3.1.4. the drug strength, quantity, and formulation (tablet, liquid, patch);
- 3.1.5. the dose and directions for use;
- 3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal is required on all prescriptions OR is required on new and off-label prescriptions only OR Is recommended on all prescriptions; (Refer to consultation document)
- 3.1.7. the full date the prescription was issued (day/month/year);
- 3.1.8. the total quantity and interval between part-fills must be specified for:
  - 3.1.8.a. Any medication on the M3P drug list
  - 3.1.8.b. Any medications that are classified federally as a narcotic or a controlled substance. (Refer to the appendix for a complete listing of these medications.);

[3] Limited exceptions are:

- Having reasonable grounds to believe the person who conducted the assessment has the appropriate knowledge, skill, and judgment to do so and the prescriber themselves evaluating the assessment and judging it to be appropriate (e.g., true group practices or call groups, healthcare institutions);
- Prescribing for the sexual partner of a patient with a sexually transmitted infection; or
- Prescribing a prophylaxis as part of a Public Health program, including Naloxone.

[4] Paper prescriptions handed to the patient must be signed in ink by the prescriber. Electronically transmitted prescriptions may be signed electronically. Rubber stamped signatures are not permitted.

3.1.9. method to contact the prescriber (telephone number[5], email address, or facsimile number).

3.2. Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).

3.3. If the prescriber is an associate registrant (Resident, Physician Assistant, Clinical Assistant), the prescription must also include:
- 3.3.1. Their designation (e.g., PA or Cl.A);
- 3.3.2. Treatment goal and/or diagnosis and/or clinical indication; and
- 3.3.3. The name of their supervising physician.

4. Format of Prescriptions including Verbal

4.1. Prescriptions may be handwritten (legibly), electronically generated in accordance with the Practice Direction on Electronic Transmission of Prescriptions, verbally relayed, or in the physician's order sheet in a hospital, PCH, or residential healthcare institution as per Part B of this Standard.

4.2. Verbal prescriptions for all drugs must include all information included in section 3.1 above other than the signature and prescription issue date.

4.3. Verbal prescriptions are permitted for all drugs and substances, subject to section 7 of this Standard and any institutional policies.

5. Sample Medication

5.1. A registrant must:
- 5.1.1. keep sample medication in a secure location;
- 5.1.2. dispose of sample medication in a safe and environmentally acceptable manner;
- 5.1.3. not offer to sell or barter sample medication for any purpose whatsoever; and
- 5.1.4. not have any form of material gain from distributing the sample medication.

5.2. A registrant must ensure if a sample drug is provided to the patient it is provided with clear instructions for its use, including any precautions, and it is not expired.

[5] This can be the hospital, clinic, or institutional phone number. If desired, a prescriber may also include a personal phone number on electronic prescriptions.

6. Direct Patient Contact

6.1 Prescribing medication or counter-signing a prescription without direct patient contact does not meet an acceptable standard of care. Subject to section 2, there is no direct patient contact when the registrant relies upon a mailed, faxed or an electronic medical questionnaire.

6.2 An exception to the requirement for direct patient contact exists for registrants who:

- 6.2.1 are fulfilling responsibility as part of a call group;
- 6.2.2 treat their own patients after normal office hours;
- 6.2.3 are in an academic teaching environment;
- 6.2.4 are providing Naloxone as part of a harm reduction strategy for substance use/substance use disorders;
- 6.2.5 prescribe a prophylaxis as part of a Public Health Program;
- 6.2.6 prescribe for the sexual partner of a patient with a sexually transmitted infection;
- 6.2.7 prescribe anti-retroviral medication within the Provincial HIV program; or
- 6.2.8 prescribe a medication available in Manitoba without requiring a prescription (e.g., an over-the-counter medication such as acetaminophen).

6.3 In order to meet an acceptable standard of practice, the registrant **must** demonstrate that there has been:

- 6.3.1 a documented patient evaluation by the registrant signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
- 6.3.2 sufficient direct dialogue between the registrant and patient regarding treatment options and the risks and benefits of treatment(s);
- 6.3.3 a review of the course and efficacy of treatment to assess therapeutic outcome, as needed; and
- 6.3.4 maintenance of a contemporaneous medical record that is easily available to the registrant, the patient, and the patient's other healthcare professionals.

7. Manitoba Prescribing Practices Program (M3P Drugs)

7.1. Physicians **must** prescribe the drugs listed on the attached M3P schedule in the manner prescribed in the Regulation and this Standard.

7.2. Section 7 of this Standard does not apply to:

- 7.2.1. prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act;
- 7.2.2. prescriptions for drugs administered in a hospital or institutional residential healthcare facility; and
- 7.2.3. the direct administration of a designated drug to a patient by a prescriber.

7.3. All prescription drugs on the attached Schedule must be written on a prescription form as is approved by CPSM. This requirement for a written form is exempt from verbal prescribing under section 7.8.

7.4. The treatment goal, and/or diagnosis, and/or clinical indication(s) must be included for all M3P prescriptions.

7.5. The prescription **must** contain only one drug per prescription form.

7.6. The prescription is only valid for three days after its issuance to the patient and the physician **must** so advise the patient.

7.7. Prescribers **must** prescribe in accordance with the Practice Direction for Prescribing Methadone or Buprenorphine/naloxone.

7.8. Verbal prescribing of M3P drugs is to be **used sparingly, in very limited circumstances when timely fax or electronic transmission of a prescription is not possible and may otherwise lead to a delay in access to urgently needed medication for a patient**. This is not to be used as a routine workaround to the usual M3P process. If verbal prescribing for M3P medications the prescriber **must**:

7.8.1. notify the pharmacist the verbal order is required as timely access to fax or electronic transmission is not possible **and** the medication is urgently required by a Manitoba patient;

7.8.2. clearly communicate the verbal order directly to the pharmacist[6], including all the information on the M3P form required for an M3P prescription;

7.8.3. ask the pharmacist to repeat back all contents of the prescription required in section 3 (Contents of Prescription) to ensure accuracy and patient safety.

7.8.4. fax or electronically transmit the same M3P prescription that was provided via a verbal order to the pharmacist. This must be done as soon as reasonably possible;

7.8.5. indicate the following on the faxed electronic prescription, “This prescription was previously provided as a verbal order”; and

[6] This requirement cannot be sufficiently satisfied by a prescriber leaving a voice message. If a voice message is left by a prescriber, a direct callback number must be included to facilitate the pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a pharmacist speaks directly with the prescriber to verify the order.

Part B - Prescribing in a Hospital, PCH, or Residential Healthcare Institution (Orders)

8. Sections 8 and 9 apply to prescribing of drugs that are administered:

- As per section 1.1

Notwithstanding the above, prescribers in these facilities **must** only do the following:

8.1. Content of prescription orders:

8.1.1. the name of the drug;

8.1.2. the drug strength, quantity, and formulation (tablet, liquid, patch);

8.1.3. the dose and directions for use (for example the exact time of administration, if applicable);

8.1.4. the full date and time the prescription was issued (hour/day/month/year); and

8.1.5. the prescriber's printed name and signature.

9. Before Prescribing in a Hospital, PCH, or Residential Healthcare Institution

9.1. Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

9.2. Before prescribing a drug, prescribers **must:**

9.2.1. document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate);

9.2.2. consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and

9.2.3. use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).

9.3. For verbal prescribing/orders, in addition to the requirements under section 9.1 and 9.2, prescribers **must**:

9.3.1 provide the verbal order to a nurse or pharmacist, including all required content;

9.3.2 ensure if a voice message is left that a direct callback number is included to facilitate the nurse or pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a nurse or pharmacist speaks directly with the prescriber to verify the order;

9.3.3 ensure the nurse or pharmacist documents all requirements in section 8.1, as well as their name and the name of the prescriber; and

9.3.4 sign the order within a reasonable timeframe, to be determined by the institution's operating policy.