Consultation Companion Guide

Why are you seeing changes to multiple standards?

The Government of Alberta's legislative changes required CPSA to develop new standards of practice for gender-affirming care and written orders for office supply of opioid agonist therapy. During that work, CPSA also reviewed related standards to ensure the standards suite remains internally consistent, reflects current legislation and practice, and avoids duplication or conflicting expectations

Rows identified as Legislative Alignment highlight amendments made to reflect changes in legislation, regulations, Orders in Council or Ministerial Orders.

This workbook summarizes the significant amendments proposed for consultation. It is intended to complement—not replace—the accompanying marked versions of the standards. Formatting changes, renumbering, and other minor amendments are shown in the marked versions but are not individually described here.

The amendments fall into four categories:

Legislative alignment (Bills 9 and 29)

Changes required to align terminology or obligations with legislation, regulations or Ministerial Orders

Standards harmonization

Changes that clarify which standard owns a particular professional obligation and improve consistency across the standards suite

Legislative alignment/Standards harmonization

Changes prompted by the dual practice legislative framework that harmonize terminology and professional expectations across the standards suite

Modernization

Changes that reflect current professional practice and communication methods without changing the underlying regulatory principles.

cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

CANNABIS FOR MEDICAL PURPOSES - PROPOSED RETIREMENT

CPSA recommends retiring the *Cannabis for Medical Purposes* standard of practice. The standard was developed in a pre-legalization environment and contains detailed, cannabis-specific requirements that no longer fit the current regulatory landscape. Other jurisdictions have reached similar conclusions, and CPSA has observed very little activity or concern requiring a standalone standard.

Retiring the standard would not remove physicians' obligations when authorizing cannabis for medical purposes: regulated members would remain responsible for complying with applicable federal legislation and CPSA *Standards of Practice* relating to clinical judgment, informed consent, continuity of care, conflicts of interest and patient records. Any requirements that remain necessary can be retained through those existing standards or related guidance. This would reduce duplication and support a more current, coherent and principle-based standards framework.

This approach is consistent with the retirement framework, which supports retirement where no unique enforceable expectations would be lost and public protection remains safeguarded elsewhere.

PRIMARY DRIVER	CURRENT PROVISION(S)	AMENDED PROVISION(S)	RATIONALE
Modernization	Entire *Cannabis for Medical Purposes* standard	Retire the standalone standard. Relevant expectations will continue to be addressed through broader standards and applicable resources.	The legal and practice environment has changed since the standard was developed, and CPSA has received very little activity related to it. Maintaining a topic-specific standard is no longer necessary where the applicable expectations can be addressed through existing, broadly applicable standards. Retirement also supports a more consistent standards framework that avoids duplicating general professional obligations.

EXISTING EXPECTATION	DISPOSITION	WHERE IT WILL BE ADDRESSED
Clinical assessment, treatment planning and prescribing decisions	Consolidated	*Safer Prescribing* and *Informed Consent*
Discussion of risks, benefits and alternatives	Consolidated	*Informed Consent*
Documentation of assessment, rationale and follow-up	Consolidated	*Patient Record Content* and other applicable documentation requirements
Continuity, monitoring and transfer of care	Consolidated	*Continuity of Care* and *Transfer of Care*
Cannabis-specific information that is no longer necessary as a standalone requirement	No longer required	General professional obligations and, where appropriate, external educational resources

DISPENSING DRUGS

PRIMARY DRIVER	CURRENT PROVISION(S)	AMENDED PROVISION(S)	RATIONALE
Legislative alignment (Bill 29) / Standards harmonization	Title and scope limited the standard to dispensing Schedule 1 and 2 drugs to a patient for a fee.	Changed the title to *Dispensing Drugs* and broadened the scope to dispensing activities generally. Defined *dispense* as providing a drug to a person pursuant to a prescription.	Clarifies the distinction between patient-specific dispensing and the separate office-supply model created by Bill 29, which permits authorized prescribers to obtain limited quantities of certain Schedule 1 drugs under a written order. The office-supply model is addressed separately in the proposed *Office Supply for OAT* standard.
Modernization	Entire document	Added a purpose and scope section addressing patient safety, clinical appropriateness, drug security, patient choice, documentation and financial interests.	Provides context for the standard and clarifies the principles that apply to all dispensing activities.
Legislative alignment / Standards harmonization	Existing definitions and references to Schedule 1 and 2 drugs, dispensing and compounding.	Added definitions for *compound*, *dispense*, *manufacture*, *medication samples*, *prescription drug list* and *procurement*.	Clarifies the activities regulated by the standard and aligns terminology with the federal and provincial legal framework governing drugs. The definition of *dispense* also supports the distinction between dispensing to a patient under a prescription and office supply under Bill 29's written-orders framework.

Legislative alignment / Standards harmonization	Clause 1: Dispensing permitted when drugs are relevant to the medical consultation or surgical procedure.	Requires regulated members to meet the same dispensing standards as pharmacists and comply with applicable provincial and federal legislation. Also requires members to dispense only to patients they are treating and only when the drugs are relevant and appropriate to the consultation or procedure.	Makes the legal and professional framework explicit and aligns physician dispensing expectations with pharmacist standards. This supports compliance with the amended *Pharmacy and Drug Act* , while recognizing that Bill 29's written-order provisions apply to the separate office-supply activity.
Modernization	Clauses 5–7: Patient counselling, labelling, child-proof containers and expiry dates.	Reorganized and expanded expectations respecting patient identity, the patient's option to use a pharmacy of their choice, expiry dates, patient counselling, packaging and labelling.	Updates existing requirements and aligns physician dispensing expectations with pharmacist standards and patient-centred decision-making.
Modernization	Not addressed separately in the current standard.	Added requirements for medication samples, including documentation of the drug name, dose, directions for use, quantity and lot number.	Addresses medication samples, which were not specifically regulated by the current standard.

Standards harmonization	Clause 2: Fees limited to the cost of the drug and reasonable handling costs. Clauses 3 and 8: No fee for required documentation and transaction records.	Revised the fee provision to permit a dispensing fee that includes reasonable costs associated with maintaining drugs, in accordance with applicable legislation and the Charging for Uninsured Professional Services standard. Prohibited charging a separate fee for maintaining required documentation relating to inventory control or dispensing.	Clarifies the costs that may be included in a dispensing fee and confirms that a separate fee cannot be charged for required documentation. These provisions are not specifically driven by Bill 29.
Modernization	Clauses 8–14: Transaction records, inspection of drugs received, secure and temperature-appropriate storage, federal storage requirements, disposal and prohibition on reuse of returned drugs.	Added or reorganized expectations respecting records of purchases and sales, procurement methods, drug origin and chain of custody, secure storage, loss audits, recalls, patient notification and safe disposal.	Reorganizes existing safety and recordkeeping requirements and adds broader medication-management expectations. These provisions align with pharmacist standards and applicable drug legislation but are not specifically driven by Bill 29.

Standards harmonization	Clause 8: Transaction log identifying the patient, prescriber, date, drug, strength, dosage form and quantity.	Requires a transaction log identifying the patient, prescriber or dispenser, date, drug, strength, dosage form and quantity. The log must be available to CPSA on request, and dispensing must be documented in the patient record.	Improves traceability and aligns dispensing documentation with *Patient Record Content* and broader practice-management expectations.
Standards harmonization	Related standards and companion resources.	Updated the related standards and companion resources to include *Charging for Uninsured Professional Services* , *Conflict of Interest* , *Patient Record Content* , *Responsibility for a Medical Practice* and other related resources.	Improves navigation and demonstrates how dispensing connects with related professional, financial, documentation and practice-management obligations. The proposed *Office Supply for OAT* standard should also be considered for inclusion as a related standard once its title and status are finalized.

GENDER-AFFIRMING CARE - LEGISLATIVE MAPPING

PRIMARY DRIVER	STANDARD SECTION	KEY EXPECTATIONS	RATIONALE
Legislative alignment (Bill 9)	Purpose and scope	Establishes minimum expectations for regulated members who assess or provide care to minors in Alberta for gender dysphoria or gender incongruence. Does not establish requirements for care provided to adults.	Clarifies the population and care covered by the standard. Explicitly directs regulated members to the companion Gender-Affirming Care Advice to the Profession for more detailed guidance on applying relevant legislative requirements and professional obligations.
Legislative alignment (Bill 9)	Definitions	Defines gender dysphoria and gender incongruence.	Clarifies the terminology used in the standard. Definitions associated with the removed detailed legislative provisions are no longer included.
Legislative alignment (Bill 9)	Standard requirements	Requires care to comply with applicable legislative requirements, including sections 1.91 and 1.92 of the Health Professions Act and M.O. 31/2025, CPSA's Standards of Practice and current best available evidence relevant to the patient's presentation.	Following legal review, references the applicable legislative provisions and Ministerial Order rather than repeating their wording. This reduces duplication and the need to amend the standard when legislative wording changes. Detailed guidance remains in the companion Advice to the Profession.

OFFICE SUPPLY FOR OPIOID AGONIST THERAPY - LEGISLATIVE MAPPING

PRIMARY DRIVER	STANDARD SECTION	KEY EXPECTATIONS	RATIONALE
Legislative alignment (Bill 29)	Entire standard	Introduces a new standard governing the use of written orders to obtain and maintain an office supply of OAT medications.	Bill 29 amended the *Pharmacy and Drug Act* to create a written-orders framework allowing an authorized regulated health professional to direct a pharmacy to sell a specified quantity of an authorized Schedule 1 drug to the professional. The legislation also permits the Minister to establish limits, processes and restrictions respecting written orders.
Legislative alignment (Bill 29)/Standards harmonization	Purpose and scope	Limits written orders under this standard to obtaining OAT medications for administration to patients in rural or remote clinical practice locations with limited access to pharmacy services. Excludes medications other than OAT and medications obtained for dispensing outside the regulated member's clinical practice.	Operationalizes the Bill 29 framework within the intended context of improving timely access to OAT in rural and remote communities. The standard establishes a narrower CPSA professional framework than the broader legislative authority created by Bill 29.
Legislative alignment (Bill 29)	Definitions	Defines *office supply*, *regulated health professional* and *written order*.	Aligns the standard with the new terminology in the *Pharmacy and Drug Act*, including the definition of a written order and the regulated health professionals who may issue one.
Legislative alignment (Bill 29)/Standards harmonization	Clause 1: Authorization and permitted use	Permits a regulated member to use a written order only to obtain OAT medications for patient treatment and requires compliance with applicable legislation, regulations, Ministerial Orders and CPSA standards.	Reflects the statutory requirement that drugs obtained through a written order may be used only for patient treatment in accordance with the applicable Ministerial Order. It also connects the new written-order activity to existing CPSA prescribing and OAT expectations.

Standards harmonization	Clause 2: Eligibility and approval	Limits written-order use to regulated members who are registered and in good standing with TPP Alberta, have CPSA OAT initiation approval and have CPSA approval to issue written orders, practise in a rural or remote location with limited pharmacy access and can enter dispensing information into PIN in real time.	Adds CPSA safeguards that are not fully specified in Bill 29. These requirements support appropriate OAT training and oversight, limit use of written orders to the access problem the standard is intended to address and align the process with existing CPSA OAT and dispensing expectations.
Legislative alignment (Bill 29)	Clause 3: Written-order content	Requires written orders to be accurate, legible and include the date, medication name, formulation, quantity, prescriber information, clinic information and a valid signature that allows the dispenser to verify authenticity.	Bill 29 authorizes standards respecting the sale of drugs under written orders and the content of written orders. This clause establishes the minimum information required for pharmacies to process written orders safely and supports traceability.
Legislative alignment (Bill 29)/Standards harmonization	Clause 4: Quantity and frequency	Limits the quantity and frequency of written orders to the parameters established through the CPSA OAT written-order approval process.	Supports the Bill 29 framework, which permits limits on the quantity of drugs that may be obtained through a written order. The clause also provides a mechanism for CPSA to apply additional safeguards where the legislation or Ministerial Orders do not establish sufficient operational detail.
Standards harmonization	Clause 5: Naloxone	Requires a regulated member using a written order to provide a naloxone kit at the patient’s first encounter and as clinically indicated at later encounters.	Adds a patient-safety expectation that is specific to OAT and is not created by the written-orders provisions in Bill 29.

Standards harmonization	Clauses 6–7: Storage, reconciliation and quality assurance	Requires a clear and confidential reconciliation process, regular review of the office supply for quality assurance, secure storage in a fixed metal safe with a time-delay lock and relevant safety signage.	Establishes CPSA requirements for the secure management of medications obtained through written orders and addresses risks associated with maintaining a non-patient-specific office supply.
Standards harmonization	Clauses 8–9: Administration, observation and adverse reactions	Requires documentation of each administration, including patient, medication, dose, formulation, route, quantity, prescriber and administering staff member. Requires an appropriate in-clinic observation period and documentation of adverse reactions.	Distinguishes administration from dispensing and establishes the clinical documentation and monitoring expectations needed when medications are administered from an office supply.
Standards harmonization	Clause 10: PIN reporting	Requires all OAT medications administered from an office supply obtained through a written order to be entered into PIN in real time.	Adds a CPSA system and documentation safeguard that supports medication tracking and aligns the standard with the real-time PIN expectations in the *Dispensing Drugs* standard. This requirement is not expressly set out in Bill 29's written-orders provisions.
Standards harmonization	Related standards and companion resources	Links the standard to *Patient Record Content*, *Prescribing: Administration*, *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harms* and *Safe Prescribing for Opioid Use Disorder*.	Ensures that written-order activity is read together with existing CPSA requirements respecting prescribing, OAT, patient records and medication administration.

SAFER PRESCRIBING

PRIMARY DRIVER	CURRENT PROVISION(S)	AMENDED PROVISION(S)	RATIONALE
Standards harmonization	*Prescribing: Administration*, entire standard; *Prescribing: Drugs Associated with Substance Use Disorders or Substance-Related Harms*, entire standard	Combined both standards into a single *Safer Prescribing* standard. The draft applies general prescribing requirements to all prescribing and adds additional requirements when the medication or prescribing context creates heightened risk.	Creates a clearer hierarchy between general prescribing expectations and additional safeguards for medications associated with misuse, diversion, dependence, overdose or other substance-related harms.
Modernization	Existing preambles and clause-based structure	Added purpose and scope sections describing clinically indicated prescribing, appropriate assessment, scope of practice, expected benefits and risks, available alternatives, independent clinical judgment and documentation.	Modernizes the standard's structure and provides a clearer framework before the detailed requirements.
Standards harmonization	*Prescribing: Administration*, clause 1; *Prescribing: Drugs...*, clauses 1–2	Added general prescribing requirements respecting clinical assessment, pharmacological and non-pharmacological alternatives, medication choice, benefits, risks, side effects, patient understanding and documentation of the prescribing rationale.	Consolidates the existing assessment, treatment-choice, patient-discussion and justification requirements from both standards into one general prescribing framework.
Standards harmonization	*Prescribing: Administration*, clause 1	Consolidated prescription-content requirements into a general provision requiring patient identifiers, date, medication name, strength, form, quantity, directions, refill instructions, prescriber identifiers and valid authorization.	Retains the existing prescription-content requirements while applying them consistently to prescriptions generally rather than only to substances regulated under the *Food and Drugs Act* or *Controlled Drugs and Substances Act*.

Standards harmonization	*Prescribing: Administration*, clauses 2–3 and 5–6	Reorganized requirements respecting prescription transmission, including patient choice of pharmacy, confidentiality, secure transmission methods and limits on verbal prescriptions.	Consolidates the existing transmission requirements into a shorter, more general framework and removes the detailed platform-specific requirements from the standard.
Standards harmonization	*Prescribing: Administration*, clause 7	Reframed the requirements respecting pharmacy choice as an expectation to respect patient choice unless there is a compelling clinical reason to direct the patient elsewhere.	Preserves the underlying patient-choice expectation while using broader, principle-based language.
Standards harmonization	*Prescribing: Drugs...*, clauses 1–2	Incorporated requirements to justify prescribing decisions, consider alternative treatments, discuss benefits and risks and document the rationale in the patient record.	Consolidates the substance-related prescribing requirements with the general prescribing expectations instead of maintaining a separate standard for documentation and treatment discussions.
Standards harmonization	*Prescribing: Drugs...*, clauses 3–4	Retained requirements to review medication history from PIN or Netcare before initiating and renewing prescriptions and at least every three months for long-term treatment. Retained the limited exception where PIN is inaccessible and the minimum amount may be prescribed until medication history is available.	Preserves the existing medication-history safeguards while integrating them into the new section on safer prescribing of high-risk medications. These requirements are not specifically driven by Bill 29.
Modernization	*Prescribing: Drugs...*, footnote and clauses 3–5	Expanded the high-risk medication section to expressly include opioids, gabapentinoids, benzodiazepines, sedatives and stimulants and added requirements respecting overdose, misuse, diversion and substance-use-disorder risk factors, concurrent medications, comorbidities, high-risk combinations and harm-mitigation strategies.	Updates the scope of high-risk prescribing expectations and reflects a broader range of medications and prescribing risks than the current standard addresses expressly.

Standards harmonization	*Prescribing: Drugs...*, clause 5	Reorganized long-term opioid therapy requirements into a dedicated section. Retained measurable goals, lowest effective dose, reassessment, continuation only where benefits outweigh risks and justification for higher-than-guideline doses.	Preserves the core LTOT safeguards while placing them within the broader *Safer Prescribing* framework.
Modernization	*Prescribing: Drugs...*, clause 5	Added an expectation that regulated members engage patients in a clinically appropriate taper plan when discontinuation is indicated, unless immediate cessation is required for safety or is otherwise clinically justified.	Adds explicit guidance respecting tapering and recognizes that discontinuation decisions must be clinically justified and documented.
Modernization	*Prescribing: Drugs...*, clause 5	Broadened the long-term opioid therapy section so that it applies to LTOT generally, while continuing to exclude active cancer, palliative and end-of-life care.	Clarifies the scope of the LTOT requirements and avoids limiting the provision to the terminology used in the current standard.
Standards harmonization	*Prescribing: Administration*, clause 4; related requirements in *Prescribing: Drugs...*	Prescription transmission, TPP, PIN/Netcare, patient-record and pharmacy-related expectations are placed within the broader *Safer Prescribing* framework and connected to related standards and resources.	Improves consistency across prescribing, dispensing, patient-record and OAT requirements.
Standards harmonization	Related standards and companion resources for both current standards	Updated the structure and references to reflect the new *Safer Prescribing* standard and its relationship to *Safe Prescribing for Opioid Use Disorder*, *Dispensing Drugs* and other related standards.	Supports navigation across the consolidated standards suite and clarifies that OUD-specific prescribing remains addressed in a separate, more specialized standard.

SAFER PRESCRIBING FOR OPIOID USE DISORDER

PRIMARY DRIVER	CURRENT PROVISION(S)	AMENDED PROVISION(S)	RATIONALE
Modernization	Existing preamble, glossary and clause-based structure.	Added purpose and scope sections addressing evidence-based care, competence and training, patient safety, harm reduction, continuity of care, dignity, autonomy, diversion, misuse and overdose.	Modernizes the structure and provides a clearer framework for the requirements that follow.
Modernization	Scope limited the standard to OAT using full opioid agonists. Partial opioid agonist and antagonist medications were expressly excluded.	Applies the standard to medications used to treat OUD, including OAT. Defines OAT for this standard as including full opioid agonist medications and no longer expressly excludes partial opioid agonist or antagonist medications.	Broadens the standard to reflect the range of medications used to treat OUD and avoids limiting the standard to full opioid agonist treatment.
Standards harmonization	Current provisions separately addressed initiation, maintenance, approval categories, training, transfer of care and prescribing in inpatient or correctional settings.	Consolidated these expectations under "Prescriber roles and practice settings." Requires appropriate CPSA approval and training where required, compliance with approval conditions, appropriate practice settings, continuity planning, information-sharing during transfers and avoidance of abrupt discontinuation unless clinically necessary.	Combines overlapping requirements and creates a more flexible framework that can apply across OUD treatment settings and models of care.
Standards harmonization	Clause 1: Requirement to prescribe OAT according to evidence-based guidelines and practices.	Requires care to be delivered using current evidence-based guidance and independent clinical judgment, while expressly stating that the standard is not prescriptive about a specific treatment guideline.	Preserves the existing evidence-based expectation while recognizing that treatment modalities and guidance continue to evolve.

Standards harmonization	Clause 2: Initiation requirements, including CPSA-approved training, OAT prescribing approval, appropriate setting, access to laboratory and pharmacy services, access to another approved prescriber, multidisciplinary support and transfer information.	Requires an appropriate clinical assessment, confirmation of OUD, review of medication and prescription history, assessment of co-occurring conditions and safety risks, discussion of treatment options and a treatment plan that includes monitoring and follow-up.	Retains the core clinical safeguards for initiation while reorganizing them around assessment, patient discussion, treatment planning and follow-up.
Standards harmonization	Clause 3: Maintenance requirements, including knowledge of OAT pharmacology, a letter of support and information checklist, CPSA maintenance approval, education, another approved prescriber, collaboration and access to laboratory, pharmacy and prescription database services.	Requires ongoing monitoring of treatment effectiveness and patient safety, regular reassessment, adjustment of therapy as clinically indicated and attention to diversion, misuse and treatment instability.	Consolidates the ongoing-treatment expectations and focuses the enforceable requirements on clinical monitoring, reassessment and patient safety.
Modernization	Clauses 4–6: Special provisions for regulated members without CPSA OAT approval who prescribe in inpatient or correctional settings, including five-day transition prescriptions, daily witnessed dosing, consultation with the community prescriber and transition-of-care requirements.	Replaced the detailed setting-specific provisions with general requirements respecting appropriate CPSA approval, continuity of care, information-sharing and avoiding abrupt discontinuation.	Simplifies the standard and avoids embedding detailed operational processes that may change over time. The continued applicability of any legislative or regulatory requirements for these settings should be confirmed before finalizing this row.
Standards harmonization	Clause 7: Full agonist opioid prescribing for OUD required CPSA approval to initiate or maintain.	Requires appropriate CPSA approval and training where required by legislation, regulation or CPSA policy and requires members to comply with approval conditions.	Preserves the approval and training expectations while using broader language that can accommodate changes to CPSA approval programs.

Modernization	Clause 8: Prescribing full agonist opioids other than methadone or slow-release oral morphine for OUD was permitted only within a government-licensed program, as required by provincial regulation.	Removed the specific reference to narcotic transition services and the list of medications subject to that restriction.	Removes detailed regulatory and program-specific language from the standard. The rationale should be confirmed against the current *Mental Health Services Protection Regulation* before consultation, because the current standard's restriction was expressly linked to that regulation.
Standards harmonization	Existing transfer-of-care requirements, including information checklists, letters of support and collaboration with the receiving prescriber and care team.	Requires reasonable efforts to ensure continuity of treatment during transfer, provision of relevant clinical information and avoidance of abrupt discontinuation.	Aligns the standard with the broader *Continuity of Care* and *Transfer of Care* standards while preserving the underlying patient-safety expectations.
Modernization	Existing requirements were focused primarily on initiation, maintenance and transitions between prescribers.	Added a dedicated "Addressing safety concerns" section requiring reassessment of the treatment plan, attention to underlying concerns and clinically appropriate modification of treatment when diversion, misuse, safety or adherence concerns arise.	Provides a clearer response framework for treatment instability and other safety concerns.
Standards harmonization	Existing documentation requirements were distributed across clauses respecting assessment, treatment planning, prescribing approval, transfer and maintenance.	Requires documentation of assessment and diagnosis, treatment planning and patient discussions, prescribing decisions, monitoring and reassessment.	Consolidates documentation expectations and aligns them with *Patient Record Content* .

Standards harmonization	Related standards included *Prescribing: Administration*, *Prescribing: Drugs Associated with Substance Use Disorder or Substance-Related Harm* and *Transfer of Care*.	Updated the standard's structure and related resources to support its relationship with the consolidated *Safer Prescribing* standard, *Continuity of Care*, *Patient Record Content* and *Transfer of Care*.	Improves navigation across the revised prescribing standards suite and clarifies the relationship between general, high-risk and OUD-specific prescribing expectations.