FNIHB-OR Nursing Policy and Procedure

Section:	**Pharmacy**	Policy Number:	**III-11**
Subject:	**Over the Counter Medication in Public Health Centres**	Issued: Revised:	**2017-05-05** **2017-06-28**

1. POLICY

1.1 Community Health Nurses (CHNs) may provide certain Over-the-counter (OTC) medications to support the delivery of public health programs.

1.2 OTC medications provided are restricted to those outlined in *Appendix A*.

1.3 OTC medications must be provided in a consistent and therapeutically appropriate manner.

1.4 CHNs providing OTC medications must have the knowledge, skill and judgement to dispense these medications. They must be aware of:

a) Client allergies;
b) Medication interactions;
c) Contraindications;
d) Any potential adverse events.

1.5 This policy does not include medications used for vaccine-related anaphylaxis. CHNs are asked to continue to follow current anaphylaxis protocols as outlined in the *First Nations Inuit Health Branch – Ontario Region (FNIHB-OR) Immunization Protocol.*

2. PRINCIPLES

2.1 Nurses are authorized, under the *Registered Health Professionals Act (1991)*, to dispense medications for which an order is not required. This includes all OTC medications.

2.2 Communities in which nurses provide public health services may have limited resources for clients to obtain OTC medications.

2.3 Non-insured Health Benefits (NIHB) covers the cost of OTC medications for eligible clients. However, these must either be prescribed by a physician or Nurse Practitioner, or in some

cases may be initiated by a pharmacist, for coverage. CHNs working in Public Health Centres are able to provide these OTC medications for the specific indications, thus facilitating client access to treatment.

3. DEFINITIONS

Dispensing: For the purpose of this policy, this refers to nurses providing medication according to the *CNO Reference Document; Legislation and Regulation; Registered Health Professionals Act: Scope of Practice, Controlled Acts Model (2017)* and *FNIHB-OR Policy III-03 Dispensing Medications*.

Non-Insured Health Benefits Program: The Non-Insured Health Benefits (NIHB) Program covers prescription and over-the-counter medications that are not covered by other private or provincial/territorial health insurance plans. The objective of the drug benefit program is to provide eligible clients with access to pharmacy services that will contribute to optimal health outcomes in a fair, equitable and cost-effective manner.

Public Health Centre: For the purpose of this policy, Public Health Centre refers to a nursing facility that focuses on public health and does not provide treatment or use the *FNIHB-OR Formulary*. For this reason, Nursing Stations and Health Centres with Treatment are excluded from this definition.

Over the Counter Medication: Over-the-counter (OTC) medications are those that can be purchased by an individual without a prescription. These drugs are intended to relieve the symptoms of minor, self-limiting illnesses.

4. PROCEDURE

4.1 Client Assessment

4.1.1 The nurse should interview the client to determine and assess (as appropriate to the request):

a) The condition or symptoms to be treated concurs with either the client's self-diagnosis, or a physician diagnosis of the situation;
b) The background and history of the client's complaint, disease state and urgency of the situation;
c) The history of current disease states (as they relate to the condition being treated); known client risk factors for adverse drug reactions, drug allergies or sensitivities; known contraindications to non-prescription drug use and dietary restrictions;
d) Other medications or treatments that the client may have previously tried for this condition and subsequent effectiveness or problems;

e) Other medications, non-pharmacologic therapies or treatments the client is currently taking that may interact with suggested therapy;
f) The acuteness and severity of the symptoms which may indicate the need for referral to another health care professional or an emergency treatment centre.
g) Additional assessment as presented in *Appendix B* (*Protocol for the use of Emergency Contraception*) or *Appendix C* (*Protocol for the Use of Pediculicides*).

4.2 Medication Profile

4.2.1 As part of a therapeutic care plan, the nurse will consult, review and update the client medication profile, when indicated.

4.3 Management of Client

4.3.1 As part of the nursing care plan and in collaboration with the client, the nurse will determine the need for referral to another health professional, the appropriateness of drug therapy, or the advisability of non-drug therapies.

4.3.2 The following situations should prompt the referral of a client to another appropriate health care professional or emergency treatment centre for further evaluation:
a) information from the client indicating a potentially severe or worsening condition;
b) client uncertainty about the symptoms or condition;
c) doubt about the accuracy of the client's self-diagnosis; and/or
d) failure of appropriate treatment to remedy a condition within a predetermined period of time
e) in the case of Emergency Contraception (EC), possible sexual assault or violence

4.4 Drug Therapy

4.4.1 As part of the nursing care plan, the nurse should recommend appropriate therapy with an OTC, from the OTC Medication List (*Appendix A*) which meets the client's needs. The nurse should have access to a current drug therapy handbook that contains information on the listed medications, e.g. Compendium of Pharmaceutical Specialties (CPS), RxVigilance;

4.4.2 Discuss with the client the recommended drug therapy, and provide any available written information, as appropriate, on:
- directions for the proper use;
- how to monitor the response to therapy and expected outcomes within defined time periods;
- common adverse effects;

- precautions;
- correct storage;
- when to seek the attention of another health care professional.

4.4.3 Document the assessment findings, planned interventions including recording any OTC medications (drug and quantity) provided to the client, and follow-up care in the client's chart/profile as per *FNIHB-OR Policy II-08: Documentation Standards.*

4.5 Medication Security and Storage

4.5.1 Over-the-counter medications are to be located in an area of the Health Centre where there is no public access and only authorized personnel are allowed entry. These medications must also be stored under proper conditions of sanitation, temperature, light, humidity and ventilation.

5. RELATED POLICIES:

FNIHB-OR Policy III-03: *Medication Dispensing*
FNIHB-OR Policy III-09: *Medication Error Reporting*
FNIHB-OR *Policy II-36 Suspected Presence of Fentanyl or Carfentanil: Personal Protective Equipment and Procedure for Exposure of Health Care Worker.*

6. REFERENCES AND FURTHER READING

British Columbia Centre for Disease Control (2017). Decision Support Tool: Administration of Naloxone. http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/NaloxoneDSTUseforRN.pdf

College of Nurses of Ontario: *Practice Standards: Medication (2015).*

CNO Reference Document: *Legislation and Regulation: Registered Health Professionals Act: Scope of Practice, Controlled Acts Model (2017).*

FNIHB Clinical Practice Guidelines for Nurses in Primary Care: *Skin, (2009).* http://hc-sc.gc.ca/fniah-spnia/services/nurs-infirm/clini/adult/skin-peau-eng.php#tc12

FNIHB Clinical Practice Guidelines for Nurses in Primary Care: *Women's Health and Gynecology* (2009) http://www.hc-sc.gc.ca/fniah-spnia/services/nurs-infirm/clini/adult/women-femmes-fra

Society of Obstetricians and Gynecologists: *Canadian Contraception Consensus* (2015) https://sogc.org/wp-content/uploads/2015/11/gui329Pt1CPG1510.pdf

Non-Insured Health Benefits *3.13 Pharmacist Initiated Treatment Policy* (2017) http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_drug-med/2017-prov-fourn-guide/index-eng.php#a313

Approved by:		**Effective Date:**
	JUN 2 8 2017	**June 28, 2017**
Director of Nursing, Ontario Region FNIHB	**Date:**	
	June 20, 2017	
Regional Executive Officer, Ontario Region, FNIHB	**Date:**	

APPENDIX A: Over the Counter Medication List for Public Health Centres

Analgesic/Antipyretic (for immediate use as appropriate)

acetaminophen infant drops (e.g., Tylenol 80 mg/mL)	24 mL
acetaminophen suspension (e.g., Tylenol 160 mg/5 mL)	100 mL
acetaminophen (325 mg)	12 tab/btl

Emergency Contraception

levonorgestrel 0.75 mg x 2 tablets/package	(Plan B)

Pediculicide

permethrin 1% creme rinse (e.g., Nix Creme Rinse)	60 mL

Scabicide

permethrin 5% dermal cream (e.g., Nix)	30 g

Vitamins

vitamin D infant drops (e.g., D-Vi-Sol)
infant multivitamins
prenatal vitamins
folic acid 0.4 or 1 mg tablets

Miscellaneous Topical Therapies

bacitracin-containing ointment (e.g., Polysporin)
lubricant, water-based (e.g., Muko, K-Y)

Antinauseant

dimenhydrinate 50mg tablets and 15mg/5mL oral liquid

Vaginal Candidiasis

Clotrimazole vaginal cream or suppositories (e.g. Canesten)

Opioid Antidote (for use by CHNs)

Naloxone (injectable or spray formulation)

*This list represents the maximum list of OTC medications that can be stocked at Health Centres. Stock only the OTC products based on particular Health Centre needs

Protocol for the use of Emergency Contraception (EC) (excerpted from FNIHB Clinical Practice Guidelines: Women's Health, 2011).

Emergency Contraception: The use of hormonal medications within 120 hours (5 days) of unprotected or inadequately protected intercourse for the prevention of unintended pregnancy. The product available to be dispensed by CHNs is Levonorgestrel 0.75 mg (LNG 0.75), commonly known as Plan B

Protocols for Emergency Hormonal Contraception

Levonorgestrel (Plan B) tablets contain only the progestin levonorgestrel. The LNG0.75 regimen is the preferred method of hormonal emergency contraception because it is more effective and has a lower incidence of side effects than the alternative.

Mechanism of Action

- Unknown
- Thought to primarily inhibit ovulation
- Might slow the movement of the ovum and sperm in the fallopian tubes
- Might prevent fertilization
- Might interfere with the maturation of the corpus luteum
- Depends on when during the cycle the emergency contraception is taken

Efficacy: LNG0.75 Regimen

- Effective in 95% of cases when used within 24 hours of intercourse
- Effective in 85% of cases when used 25-48 hours after intercourse
- Effective in 58% of cases when used 49-72 hours after intercourse

Indications for Use

- Unprotected intercourse within the preceding 72-120 hours
- Inadequately protected intercourse within the preceding 72-120 hours; this can include, but is not limited to: missing 2 or more consecutive oral contraceptive pills; slipped or broken condom

Contraindications for Use

- Known pregnancy
- Undiagnosed abnormal vaginal bleeding
- Hypersensitivity to any component of the drug(s)
- LNG0.75 may be less effective in women with a body mass index > 25 kg/m2. However, this may still retain some effectiveness regardless of a woman's body weight or body

mass index (SOGC 2015). Women may still be offered this medication but should be encouraged to promptly follow up with their health care provider for discussion of other options.

Breast-feeding and Pregnancy Considerations

- EC will not interrupt a pregnancy that has already implanted in the uterine lining
- There are no known teratogenic effects if progestin-only emergency contraception is taken during pregnancy
- EC can be given to a woman who is breast-feeding

History: *It is necessary to determine last menstrual period, time of most recent unprotected sex, relevant medical conditions, medications and allergies before providing emergency contraception. However, client information about sexual history, past emergency contraception use and sexually transmitted infection (STI) exposure risk is optional and should not prevent the client from receiving the medication.*

- Date and characteristics of last menstrual period to estimate potential time of ovulation and risk of pregnancy
- Time of most recent unprotected or inadequately protected intercourse
- Current use of any other contraceptive methods (e.g., condoms)
- Use of emergency contraception in the past
- Assess STI exposure risk
- Concurrent medical conditions (e.g., diabetes, hypertension, migraines)
- Medications
- Allergies

If the woman was the victim of assault or abuse, maintain the chain of evidence and commence with a complete history, physical examination and plan of care appropriate to the situation.

Laboratory Investigations

A pelvic exam is not necessary before prescribing emergency hormonal contraception. A urine HCG is not required before use of emergency contraception; however, if the client is seen in person, a urine HCG is usually documented. Clients that have had unprotected sex may be at increased risk for STIs. The CHN should offer an STI risk assessment and information, and refer clients to their primary care provider or sexual health clinic for testing and treatment.

Management

Nonpharmacologic Interventions

Client Education

- Advise client about potential side effects (e.g., nausea, vomiting, abdominal pain, fatigue, headache and breast tenderness)
- Advise the client that a normal period should occur within 3 weeks of using emergency contraception
- Client should be counselled to use a backup method of contraception until the next menstrual cycle
- If the client has diabetes, provide education regarding blood glucose monitoring and request an earlier follow-up because the effect of progestin on blood glucose levels is not known

Pharmacologic Interventions: Plan B Regimen

LNG0.75, 2 doses PO; both doses can be taken at the same time

Monitoring and Follow-Up

When emergency contraception is prescribed, the client should be seen at follow-up by a healthcare provider if she has not had a menstrual period within 3 weeks or after the next menstrual period:

- To test for pregnancy
- To assess the need for STI testing
- To discuss more effective contraception
- For education regarding safe sexual practices
- There does not appear to be any adverse risk with repeated use of progestin-only emergency contraception; however, repeated use of emergency contraceptives requires further counselling and education on contraceptive choices

Health Promotion/Disease Prevention

Discuss and provide materials, as appropriate, concerning:

- Safe sex practices
- Future use of emergency contraception
- STI prevention

Current Contraception

- Method chosen and date initiated
- Missed pill guidelines for oral contraceptives
- Advance prescription of emergency contraceptive (women can receive this from primary care provider)

Consultation/Referral

- Consult and refer to physician or Nurse Practitioner as needed (e.g., for medroxyprogesterone [Depo-Provera] prescription)
- Refer to a physician or Nurse Practitioner if the possibility of pregnancy or irregular bleeding has occurred.

Protocol for the Use of Pediculides and Scabicides (excerpted from FNIHB Clinical Practice Guidelines: Skin, 2011).

Pediculosis (Lice Infestation)

Causes

There are 3 types: head lice, body lice and pubic lice.

Risk Factors

- Crowded housing (for example, shared beds), crowded schools
- High pediatric population
- Failure to recognize an infestation
- Faulty application of treatments
- Failure to treat close contacts simultaneously
- Failure to eradicate lice from linens and clothing at time of treatment
- Lack of running water, which can predispose to poor hygiene and secondary skin infection

History

- *Head lice*: involve scalp
- *Body lice*: involve body
- *Pubic lice*: involve pubic area and may be found in hairs of abdomen, thighs, axillae, eyebrows, eyelashes
- Severe itching of involved area
- Excoriation of skin
- Secondary bacterial infection may occur
- Client may find lice or nits on bedclothes, in seams of clothing

Physical Findings

- Small gray-white nits cemented to base of hair shafts
- Lice may be visualized
- Excoriation of skin

Differential Diagnosis

- Dandruff

Complications

- Recurrent infestation
- Skin infection

Goals of Treatment

- Eradicate infestation
- Prevent recurrences
- Prevent spread to close contacts

Nonpharmacologic Interventions

- Remove dead lice and nits with tweezers or nit comb
- Avoid irritation of eyes and mucous membranes
- Remove nits on eyelashes with petroleum jelly (nits become coated, and ova die from suffocation)
- Instruct client to place small amount of petroleum jelly on tips of fingers, then close eyes and rub petroleum jelly into lids and brows; repeat two to four times daily for 10 days
- Examine all family members and close personal contacts, including schoolmates and daycare contacts, and treat if infested
- Also treat anyone who shares a bed with the person who has head lice

Client Education

- Counsel client about proper use of medication and side effects
- Recommend that combs, brushes, hats, coats, bedding and clothing of all household members be washed in warm soapy water
- Items that cannot be washed should be sealed in a plastic bag for 3 weeks
- Recommend avoidance of sharing of combs, brushes, hats, etc.
- Suggest that mattresses (which can harbour lice) be vacuumed thoroughly

Pharmacologic Interventions

Insecticide shampoos for head lice:

- permethrin (Nix) cream rinse
- pyrethrin shampoo (R&C shampoo)

Two bottles are often needed for thick or long hair.

Monitoring and Follow-Up

Follow up in 7 days. Ensure treatment is repeated in 7-10 days after original application.

Referral

Usually not necessary, however clients may need to see a physician or nurse practitioner if there is a secondary infection.

Scabies

Infestation of the skin by a parasitic mite.

Causes

Sarcoptes scabiei

Direct (skin to skin) contact with contaminated articles for up to 48 hours

Risk Factors

- Faulty application of treatment regimens
- Failure to treat close contacts
- Failure to eradicate mites from clothing and bed linen
- Daycare settings
- The Aboriginal population is particularly at risk because of a number of additional factors:
- Crowded housing, shared beds, crowded schools and daycare centres
- High pediatric population
- Reduced access to medical or nursing care
- Lack of running water, which may predispose to poor hygiene and secondary skin infection
- Mites can survive much longer than 36 hours in colder conditions with high relative humidity

History

- Severe itching
- Itching generally worse at night or after a hot shower
- Rash of hands, feet, flexural folds
- Transmitted by intimate or sexual contact with infected person
- Transmitted by clothes
- Symptoms may take 6 weeks to develop after initial contact with mite
- Symptoms are due to hypersensitivity to mite and its products

Physical Findings

- Usually affects interdigital web spaces, flexures of wrists and arms, axillae, belt line, lower folds of buttocks, genitalia, areolae of nipples
- Diffuse red rash
- Primary lesions: papules, vesicles, pustules, burrows

- Secondary lesions: scabs, excoriations, crusts, nodules, secondary infection
- Lesions in various stages present at the same time
- Secondary lesions may predominate
- Burrows (gray or flesh-coloured ridges 5-15 mm long) may be few or many
- Burrows commonly seen on anterior wrist or hand and in interdigital web spaces

Differential Diagnosis

- Pediculosis
- Impetigo
- Eczema
- Contact and irritant dermatitis
- Complications
- Secondary bacterial infection

Goals of Treatment

- Eradicate infestation
- Control secondary infection
- Relieve symptoms
- Appropriate Consultation
- Consult physician if unsure of diagnosis.
- Nonpharmacologic Interventions

Client Education

Counsel client about proper use and side effects of medication.

Control Measures

- Prophylactic therapy essential for all household members, since signs of scabies may not appear for 1-2 months after the infection is acquired
- Treat all household members at the same time to prevent re-infection
- All bed linen (sheets, pillow slips) and clothing worn next to the skin (underwear, T-shirts, socks, jeans) should be laundered in a hot soapy wash and dried with a hot drying cycle, as available
- If hot water is not available, place all bed linen and clothing into plastic bags and store away from family for 5-7 days, as the parasite cannot survive beyond 4 days without skin contact
- Children may return to daycare or school the day after treatment is completed
- Health care workers who have had close contact with clients with scabies may themselves require prophylactic treatment

- Community education, aimed at early recognition and awareness of scabies, is important.
- In widespread scabies epidemics, prophylactic treatment of a whole community may be optimal management

Pharmacologic Interventions

- Scabicide cream or lotion, to be applied to entire body, from chin to toes (emphasize that scabicide must be applied in skin creases, between fingers and toes, between buttocks, under breasts and to external genitalia):
- permethrin 5% dermal cream (Nix) (drug of choice)
- Leave on skin for 8-14 hours. A single application is usually curative but medication may be reapplied after 1 week if symptoms persist.

- The safety of permethrin in pregnant and lactating women has not been established.

- Pruritus may be a problem, particularly at night. If so, the patient should see a physician for further treatment such as a prescription antihistamine.

- Instruct client that itching, nodular skin lesions and dermatitis may persist for weeks or months, even after successful treatment. Mid-potency topical corticosteroids such as betamethasone valerate cream 0.1% may help manage these.

Monitoring and Follow-Up

Follow up in 1 week to assess response to treatment

Advise client to see physician or Nurse Practitioner immediately if signs of secondary infection develop

Referral

Rarely necessary if original diagnosis is correct and adequate eradication treatment is followed by the client and his or her contacts.

Protocol for use of Naloxone for Opioid Overdose (excerpted from FNIHB Clinical Practice Guidelines: General Emergencies Overdose Management, 2011)

This protocol describes the use of naloxone by CHN to treat clients that have presented with suspected opioid overdose.

Naloxone is an opiate antagonist. It partially blocks opioid receptors so an opioid may not bind to them. This can improve respiration for a person that has overdosed on opioids. It can also diminish the pain relief and euphoria that persons experience when using opioids, leading to withdrawal symptoms. Naloxone has a short clinical effect of only 10-30 minutes. (FNIHB *Clinical Practice Guidelines*, 2011).This means that persons that have had clinical improvement with naloxone must be closely monitored for deterioration and medevaced promptly, as the opiate they have taken may have a longer duration of action than naloxone – respiratory depression and other symptoms may recur within 10-30 minutes. Naloxone does not reverse respiratory depression caused by non-opioid drugs (alcohol, benzodiazepines etc.) or conditions (hypoglycaemia, stroke etc.) and may be only partially effective for buprenorphine (suboxone)-induced respiratory depression. If Naloxone is not effective, rescue breathing or lifesaving measures according to the provider's ability should be initiated (Canadian Pharmacists Association, 2016).

CHNs must be aware that many substances and conditions can alter mental status and respiratory rate and confound the diagnosis of opioid overdose. These include but are not limited to:

- Alcohol
- Gamma Hydroxybutyrate (GHB)
- Marijuana
- Sedative-hypnotics (eg. barbiturates, benzodiazepines)
- Clonidine
- Hypoglycemic medications
- Carbon monoxide
- Acute neurological presentations of opportunistic infections
- Sepsis
- Metabolic causes such as hypoglycaemia and electrolyte disturbances, and
- Structural causes such as head trauma and intracranial haemorrhage (BCCDC, 2017)

Dosing

Naloxone may be given intramuscularly (IM) or intranasally in the Public Health Facility, depending on formulation available.

For IM dosing, start with 0.4-2 mg in adults; dose may be repeated if needed, at 2 to 3 min intervals (FNIHB *Clinical Practice Guidelines*, 2011).

For intranasal dosing, follow manufacturer's instructions.

Several bodies of evidence suggest there is no maximum dose of naloxone that can be administered; however, other causes of altered mental status/loss of consciousness should be

considered if there is no clinical response following administration of multiple doses of naloxone. Clinical judgment needs to be weighed against the number of doses of naloxone given, time elapsed since administration of first dose (e.g. if 5-6 doses of naloxone are given, this should equate to a time lapse of approximately 20-30 minutes), client responsiveness (most importantly presence or absence of pulse and/or respirations) and presenting scenario. Regardless, it remains important to stay with the individual until EMS arrives. Continue rescue breathing +/- CPR until the individual is able to breathe on their own (BCCDC, 2017).

Naloxone produces acute withdrawal from opiates and may precipitate shock, seizures, arrhythmias, hypertensive crisis, pulmonary edema and intractable ventricular fibrillation (FNIHB, 2011). The CHN should be aware of this, but these possible adverse reactions should not preclude the use of lifesaving naloxone in an overdose situation where respiration is ineffective and the client is at risk of death.

Clients may have recurrent narcotization when naloxone wears off; therefore, it is imperative that prompt transfer to higher level of care is arranged (FNIHB, 2011).

APPENDIX E: Rationale for the Deletion/Addition of Items to the Current list of Over-the-Counter Drugs

Rationale for the Deletion of Items from the Current List of OTC Drugs

Guaifenesin: As specified in the 2001 OTC policy, guaifenesin has been deleted from this list. This decision is based on a general lack of evidence for the efficacy of OTC medications in the treatment of acute cough. This lack of evidence combined with the December 2008 Health Canada decision that over-the-counter cough and cold medicines should not be used in children under six years of age resulted in the removal of this medication.

Topical medications: Certain topical medications have been removed from the OTC List as they were not in line with supporting public health programs or have limited evidence to support their use.

Anaphylaxis management was removed from this policy since health centres have appropriate anaphylaxis protocols in place that should continue to be followed and updated as necessary. Medications such as diphenhydramine and epinephrine which may be included in these policies should continue to be stocked in health centres. They have been excluded from this policy since they are for use in an urgent or emergent situation. As well, epinephrine supplied in ampoules is not considered an OTC medication by the national drug schedule.

Rationale for the Addition of Items to the Current List of OTC Drugs

Plan B: Unwanted pregnancy has been recognized as a public health concern. In jurisdictions where it is permitted, Plan B can be supplied where the nurse has the knowledge, skill and judgement to assess the patient and provide Plan B when appropriate.

APPENDIX F: Drug Schedules and Provincial Regulations

Drug schedules and provincial regulations were consulted in the preparation of the List. The drug schedules have undergone extensive national review with resultant changes to the pharmacy acts in each province to nationally harmonize the sale of these drugs to the public.

The drug schedules include:

Schedule I* Schedule I drugs require a prescription for sale and are provided to the public by the pharmacist following the diagnosis and professional intervention of a practitioner. There are no Schedule I medications on the OTC Medication List.

*In Quebec, Plan B is a product that requires a prescription for sale.

Schedule II Schedule II drugs do not require a prescription but are available only from the pharmacist and must be retained within an area of the pharmacy to which public access is restricted and there is no opportunity for self-selection. These drugs may be sold only in a pharmacy. The following drug in the OTC Medication List falls into this category:

- permethrin dermal and creme rinse (e.g., Nix)

Schedule III Schedule III drugs are available without a prescription, but sold only from the self-selection area of the pharmacy which is operated under the direct supervision of the pharmacist. They may be subject to increased degrees of control at the local level when problems with self-selection have been identified. These drugs may be sold and dispensed only from a pharmacy. The following drug in the OTC Medication List falls into this category (except in Quebec where Plan B is a prescription medication):

- Plan B (levonorgestrel 0.75 mg) for emergency contraception
- Gravol as an adjunct treatment with Plan B

Unscheduled These medications can be sold in any retail outlet without professional supervision.

Adequate information is available on the packaging for the client to make a choice and the labelling is deemed sufficient to ensure appropriate use of the medication. The following medications on the OTC Medication List are unscheduled:

- acetaminophen
- bacitracin ointment
- folic acid
- infant multivitamins

- lubricant
- prenatal vitamins
- vitamin D

The following has been adapted from ***Pharmacy Standards for First Nations and Inuit Health Branch Health Facilities.*** It deals specifically with unregulated staff providing OTC medications. Existing provincial policies regarding delegation to unregulated staff should be consulted.

4.5.1 Provision of OTCs by Unregulated (Nonprofessional) Staff

Where unregulated staff provides over-the-counter medication to clients, the following conditions must be met:

- sufficient initial and ongoing training must be provided
- scope of drugs provided will be limited to those on the OTC Medication List for Health Centres
- consultation with a professional health care provider must occur
- employer policies and procedures must be in place to guide the unregulated staff; where provincial guidance regarding delegation to unregulated staff exists, it should be consulted