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WAC 246-960-050 Definitions
The definitions in WAC 246-945-010 apply throughout this chapter unless the context clearly requires otherwise. In addition to RCW 18.64.011.

WAC 246-955-010 Pharmacist’s Professional Responsibilities
(1) A pharmacist’s primary responsibility is to ensure patients receive safe and appropriate medication therapy.
(2) The pharmacist shall retain the professional and personal responsibility for any delegated act performed by pharmacy interns and pharmacy technicians in their employ and under their supervision.
(3) Performance of an act is within the accepted standard of care that would be provided in a similar setting by a reasonable and prudent credential holder with similar education, training and experience.

WAC 246-955-020 Unauthorized Conduct
(1) In addition to RCW 18.130.180, it is considered unprofessional conduct for any person authorized to practice or assist in the practice of pharmacy to engage in any of the following:
   (a) Destroy unfilled lawful prescription;
   (b) Refuse to return unfilled lawful prescriptions;
   (c) Violate a patient's privacy;
   (d) Discriminate against patients or their agent in a manner prohibited by state or federal laws; and
   (e) Intimidate or harass a patient.

WAC 246-955-030 Delegation of Pharmacist Functions
(1) A pharmacist may delegate to and allow performance of limited functions by a pharmacy assistant.

(2) A pharmacist may delegate to and allow performance by a pharmacy technician only those non-discretionary professional functions performed in pharmacy operations that meet the following criteria:
   a. The function is commensurate with the scope of practice, education, skill, and experience of the pharmacy technician;
   b. All delegated pharmacy functions are performed under a pharmacist’s supervision.

(3) Any function that requires the use of a pharmacist’s professional judgement may be performed by a pharmacy intern based on the education, skill and experience, except supervising other pharmacy personnel.
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WAC 246 – 955 –040 Non Delegable Tasks

(1) A pharmacist shall not delegate the following professional responsibilities:
   (a) Receipt of a verbal prescription other than refill authorization from a prescriber.
   (b) Consultation with the patient regarding the prescription, both prior to and after the prescription filling and/or regarding any information contained in a patient medication record system provided that this shall not prohibit pharmacy ancillary personnel from providing to or receiving from the patient or the patient's health care giver certain information where no professional judgment is required.
   (c) Consultation with the prescriber regarding the patient and the patient's prescription.
   (d) Interpretation of data in a patient medication record system.
   (e) Dispense, as defined in RCW 18.64.011 (11), prescriptions to patient with proper patient information as required by WAC 246-955-045.
   (f) Decision to not dispense lawfully prescribed drugs or devices or to not distribute drugs and devices approved by the FDA for restricted distribution by pharmacies.

(2) Any function that requires the use of a pharmacist's professional judgement may be performed by a pharmacy intern based on the education, skill and experience, except supervising other pharmacy personnel.

WAC 246-955-045 Patient Counseling

The pharmacist shall counsel the patient or patient's agent, or the patient shall be provided with effective communication on how to contact a pharmacist for counseling and information about the medication. This does not apply to medications that are administered by a licensed health professional authorized to administer medications.

WAC 246-955-050 Responsibilities and Limitations – Responsible pharmacy manager

(1) Pharmacies and health care entities must have a designated responsible pharmacy manager by the date of opening and must not allow a vacancy of a designated responsible pharmacy manager to continue for more than thirty 30 sequential days and reported in compliance with WAC 246-960-170 (operational standards).

(2) The responsible pharmacy manager, all pharmacy credentialed personnel, and the pharmacy each have corresponding and individual responsibility for compliance with applicable state and federal laws and these rules.

(3) A person may neither be designated nor function as a responsible pharmacy manager for more than three pharmacies concurrently. This limitation does not apply to health care entities.

Commented [GCO(2): Missing from current WAC, do we want to include:

(d) Extemporaneous compounding of the prescription, however, bulk compounding from a formula and IV admixture products prepared in accordance with chapter 246-871 WAC may be performed by a pharmacy technician when supervised by a pharmacist.

(f) Ultimate responsibility for all aspects of the completed prescription and assumption of the responsibility for the filled prescription, such as: Accuracy of drug, strength, labeling, proper container and other requirements.

(h) Signing of the poison register and the Schedule V controlled substance registry book at the time of sale in accordance with RCW 69.38.030 and WAC 246-887-030 and any other item required by law, rule or regulation to be signed or initialed by a pharmacist.

(i) Professional communications with physicians, dentists, nurses and other health care practitioners.
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licensed under RCW 18.64.450.

WAC 246-955-060 Partial Filling of Prescription Medications

(1) A prescription for non-controlled legend drugs may be partially filled. The total quantity dispensed and delivered in partial fillings must not exceed the total quantity prescribed including refills or as allowed by law RCW 18.64.520.

(2) Controlled substances may be partially filled within the limits of the Comprehensive Addiction Recovery Act, Pub. L. No 114-198, 130 Stat 695.

WAC 246-955-070 Refilling Prescriptions

A prescription drug order may be refilled when permitted by state and federal law and only as specifically authorized by the prescriber. However, a pharmacist may renew a prescription for a non-controlled drug one (1) time in a six (6)-month period when the prescriber is not available for authorization. In such cases, a pharmacist may dispense a refill up to the quantity on the most recent fill or a thirty (30)-day supply, whichever is less.

WAC 246-955-080 Prescriptions Orders: Adaptation.

(1) A pharmacist using professional judgement may change the quantity, dosage, dosage form, or direction of medication dispensed if it meets the intent of the prescriber.

(2) A pharmacist may complete missing information on a prescription if there is sufficient evidence to support the change.

(3) A pharmacist may extend a maintenance drug for the limited quantity necessary to coordinate a patient’s refills in a medication synchronization RCW 48.43.096.

(4) A pharmacist who adapts a prescription in accordance with these rules must document the adaptation in the patient’s record.

WAC 246-955-090 Prescriptions and Chart Orders: Drug Product Substitution.

Drug product substitutions are allowed as follows:

(1) The determination of the drug product to be dispensed on a prescription is a professional responsibility of the pharmacist, and the pharmacist shall not dispense any product that in his/her professional opinion does not meet adequate standards.

(2) Pharmacists may utilize as the basis for their decisions on therapeutically equivalent drug products:
   a. Available drug product information from federal and state agencies, official compendia, and drug manufacturers;
   b. Other scientific or professional resources; or
   c. The FDA "approved drug products" as a commission approved reference for a positive formulary of therapeutically equivalent products within the limitations stipulated in that publication.
   d. A preferred drug substitution list developed in conjunction with pharmacy personnel.

Commented [GCO(3)]: Update with opioid rcw – SB 5380

Commented [GCO(4)]: Does this need to be changed?
WAC 246-955-100 Prescriptions: Transfers.

(1) Upon patient request, a prescription drug order may be transferred within the limits of state and federal law.

(2) Sufficient information needs to be exchanged in the transfer of a prescription to maintain an auditable trail, and all elements of a valid prescription.

(3) Pharmacies electronically sharing a real-time database are not required to transfer prescription drug order information for dispensing.

(4) Prescriptions must be transferred by electronic means or facsimile, except in emergent situations.

WAC 246-955-110 Collaborative Drug Therapy Agreements.

(1) A pharmacist planning to exercise prescriptive authority in his or her practice (see RCW 18.64.011(28)) by initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for his or her practice by a practitioner authorized to prescribe drugs must have on file at his/her place of practice a properly prepared written guideline or protocol indicating approval has been granted by a practitioner authorized to prescribe. A copy of the written guideline or protocol must also be on file with the commission.

(2) For purposes of pharmacist prescriptive authority under RCW 18.64.011(28), a written guideline or protocol is defined as an agreement in which any practitioner authorized to prescribe legend drugs delegates to a pharmacist or group of pharmacists authority to conduct specified prescribing functions. Any modification of the written guideline or protocol shall be treated as a new protocol. It shall include:

(a) A statement identifying the practitioner authorized to prescribe and the pharmacist(s) who are party to the agreement. The practitioner authorized to prescribe must be in active practice, and the authority granted must be within the scope of the practitioner’s current practice.

(b) A time period not to exceed 2 years during which the written guideline or protocol will be in effect.

(c) A statement of the type of prescriptive authority decisions which the pharmacist(s) is (are) authorized to make, which includes:

(i) A statement of the types of diseases, drugs, or drug categories involved, and the type of prescriptive authority activity (e.g., modification or initiation of drug therapy) authorized in each case.

(ii) A general statement of the procedures, decision criteria, or plan the pharmacist(s) is (are) to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved.

(d) A statement of the activities pharmacist(s) is (are) to follow in the course of exercising prescriptive authority, including documentation of decisions made, and a plan for communication or
feedback to the authorizing practitioner concerning specific decisions made. Documentation may occur on the prescription record, patient drug profile, patient medical chart, or in a separate log book.

WAC 246-955-120 Monitoring of drug therapy by pharmacists.

The term “monitoring drug therapy” used in RCW 18.64.011(28) shall mean a review of the drug therapy regimen of patients by a pharmacist for the purpose of evaluating and rendering advice to the prescribing practitioner regarding adjustment of the regimen. Monitoring of drug therapy shall include, but not be limited to:

1. Performing patient assessment; and

2. Ordering, administering, and evaluating the results of laboratory tests.

WAC 246-955-130 Intent and approval of impaired practitioner substance abuse monitoring program.

The commission will approve practitioner recovery, assistance, and monitoring programs, which will participate in the commission’s substance abuse monitoring program under RCW 18.130.175.

WAC 246-955-140 Sexual Misconduct

1. These rules do not prohibit:

   a. Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

   b. Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or

   c. Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

2. A pharmacy health care practitioner must not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action.

3. Practitioner under this section shall be defined as any person credentialed under RCW 18.64.080, or Chapter 18.64A RCW.

4. Sexual misconduct includes, but is not limited to:

   a. Sexual intercourse;
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(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice within the health care practitioner's scope of practice;
(c) Rubbing against a patient or client or key party for sexual gratification;
(d) Kissing;
(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;
(f) Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;
(g) Not providing the patient or client a gown or draping except as may be necessary in emergencies;
(h) Dressing or undressing in the presence of the patient, client or key party;
(i) Removing patient's or client's clothing or gown or draping without consent, except emergent medical necessity or being in a custodial setting;
(j) Encouraging masturbation or other sex act in the presence of the health care provider;
(k) Masturbation or other sex act by the health care provider in the presence of the patient, client or key party;
(l) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;
(m) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;
(n) Soliciting a date with a patient, client or key party;
(o) Discussing the sexual history, preferences or fantasies of the health care provider;
(p) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;
(q) Making statements regarding the patient, client or key party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;
(r) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key party;
(s) Photographing or filming the body or any body part or pose of a patient, client, or key party, other than for legitimate health care purposes; and
(t) Showing a patient, client or key party sexually explicit photographs, other than for legitimate health care purposes.

(5) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

(6) A health care practitioner must not:
   (a) Offer to provide health care services in exchange for sexual favors;
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(b) Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;
(c) Use health care information or access to health care information to meet or attempt to meet the health care practitioner's sexual needs.

(7) A health care practitioner must not engage or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client, or key party if:
   (a) There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care practitioner; or
   (b) There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

(8) When evaluating whether a health care provider engaged or attempted to engage, in sexual misconduct, the commission will consider factors including, but not limited to:
   (a) Documentation of a formal termination and the circumstances of termination of the practitioner-patient relationship;
   (b) Transfer of care to another health care practitioner;
   (c) Duration of the practitioner-patient relationship;
   (d) Amount of time that has passed since the last health care services to the patient or client;
   (e) Communication between the health care practitioner and the patient or client between the last health care services rendered and commencement of the personal relationship;
   (f) Extent to which the patient's or client's personal or private information was shared with the health care practitioner;
   (g) Nature of the patient or client's health condition during and since the professional relationship;
   (h) The patient or client's emotional dependence and vulnerability; and
   (i) Normal revisit cycle for the profession and service.

(9) Patient, client or key party initiation or consent does not excuse or negate the health care practitioner's responsibility.