BOULDER COMMUNITY HEALTH
2024-2025 PGY1 RESIDENCY MANUAL

Approved by:

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Director of Pharmacy, BCH

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PGY1 Pharmacy Residency Program Director

The Resident accepts appointment by Boulder Community Health (BCH) as a Resident in the BCH system for the period from June 24, 2024, through June 30, 2025, and agrees to participate in the training program of BCH and its affiliated institutions for the full term of this appointment.

I have read the manual and agree to comply with the guidelines as stated. I understand that failure to comply with these guidelines could result in failure to successfully complete the residency program.

_____ _____
Resident Signature Date
(A signed copy of this page is to be returned to the Residency Program Director)

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PURPOSE

The purpose of this manual is to define the policies and procedures for the PGY1 pharmacy residency program conducted at Boulder Community Health (BCH). The Residency Advisory Committee (RAC) is charged with the responsibility to promulgate and enforce the policies for the residency program.

I. Accreditation - The residency program will be accredited by the American Society of Health-System Pharmacists (ASHP). Payment of accreditation fees and annual fees will be included in the BCH budget. The RAC will be the oversight body to ensure that accreditation is achieved and that the program is in compliance with standards.

II. Program Purpose Statement - A PGY1 pharmacy residency program builds on the Doctor of Pharmacy (PharmD.) education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, to prepare them for board certification, and postgraduate year two (PGY2) pharmacy residency training.

III. Recruitment
   a. Application Process
      i. BCH participates in the ASHP Resident Matching Program. This residency site agrees that no person at this site will solicit, accept, or use any ranking-related information from any residency applicant. The BCH Pharmacy Department abides by the rules for the ASHP Pharmacy Resident Matching Program. Candidate selection guidelines are reviewed annually by the RAC.
      ii. Applicants must be a PharmD graduate of an ACPE-accredited college of pharmacy or one in the process of pursuing accreditation. BCH does not accept applicants who have a Foreign Pharmacy Graduate Equivalency Committee (FPGEC) certificate from the National Association of Boards of Pharmacy (NABP). Application Requirements - In order to apply for the Boulder Community Health ASHP-candidate PGY1 Residency, the following materials must be submitted:
         1. Eligibility for licensure in Colorado

2. Participation in PhORCAS match portal
3. Letter of intent
4. Curriculum vitae
5. Supplementary essay
6. Official college of pharmacy transcript
7. Three letters of reference

iii. The RAC uses a standardized evaluation form to evaluate and document each applicant's ability to meet the program's educational goals and objectives. All applications will be reviewed by a minimum of two reviewers. Final rankings are based on:
1. Academic Performance
2. Work experience
3. Letters of recommendation
4. Writing samples
5. Leadership Professional activities and experiences
6. Presentations & publications

iv. The RAC reviews final applicant rankings prior to sending invitations to interview. Applicant scores are reviewed for consistency among RAC members. Discrepancies in individual criteria scores are discussed among the group, the candidate's application is reviewed, and a final score is determined by consensus of the group. Invitations to interview are sent based on applicants' final rankings.

b. Interview Process
i. An interview is required. The residency manual and professional policies will be distributed upon invitation to interview.
ii. Based on the application rankings, the RAC will invite a designated number of applicants for an interview. All other applicants will be contacted and informed that there is not an interview slot available. These applicants may be contacted in the future if interview slots do become available.
iii. Selected candidates will be interviewed and evaluated by standardized evaluation forms during the interview process.
iv. The RAC and all other personnel involved in interviewing the candidates will meet for a final ranking session. BCH staff members, clinical pharmacy specialists, and Pharmacy Leadership are involved in the interview process. Evaluation scores and verbal feedback will be taken into consideration when ranking applicants.
v. All applicants that match with the program will be sent a letter of acceptance that must be signed and returned by the resident prior to starting the program.
vi. Applicants who match are also required to complete an on-line application through BCH's Human Resources Department. Employment is contingent upon successful completion of Human Resources screening including a pre-employment drug screen.
vii. Resident recruitment, screening, and selection will abide by relevant BCH employment policies as it relates to equal opportunity as well as citizenship requirements.

c. Match Phase II/Scramble
i. The following procedure will be followed if required to participate in Phase II of the Residency Match or Scramble.

1. Candidates will be screened for minimum acceptance criteria per the "Requirements" section above.
2. Candidates will be evaluated using the standardized application review form.
3. Candidates will be ranked for interviews based on their application scores per the method described above.
4. Candidates will conduct an initial telephone interview with the RPD.
5. Candidates will be invited for an interview based on performance during their telephone interview.
6. Interviews will be conducted as described above.
7. Candidates will be ranked in order of preference as described above.

IV. Preceptor Responsibilities

a. Develop and maintain a working relationship with the resident to facilitate open communication and feedback.
b. Demonstrate an understanding of the layered learning model and incorporate the principles of that teaching style into the resident's learning experience.
c. On the first day of rotation, review the resident's learning style and share own teaching style. Provide goals and objectives for the rotation and ask that the resident develop 1-2 personal goals for the learning experience.
d. Review the resident's daily work and plan learning activities based on performance.
e. Complete and share written and verbal feedback with the resident on a regular basis, including progress towards meeting required and elective goals and objectives. Summative evaluations are mandatory.
f. Provide resident with clinical supervision and guidance as appropriate.
g. Attend pharmacotherapy sessions, journal clubs, or resident presentations throughout the residency year.
h. Attend Residency Advisory Committee (RAC) meetings throughout the year.
    i. Residency Advisory Committee:
        1. Meets every other week
        2. Includes the RPD, residency preceptors, and ad-hoc members per discretion of the RPD
        3. Reviews current resident progress
        4. Reviews residency program administration
        5. Reviews preceptor roles and responsibilities
i. Wellness and burnout prevention
    i. Preceptors will have knowledge of burnout syndrome, including the risks and mitigation strategies, in order to help identify and provide resources for at-risk residents.
    ii. Preceptors will support residents' wellbeing through encouraging wellness activities and incorporating resident wellbeing into regular assessments.
j. Notify the RPD of any significant performance concerns as soon as possible.
k. Comply with ASHP Accreditation Standards.

V. Resident Responsibilities

a. All residents must have an active pharmacist intern license prior to beginning the residency program. This license may be issued from any state in the United States. This license must remain active and in good standing throughout the program until obtaining pharmacist licensure. Failure to obtain a pharmacist intern license or limitations that prohibit the resident from completing program objectives on such license will result in dismissal of the resident from the residency program.

b. All residents must have a pharmacist license in good standing in any state in the United States prior to or within 120 days of the program start date. If the resident is not licensed within 120 days, the resident will be dismissed from the program. The resident may alternatively be dismissed from the program if the license has limitations which would prohibit the resident from completing program objectives. The resident may re-apply for the program the following year.
    i. Residents are encouraged to become licensed in the State of Colorado however, this is not required.
c. The residency program will be the resident's full-time and primary work commitment for the 12 months of PGY1 program.
d. The resident must achieve 80% of the program's required goals and objectives by the end of the residency year with no objectives evaluated as "Needs Improvement". All objectives under R1 must be achieved.
e. If the resident receives a "Needs Improvement" evaluation on any goal on the Summative Evaluation, the rotation will **not** be considered successfully completed. The following actions must occur:
    i. The preceptor will document the specific activities/assignments that must be completed in order for the resident to successfully complete the rotation. This is to be done simultaneously with the completion of the Summative Evaluation.
    ii. The resident will acknowledge and sign the above documentation. The assignment(s) must be completed within 15 days of the conclusion of the evaluation process or as decided appropriate per the RPD.
    iii. If the resident does not agree to the preceptor's assignment(s), then the issue will be brought to the RAC for a majority vote. The decision of this committee will be final.
f. All elements outlined on the tracking form must be successfully completed as assigned.
g. Major requirements include timely completion of the following:
    i. Residency Share Point folder maintained with the following required elements:
        1. Outlook monthly calendar of activities
        2. Personal goals and objectives
        3. Projects and presentations for each rotation
        4. All written feedback received on assignments and presentations
        5. Self-evaluations (when assigned)
    ii. Monthly duty hours assessments
    iii. Major project (completed and presented) - Residents will be given examples of projects that are available. The resident is encouraged to choose a topic which, besides being an area of interest to the resident, will also contribute to the advancement of pharmacy practice at BCH and affiliated clinics. All research projects will be in compliance with any applicable BCH, IRB, and HIPAA regulations. PGY1 residency projects are typically presented at a regional residency conference and are strongly encouraged to be submitted for publication in a peer-reviewed journal. Also, the required research project cannot be used to satisfy the requirement for performance of a Medication Use Evaluation. Residents are also required to participate in the training program, A Structured Program to Guide Residents' Experience in Research

(ASPIRE), which is conducted by BCH. A formal manuscript is encouraged. A final presentation to be given at BCH is required.

iv. Medication Use Evaluation (completed and presented) - Residents will complete two Medication Use Evaluation (MUE). Details of this project will be covered in meetings with the MUE Coordinator. Residents must work with the RPD and the BCH MUE Coordinator when designing and conducting their MUE.

v. Presentation at P&T (completed and presented) – Residents will prepare for and present one presentation at P&T. This may be a drug monograph, MUE, etc.

vi. Presentation at MUST (completed and presented) – Residents will prepare for and present one presentation at MUST. This may be a medication use policy update, medication distribution workflow change, education material for RN rounding, etc.

vii. Lead 1 topic discussion with APPE/aIPPE pharmacy students (completed and presented) – Residents will select, prepare for, and lead a topic discussion, relevant to the current clinical rotation, for APPE/aIPPE students.

viii. Residents will complete BLS, ACLS and PALS certification.

ix. Regional Pharmacy Presentation (completed and presented)

x. Attendance to and participation in the following meetings and events:
    a. Regional Pharmacy Presentation
    b. Residency Showcase
    c. Regional Residency Conference

xi. Participation in and completion of a teaching certificate program through the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences is optional

xii. Others as specified on the tracking form and as approved by the RPD or the RAC

xiii. Residents may be asked at the preceptor's discretion to present projects (MUE, research project, etc.) to various committees for educational purposes.

xiv. The Residents must return all property of BCH or any hospital or healthcare facility participating site at the time of the expiration or in the event of termination of the agreement, including without limitation, identification card, pager, books, equipment, and parking card, and to complete all available records and settle all professional and financial obligations before academic and professional credit will be verified and to the extent the Resident does not do so, the Resident authorizes a deduction from their final stipend pay check to cover the cost of such items.

xv. Wellness and burnout prevention
    1. Residents will participate in a minimum of one wellness activity per month. Time spent in these activities will be excused from rotations.
        a. Opportunities include but are not limited to: Sound bath, guided meditations, EAP visits, meeting with mentor, meeting with chaplain services, etc.

VI. Evaluation and Assessment

a. ASHP defines "residency" as a structured, postgraduate program that achieves a predetermined set of outcomes. The residency program is individualized to each resident and practice site. The residency program builds upon and compliments the practice experience and education obtained through the academic and work

experiences the resident brings to the program. The residency program concentrates on developing each resident's ability to conceptualize, integrate, and transform accumulated experiences and knowledge into improved drug therapy in cooperation with other members of the health care team.

b. All required ASHP goals and objectives and program-selected elective goals / objectives will be evaluated and must be achieved by the end of the residency year. The resident may refer to www.ASHP.org for a comprehensive list of goals and objectives.

c. Residents will be evaluated per the following scale:

Rating	Definition
Needs Improvement (NI)	• Deficient in knowledge/skills in this area • Often requires assistance to complete the objective • Unable to ask appropriate questions to supplement learning
Satisfactory Progress (SP)	• Adequate knowledge/skills in this area • Sometimes requires assistance to complete the objective • Able to ask appropriate questions to supplement learning • Requires skill development over more than one rotation
Achieved (ACH)	• Fully accomplished the ability to perform the objective • Rarely requires assistance to complete the objective; minimum supervision required • No further developmental work needed
Achieved for Residency (ACHR)*	• Resident consistently performs objective at Achieved level, as defined above, for the residency.

d. The Residency Program Director (RPD) will track progress informally with each resident at the monthly meeting using the tracking form. The RPD will formally assess progress quarterly during the quarterly evaluation process.

e. Prior to beginning the residency, each resident will complete self-assessment tools in order to help determine personal goals and areas of focus for the residency. The RPD will work with the resident over the year to develop and update a customized residency training plan.

f. On the first day of each rotation, the resident shall meet with the preceptor to discuss the goals and objectives of the rotation. If there is adequate evidence that the resident has previous competence in an objective, the preceptor may choose to challenge the resident on the objective and thereby document performance/comprehension. The objectives will be fundamentally the same for each resident, although the relative emphasis on specific areas/topics may vary according to the individual resident's needs. The preceptor and resident must complete the evaluations within seven days following the end of the rotation.

g. Each learning experience will require formal:
    i. Summative evaluation (completed by preceptor) - These evaluations must include information such as summary of activities and suggestions for improving the rotation. All reports must be reviewed with the resident, by the rotation preceptor and signed by the program director. If deficiencies are noted, appropriate remedial action will be taken.
    ii. Summative self-evaluation (completed by resident) – When required, resident must complete and submit the self-evaluation prior to meeting with the preceptor to review the summative evaluation.
    iii. Learning experience evaluation (completed by resident)

iv. Preceptor evaluation (completed by resident)
v. Longitudinal rotations will have quarterly resident assessments and self-assessment.
vi. Residents will receive feedback periodically during each rotation, with the purpose of facilitating completion of residency goals and objectives however, this is informal in nature in comparison to summative evaluations.

e. PharmAcademic will be used for formal evaluation process.
f. Quarterly evaluations will be conducted with the RPD.
g. Program evaluation will be conducted mid-year and end-of-year with the current residents, RPD, and RAC.
h. Upon completion of the residency, the resident must complete a final evaluation. This should include progress made in achieving the goals and objectives of residency, their personal goals, and suggestions for improving the residency program.
i. On successful completion of the program, the resident will receive a certificate of residency from Boulder Community Health.

VII. Rotations

a. Changes in the rotation schedule for each resident will be coordinated by the residency program coordinator. Normal daily working hours of residents are determined by the RPD, rotation preceptor, and specific needs of the rotation site. Residents are expected to be present at BCH or other assigned rotation sites during all normal working hours as determined above.
b. Required rotations include:
    i. Longitudinal Learning Experiences (1 year)
        1. Staffing: Direct patient care experience
            a. Residents will staff a weekday once every other week, a weekend once every three weeks, and one major summer and winter holiday
        2. Project: Administrative rotation and/or Direct patient care experience
            a. Occurs per administrative time (below)
            b. 1 week is allotted to the Longitudinal Project during Dec-Jan. Residents are expected to complete activities related to data collection, drafting final presentations, conducting follow-up, etc during this time.
            c. Residents are also required to present their longitudinal project at a conference. Presentation days are allotted for ASHP Midyear (Dec) and one regional conference (May-June)
        3. Pharmacy Practice Management: Administrative rotation
            a. Occurs per administrative time (below)
            b. 1 week is allotted to Pharmacy Practice Management during Dec-Jan. Residents will be expected to complete the following tasks during this time:
                i. Attend meetings such as MUST, P&T, Medication Events, GPO meetings, etc to meet objectives for the rotation.
                ii. Review no fewer than 10 applications for the residency program.
                iii. Complete quarterly evaluations.
                iv. Select projects to fulfill deliverable requirements.

c. Residents are also required to participate in residency recruitment and interviews as a part of this rotation including; 1 day allotted to the ASHP Midyear booth (Dec) and 3 days in Feb for interviews

4. Medication Safety/Drug Information: Administrative rotation
    a. Occurs per administrative time (below)
    b. 1 week is allotted to Medication Safety/Drug Information during Dec-Jan

ii. Required Core Learning Experiences
1. Orientation/Hospital Practice: Direct patient care (5 weeks)
2. Advanced Independent Practice: Direct patient care experience (3 weeks)
3. Residents will complete 5/7 of the following experiences based on their entering interest survey and scheduling availability:
    a. Emergency Medicine: Direct patient care experience (6 weeks)
    b. Internal Medicine: Direct patient care experience (6 weeks)
    c. Critical Care: Direct patient care experience (6 weeks)
    d. Oncology/Orthopedics: Direct patient care experience (6 weeks)
    e. Cardiology: Direct patient care experience (6 weeks)
    f. Informatics: Administrative rotation (6 weeks)
    g. Pharmacy Administration: Administrative rotation (6 weeks)

c. Elective learning experiences (choose 2):
i. Infectious Disease/Antimicrobial Stewardship: Direct patient care experience (5 weeks)
ii. Transitional Care/Ambulatory Care: Direct patient care experience (5 weeks)
iii. Behavioral Health: Direct patient care experience (5 weeks)
iv. Advanced Emergency Medicine: Direct patient care experience (5 weeks)
v. Advanced Oncology: Direct patient care experience (5 weeks)
vi. Others under development

VIII. Staffing Hours

a. Residents are required to provide a determined number of service hours to the hospital to be completed by staffing a combination of operational and clinical shifts. This commitment cannot be satisfied before the end of the residency year by working additional shifts early in the year. Residents will work one weekend every 3 weeks. Additionally, they will work one weekday shift every other week. Residents are required to work one summer and one winter holiday. PGY1 residents will be scheduled in a variety of roles in order to gain experience in a wide range of service areas. Selection of staffing areas and scheduling of shifts will be done in a manner that balances the educational requirements of the residents with the operational needs of the Department of Pharmacy.

b. It is up to the resident to be aware of their staffing hours at all times. The RPD will routinely review the pharmacist schedule prior to publication. The RPD will review each resident's monthly duty hours assessment completed in PharmAcademic.

c. All residents are subject to duty hours regulations as approved by ASHP and which are part of the ASHP accreditation standards for pharmacy residencies. These requirements can be found on the ASHP website at https://www.ashp.org/-/media/assets/professional-development/residencies/docs/duty-hour-requirements.pdf

d. Residents may not work additional hours at BCH for pay in addition to their service obligations as listed previously. Work outside of BCH, or "moonlighting," is not allowed during the residency year.
e. Once a resident has been scheduled to cover a specific patient care area, the resident is responsible for that shift and must arrange coverage if unable to work. All residents must abide by schedule notification deadlines and personnel policies and procedures established by the BCH Department of Pharmacy.
f. Residents may trade assigned shifts under the following conditions:
    i. Duty hour agreement is not violated
    ii. The preceptor for the residents' current rotation is notified and approves of the trade
    iii. The residency program director is notified and approves of the trade

IX. Administrative Time – It is expected that residents will be given time to work on administrative projects during clinical rotations per the rotation preceptor's schedule.

X. Teaching
a. Residents are expected to provide education to the pharmacy staff and other healthcare providers as assigned by individual preceptors.
b. The resident may present lectures or other teaching exercises to PharmD students. Residents may be required to assist in the precepting of PharmD students on clerkship. The resident may attend other seminars as his/her schedule permits.

XI. Paid Time Off (PTO) and Time Away
a. Time Away
    i. PTO, conferences and leave all count towards time away from the program.
    ii. A resident spending more than 37 training days away from the program may request:
        1. An extension of the program not to exceed 90 days
        2. To complete the program year without an extension; this would result in not receiving a graduation certificate
b. Time off for holidays, vacations, meetings, interviews, and sick time is given to each resident in a vacation "bank" called PTO. The resident will begin each year with 7 PTO days. Additional details are explained in the hospital policy "Paid Time Off." No additional time off will be granted without the approval of the RAC. Only emergency situations will be considered.
c. PTO requests need to be approved by the RPD and rotation preceptor.
d. Residents may take no more than 5 training days off in one learning experience without prior approval from the RPD and preceptor.
e. PTO will not be used for mandatory attendance days at conferences.
f. PTO will be used for non-mandatory days at the ASHP Midyear Clinical Meeting. Residents are required to attend the residency showcase and poster sessions.
g. Residents will staff one summer and one winter holiday. Residents will be given the remaining major holidays off without using PTO.
h. Any remaining PTO at the end of the residency year will not be paid out.
i. Residents dismissed from the program will receive pro-rated compensation for unused PTO.

XII. Orientation - All residents practicing at BCH will be required to attend BCH orientation and to train in the pharmacy department. This is to ensure that they will be knowledgeable about all aspects of pharmacy services and systems. Standard training normally required to complete any staffing duties for residents may be customized

and/or abbreviated in the event that a specific resident enters the program with significant past experience with pharmacy services and systems at BCH.

XIII. Probation, Remediation, Suspension and Termination

a. Evaluation of resident performance should be an ongoing and fluid process for preceptors, the RPD, and residents. As such, it is expected that most deficiencies in resident performance can be identified and addressed within the normal construct of the residency program. However, there may be instances whereby specific deficiencies in performance or conduct may need to be addressed through a formal period of probation and planned remediation. General guidelines for this process include the following:
    i. A period of probation with specific guidelines for addressing deficiencies in performance can be implemented at the discretion of the RPD if he/she feels that is the best course of action to achieve the programs stated goals and objectives.
    ii. The resident will be notified of their probationary status verbally and in the form of a written performance improvement plan outlining deficiencies from the RPD or designee.
    iii. The specific expectations on how the resident will address the identified performance deficiencies will documented in a performance improvement plan agreed upon and shared with the resident, RPD or designee, and preceptors at the discretion of the RPD.
    iv. The period and terms of probation will be at the discretion of the RPD or designee. However, if the implementation of a probationary period may impact the expected duration of the training program (i.e. extend the program beyond the standard 12 months), consultation with the Director of Pharmacy as well as pertinent Human Resources personnel must take place prior to implementation.
    v. The RPD will assess resident progress at the end of the probationary period and determine whether progress is satisfactory for the resident to move back into regular status in the program. If progress is not satisfactory, then the resident may be continued on probation, the graduation certificate may be withheld, or the resident may be dismissed.

b. The decision to dismiss a resident will first be submitted to the RAC by the RPD. If dismissal is approved by the RAC, the decision will then be recommended to the Director of Pharmacy and the BCH Human Resources Office. If the Director of Pharmacy concurs with the recommendation, the resident will be dismissed. Examples of situations/causes of termination include: failure to meet the program objectives as outlined in the residency manual, failure to abide by the policies and procedures of BCH or the residency manual, breach of confidentiality, or violation of any of the rules and regulations of the Colorado State Board of Pharmacy.

c. The following stepwise process shall be used by a resident to address any issues or decisions regarding performance or actions taken within the construct of the training program including probation and dismissal.
    i. First, discuss the issue with the preceptor of the specific rotation. Any attempts to resolve issues concerning specific rotations should first be addressed with the preceptor and issues worked out between the resident and preceptor to the best of their abilities.
    ii. Second, if unable to resolve the issue directly with the preceptor, contact the RPD to discuss the complaint.

iii. Third, if unable to resolve at the second level, then the resident would appeal to the RAC.
iv. Lastly, if unable to resolve, the resident would appeal to the BCH Pharmacy Director (or their designee).

XIV. Special Policies

a. *Leave (Family, Medical, and other):* BCH policies and procedures governing family and medical leave, or other leaves of absence shall apply to PGY1 residents. All requests for leave should be made through an approved mechanism to the RPD.
   i. The resident may take up to a maximum of 90 days of approved leave during the residency year. A resident requiring more than 90 days of leave will be dismissed from the program; the resident may re-apply for the program the following year.
   ii. The resident must demonstrate successful completion of required program goals and objectives during the course of the residency year in order to graduate. The residency year may be extended up to 90 days for qualifying circumstances per BCH's leave policies.

b. *Waiver of Required Learning Experiences:* Residents who wish to waive a required learning experience must demonstrate that they have sufficient knowledge and skills from past experience in that area to meet the goals and objectives of the residency training program. Staffing requirements cannot be waived. The following procedure should be followed if a waiver is desired by a resident:
   i. A written request must be submitted to the RPD at the beginning of the program year during the month of orientation. Requests must include the resident's CV and transcript, and specific reasons they should be eligible to waive a required learning experience, including past experience, past preceptor contact information, and future career plans.
   ii. All requests will be reviewed by the RAC. If the request is judged acceptable to qualify for waiver, the resident must meet with the members of the RAC to demonstrate competency in that specialty area.
   iii. Acceptable means of attaining knowledge and skills may include, but is not limited to, work experience as a pharmacist in the specialty area, clerkship rotation experience with sufficient similarity to activities and patient populations as those served at BCH, didactic experience concentrated in the specialty area, etc.
   iv. The RAC may contact the resident's prior preceptors from rotations which have provided experience similar to the required BCH experience to further determine whether a waiver may be indicated.
   v. Demonstration of competency will be assessed by the rotation preceptor using the goals and objectives outlined in residency program syllabus.
   vi. A waiver for a required rotation will be granted if the majority of RAC members agree that the resident's qualifications meet the goals and objectives of the program.

b. *Professional Affiliations* - All residents of ASHP accredited residencies must maintain an active membership in ASHP. All residents are encouraged to be members of the Colorado Pharmacists Society (CPS). Dues for these memberships will be the responsibility of the resident, but reimbursement funds may be available through BCH.

c. *Professional Meetings* - Residents are expected to participate in professional meetings. Listed below are examples of meetings:

i. The ASHP Midyear Clinical Meeting will be held in December. Attendance is required for all residents, and they must assist with the Residency Showcase and recruitment.
ii. Residents will attend a regional residency conference and are required to complete a presentation on his/her research project. Additionally, residents may be required to present the findings of their research projects and/or institutional service projects to staff at BCH.
iii. Attendance at other professional meetings (CPS, ACCP, etc.) is encouraged. Funding may be available through BCH. If funding is not available, it will be the responsibility of the resident.

d. *Early Commitment Process for PGY2 Programs*
   i. BCH does not offer a PGY2 program.
   ii. For all other inquiries, the resident will be directed to the ASHP website.

e. *Ethics and Code of Conduct*
   i. Residents must adhere to the BCH Code of Conduct in addition to the ASHP Code of Ethics for Pharmacists (Appendix A) and the AHA Patient's Bill of Rights (Appendix B).
   ii. Residents are frequently required to write reports, papers and manuscripts. These must be prepared with a high degree of integrity, and plagiarism of any type will not be tolerated. Appendix C and Appendix D describe plagiarism and methods to avoid it.
   iii. Artificial Intelligence:
      1. Pharmacy residents may use artificial intelligence (AI) to assist with completing assignments.
      2. Pharmacy residents must disclose when (AI) was used to assist with completing work.
      3. Pharmacy residents are encouraged to discuss potential (AI) use with preceptors prior to beginning course work to avoid potential misuse of the technology.

XV. Benefits

a. *Health Care* - Health care and other related employee benefits are available through the standard BCH employee benefit plan.
b. *Parking* - All residents will adhere to BCH parking policies
c. *Continuing Education / Travel* - Each resident is expected to budget for continuing education and travel expenses as part of their annual salary.
d. *Library Privileges/Computer Classes* – All residents may access the BCH library. All residents receive full library privileges at the University of Colorado Health Sciences Library as a privilege for precepting PharmD interns at BCH. Additionally, library classes (Ovid, Internet, etc.) are free for all residents. Tutorials for other computer applications are available. If the resident wishes to enroll in any other class, they may do so at their personal expense.
e. *Dress* - The resident is expected to adhere to the dress code of BCH or the institution in which they are on rotation.
f. *Immunizations* - All residents must have up-to-date immunizations.
g. *Sexual Harassment* - Sexual harassment will not be tolerated at BCH. All residents must read, understand, and adhere to the BCH Harassment Free Workplace Policy and Procedure.

ASHP REPORT
Code of Ethics for Pharmacists
Am J Health-Syst Pharm. 1995;52:2131

Preamble

Pharmacists are health professionals who assist individuals in making the best use of medications. This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society.

Principles

I. A pharmacist respects the covenantal relationship between the patient and pharmacist.

Interpretation: Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.

Interpretation: A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

Interpretation: A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

IV. A pharmacist acts with honesty and integrity in professional relationships.

Interpretation: A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

V. A pharmacist maintains professional competence.

Interpretation: A pharmacist has a duty to maintain knowledge and abilities as new medications, devices, and technologies become available and as health information advances.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.

Interpretation: When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.

VII. A pharmacist serves individual, community, and societal needs.

Interpretation: The primary obligation of a pharmacist is to individual patients. However, the obligations of a pharmacist may at times extend beyond the individual to the community and society. In these situations, the pharmacist recognizes the responsibilities that accompany these obligations and acts accordingly.

VIII. A pharmacist seeks justice in the distribution of health resources.

Interpretation: When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

Comments Invited
This revised Code of Ethics for Pharmacists was drafted by a committee of the American Pharmaceutical Association and adopted by the membership of the APhA on October 27, 1994. APhA has invited other pharmacy organizations to endorse the code, which consists of a preamble and eight principles. The interpretation of each principle is also printed here.
The Joint Commission of Pharmacy Practitioners, of which ASHP is a member, had encouraged APhA on behalf of the profession to (1) pursue a revision of the previous code of ethics and (2) submit the revision to JCPP member organizations for possible endorsement. The ASHP Board of Directors had endorsed the previous code of ethics developed by APhA. On June 4, 1995, the ASHP Board agreed to provisionally endorse the revised Code of Ethics for Pharmacists, to invite members' comments, and to consider official endorsement of the code pending members' comments.
Comments for the Board's consideration can be sent to the Executive Office, ASHP, 7272 Wisconsin Avenue, Bethesda, MD 20814, **by November 1, 1995.**

A PATIENT'S BILL OF RIGHTS

Appendix B

American Hospital Association

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the need for and alternatives to such a transfer. The institution to which the patient is transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to

obtain information as to the existence of any professional relationships among individuals, by name, who are treating them.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

BOULDER COMMUNITY HEALTH
STATEMENT ON PLAGIARISM

The National Institutes of Health and the National Science Foundation define misconduct in the scientific and medical community as the "fabrication, falsification, plagiarism, or other practices that seriously deviate from those that are commonly accepted" in this community.

The National Academy of Sciences and the Institute of Medicine further define plagiarism specifically as "using the ideas or words of another person without giving appropriate credit".

It has traditionally been accepted and understood that the medical community is held to higher ethical standards than other professions. It is our responsibility, as pharmacists who are part of the larger medical community, to uphold the standards of good writing and continue to strive to prevent and to respond to instances of plagiarism and misconduct appropriately. In doing this we insure the protection of the integrity of our entire medical community.

As a resident at Boulder Community Health, I understand the definitions given above and agree to avoid acts of plagiarism and misconduct.

Signed _____, Resident

U.S. Department of Health and Human Services. Responsibilities of awardee and applicant institutions for dealing with and reporting possible misconduct in science, National Institutes of Health Guide, 18, Washington DC: Government Printing Office, 1989.

First Annual Report of Scientific Misconduct Investigations Reviewed by Office of Scientific Integrity Review, March 1989 to December 1990, of the Public Health Service Semiannual Report of the Office of Inspector General of the National Science Foundation. No. 6, 1 October 1991 to 31 March 1992, and No. 7, 1 April 1992 to 39 (September 1992).

Responsible Science: Ensuring the Integrity of the Research Process (National Academy Press, Washington, DC., 1992), vol I.

UNDERSTAND PLAGIARISM AND AVOID IT

From Donald A. Sears, Harbrace Guide to the Library, 2nd ed. (New York, 1960), pp. 38-39.

It will be well to ask yourself if you fully understand what constitutes PLAGIARISM, for the range of meaning of the word is wide. At one extreme is the gross offense of trying to pass off as one's own the exact words of another; at the other extreme is the subtle manner of "borrowing a fine phrase to dress up one's own writing". In between are varying degrees of plagiarism that often puzzle a student. Through ignorance a student may in all honesty misuse his sources in such a way that he is guilty of plagiarism; but he is nonetheless guilty, for ignorance cannot be an acceptable excuse for wrongdoing.

An analogy to other kinds of dishonesty may help. To use another's words or ideas is roughly the intellectual equivalent of stealing the funds of a dormitory, fraternity, cooperative house, or sorority for one's own use. However, funds are made up of concrete money; words and ideas are abstract, and consequently the line between honest and dishonest use may be harder to define. There are, of course, correct and honorable ways of using sources just as there are correct and honorable ways of borrowing money. Forms of acknowledgment have to be included with your use of source material in the same way that legal forms have to filled out before a bank will let you use its money.

1. WORD-FOR-WORD PLAGIARISM

This includes (a) the submission of another student's work as one's own; (b) the submission of work from any sources whatever that is not properly acknowledge by footnote, bibliography, or reference in the paper itself; (c) the submission of any part of another's work without proper use of quotation marks.

2. PATCHWORK-QUILT PLAGIARISM

As our grandmothers used to put together large quilts out of scraps of cloth, a student may make the mistake of passing off as an original paper one that is stitched together with phrases and sentences taken from his sources. If he does not include quotation marks around all such borrowings he is committing plagiarism. Here rearrangement of phrases into a new pattern does not confer originality.

3. UNACKNOWLEDGED PARAPHRASE

An author's discovery of fact or original interpretation of fact is as much his property as his exact words are. Restatement by means of paraphrase does not remove the necessity of giving credit to the original sources.

The development of intellectual honesty is a primary goal of college education. Plagiarism, besides being dishonest in itself, defeats this purpose of college. When detected it is always severely punished, usually by expulsion. When undetected, punishment is nevertheless certain in the intellectual corruption of the plagiarizer.