**BOULDER COMMUNITY HEALTH**
**2026-2027 PGY1 RESIDENCY MANUAL**

Approved by:

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Christopher Zielenski, PharmD, BCPS, BCCCP
Director of Pharmacy, BCH

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Jaime Mesenbrink, PharmD, BCPS, BCCCP
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 15, 2026, through June 30, 2027, 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 policies for the residency program.

- 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.
- 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.
- Recruitment
  a. BCH participates in a variety of local, regional and national recruiting events to attract applicants that will further BCH's mission, vision, and values: https://www.bch.org/about-us/mission-vision-values/https://www.bch.org/about-us/mission-vision-values/
  b. 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 - 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
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. Final rankings for invitation to interview are based on:
    1. Academic performance
        a. Candidates from institutions not reporting a GPA will be scored excluding this measure from possible points
    2. Writing samples
    3. Rotation and work experience
    4. Leadership and professional activities and experiences
    5. Presentations and publications
iv. All applications will be reviewed by a minimum of two reviewers consisting of residents, preceptors, and/or pharmacy leadership. If there is a score difference greater than or equal to 4 points from the first two reviewers, a third reviewer will evaluate the applicant and the scores will be averaged.
v. The final applicant interview rank list will be compiled based on the average score, as a percentage of possible points, with the highest score being ranked first. If there is a tie, the RAC will determine who will be invited to interview.
    1. The RAC reviews final applicant interview rank list prior to sending invitations to interview.
vi. Invitations to interview are sent based on the final applicant interview rank list. The RAC will invite a designated number of applicants for an interview. All other applicants will be contacted and informed that there is no interview slot available. These applicants may be contacted in the future if interview slots become available.

c. Interview Process
    i. An interview is required. The residency manual and professional policies will be distributed upon invitation to interview.
    i. Selected candidates will be interviewed and evaluated by standardized evaluation forms during the interview process.
    ii. The interview team consists of preceptors, residents, and pharmacy leadership.

iii. The interview structure includes 4 sections of standardized interview questions, an individual situational judgement evaluation, and a presentation. Each of the six sections will be equally weighted to determine a final interview score which will be used to determine the rank list.
iv. The interview team will meet for a final ranking session. The rank list will be reviewed, and list position may be adjusted up to 2 spots either higher or lower based on input from the interview team.
v. The interview team will make a recommendation regarding how many applicants to rank. The RPD will make the final decision.

d. Match Phase I:
    i. 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.
    ii. Applicants who match are also required to complete an online application through BCH's Human Resources Department. Employment is contingent upon successful completion of Human Resources screening, including a pre-employment drug screen.
    iii. Resident recruitment, screening, and selection will abide by relevant BCH employment policies as it relates to equal opportunity as well as citizenship requirements.
e. Match Phase II:
    i. Applicants will be screened for minimum acceptance requirements and evaluated as listed in sections III.b.ii-III.b.vi.
    ii. Virtual interviews will be conducted with pharmacy leadership.
    iii. Selected candidates will be interviewed and evaluated by standardized evaluation forms during the interview process.
    iv. The interview structure will include 1 section of standardized interview questions, and a presentation. The interview question section will be weighted to make up 75% of the interview score, and the presentation section will make up 25% of the interview score to determine a final interview score which will be used to determine the rank list.
    v. The interview team will meet for a final ranking session. The rank list will be reviewed, and list position may be adjusted up to 2 spots either higher or lower based on input from the interview team.
    vi. The interview team will make a recommendation regarding how many applicants to rank. The RPD will make the final decision.
    vii. 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.
    viii. Applicants who match are also required to complete an online application through BCH's Human Resources Department. Employment is contingent

upon successful completion of Human Resources screening, including a pre-employment drug screen.

ix. Resident recruitment, screening, and selection will abide by relevant BCH employment policies as it relates to equal opportunity as well as citizenship requirements.

f. Scramble:

i. Applicants will be screened for minimum acceptance requirements and evaluated as listed in sections III.b.ii-III.b.iii.

ii. The first 10 applications received will be evaluated by the RPD using the standardized application review form. The RPD will determine the final interview rank list based on application review scores.

iii. The RPD will determine the number invited to interview.

iv. Virtual interviews will be conducted with pharmacy leadership.

v. Selected candidates will be interviewed and evaluated by standardized evaluation forms during the interview process.

vi. The interview structure will include 1 section of standardized interview questions.

vii. The interview question section score will determine the rank list.

viii. The interview team will meet for a final ranking session. The rank list will be reviewed, and list position may be adjusted up to 1 spot either higher or lower based on input from the interview team.

ix. The interview team will make a recommendation regarding how many applicants to rank. The RPD will make the final decision.

x. 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.

xi. Applicants who match are also required to complete an online application through BCH's Human Resources Department. Employment is contingent upon successful completion of Human Resources screening, including a pre-employment drug screen.

xii. Resident recruitment, screening, and selection will abide by relevant BCH employment policies as it relates to equal opportunity as well as citizenship requirements.

- Preceptor Responsibilities

  - Develop and maintain a working relationship with the resident to facilitate open communication and feedback.
  - Demonstrate an understanding of the layered learning model and incorporate the principles of that teaching style into the resident's learning experience.

- On the first day of the learning experience, review the resident's learning style and share own teaching style. Provide goals and objectives for the learning experience and ask that the resident develop 1-2 personal goals for the learning experience.
- Review the resident's daily work and plan learning activities based on performance.
- 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.
- Provide resident with clinical supervision and guidance as appropriate.
- Attend pharmacotherapy sessions, journal clubs, or resident presentations throughout the residency year.
- Attend Residency Advisory Committee (RAC) meetings throughout the year.
    a. Residency Advisory Committee:
        i. Meets no less than monthly.
        ii. Includes the RPD, residency preceptors, and ad-hoc members per discretion of the RPD
        iii. Reviews current resident progress
        iv. Reviews residency program administration
        v. Reviews preceptor roles and responsibilities
    b. Wellness and burnout prevention
        i. Preceptors will have knowledge of burnout syndrome, including the risks and mitigation strategies, 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.
    c. Notify the RPD of any significant performance concerns as soon as possible.
    d. Comply with ASHP Accreditation Standards.

- 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. All elements outlined on the tracking form must be successfully completed as assigned.
e. Major requirements include timely completion of the following:
    i. Residency Share Point folder maintained with the following required elements:
        1. Projects and presentations for each learning experience
        2. All written feedback received on assignments and presentations
    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 required. A final presentation to be given at BCH is required.
        1. Regional Pharmacy Presentation (completed and presented)
        2. Regional Residency Presentation (completed and presented)
        3. Second project (completed and presented) - Residents will be given examples of projects that are available. Examples of minor projects include clinical program development/enhancement/analysis, pipeline forecast, cost or budget analysis, or quality assurance.
    iv. Medication Use Evaluation (completed and presented) - Residents will complete two Medication Use Evaluations (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 learning experience, for APPE/aIPPE students.
    viii. Residents will complete BLS, ACLS, and PALS certification.
    ix. Attendance to and participation in the following meetings and events:
        a. Regional Pharmacy Presentation

b. Residency Showcase
c. Regional Residency Conference

x. Others as specified on the tracking form and as approved by the RPD or the RAC
xi. Residents may be asked at the preceptor's discretion to present projects (MUE, research project, etc.) to various committees for educational purposes.
xii. 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.
xiii. Wellness and burnout prevention
1. Residents will participate in a minimum of one wellness activity per month. Time spent doing these activities will be excused from learning experiences.
a. Opportunities include but are not limited to: Sound bath, guided meditations, EAP visits, meeting with mentor, meeting with chaplain services, etc.

- 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. Refer to www.ASHP.org for a comprehensive list of goals and objectives.
c. The resident must achieve ACHR for all R.1 objectives and have no objectives with a rating of "Needs improvement" to be considered ready for independent practice.
d. The resident must achieve ACHR for all R.1 objectives, ACHR 80% of total objectives by the end of the residency year, with no objectives with a final rating of "Needs Improvement" and complete all deliverables to successfully complete the program.
e. If the resident receives a "Needs Improvement" evaluation on any objective on the Summative Evaluation, the learning experience will **not** be considered successfully completed. The following actions must occur:
i. The preceptor will document the specific activities/assignments that must be completed for the resident to successfully complete the learning experience. 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. Residents will be evaluated per the following scale:

| Rating | Definition/Criteria |
|---|---|
| Needs Improvement (NI) | • Does not know how to perform activity<br>• Requires extensive preceptor supervision<br>• Cannot complete tasks or assignments without complete guidance from start to finish<br>• Unable to ask appropriate questions to supplement learning<br>• Other unprofessional activities noted |
| Satisfactory Progress (SP) | • At expected state for time of residency year<br>• Performs most skills independently<br>• Requires some direct preceptor intervention to complete task<br>• Improvement is noted during the learning experience but does not include mastery of the objective<br>• Able to ask appropriate questions to supplement learning |
| Achieved (ACH) | • Able to practice independently with limited preceptor supervision/preceptor mainly functions in "facilitation" preceptor role<br>• Able to perform skill and self-monitor quality<br>• Mastered the objective and consistently performed task/expectation with limited to no guidance |
| Achieved for Residency (ACHR) | • For objectives taught and evaluated in multiple learning experiences or multiple quarters, requires having an evaluation of "achieved" on two separate learning experiences |

| | |
|---|---|
| | • Objectives evaluated in a singular learning experience may be marked ACHR after a one-time evaluation of "achieved<br><br>Designated only by RPD or coordinator based upon review and assessment of each resident's performance from summative evaluations.<br><br>At any time during the residency program, if a preceptor and/or the RPD observe any resident performance as needing reinforcement, remediation and/or further assessment, the RAC can decide to remove the ACHR rating from the associated objective(s) for further training and evaluation. If this occurs, it will be documented in RAC meeting minutes, an action plan will be developed and documented, and plan will be communicated with applicable preceptor(s). |

g. The Residency Program Director (RPD) will track progress informally throughout the year using the tracking form. The RPD will formally assess progress quarterly during the quarterly evaluation process.
h. Prior to beginning the residency, each resident will complete self-assessment tools 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.
i. On the first day of each learning experience, the resident shall meet with the preceptor to discuss the goals and objectives of the learning experience. 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 learning experience.
j. 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 learning experience. All reports must be reviewed with the resident, by the learning experience 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 learning experiences will have quarterly resident assessments and self-assessment.
vi. Residents will receive feedback periodically during each learning experience with the purpose of facilitating completion of residency goals and objectives. However, this is informal in nature in comparison to summative evaluations. PharmAcademic will be used for formal evaluation process.

k. Quarterly evaluations will be conducted with the RPD.
l. Annual program evaluation will be conducted with the current residents, RPD, and RAC.
m. 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.
n. Upon successful completion of the program, the resident will receive a certificate of residency from Boulder Community Health.

- Learning Experiences
  a. Changes in the learning experience schedule for each resident will be coordinated by the RPD or residency program coordinator. Normal daily working hours of residents are determined by the RPD, rotation preceptor, and specific needs of the learning experience site. Residents are expected to be present at BCH or other assigned learning experience sites during all normal working hours as determined above.
  b. Required learning experiences include:
     i. Longitudinal Learning Experiences
        1. Staffing: Direct patient care experience (52 weeks)
           a. Residents will staff a weekday once every other week, a weekend once every three weeks, one major summer and one major winter holiday
        2. Major Project: Administrative learning experience and/or Direct patient care experience (52 weeks)
           a. Occurs per administrative time (below)
           b. 1 week is allotted to Major 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 major project at a national pharmacy conference and regional residency conference. Presentation days are allotted for ASHP Midyear (Dec) and one regional conference (May-June)

3. Pharmacy Practice Management: Administrative learning experience (52 weeks)
    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 learning experience.
        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 learning experience including; 1 day for regional residency showcase, 1 day allotted to the ASHP Midyear booth (Dec) and 3 days in Feb for interviews
4. Medication Safety/Drug Information: Administrative learning experience (52 weeks)
    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 experience (5 weeks)
2. Advanced Independent Practice: Direct patient care experience (3 weeks)
3. Residents will complete a total of 4 of 5 direct patient care learning experiences based on their entering interest survey and scheduling availability:
    a. Residents will complete at least 1 of 2 learning experiences with a high acuity patient population.
        i. Emergency Medicine: Direct patient care experience (6 weeks)
        ii. Critical Care: Direct patient care experience (6 weeks)
    b. Residents will complete at least 2 of 3 learning experiences with a moderate acuity patient population
        i. Internal Medicine: Direct patient care experience (6 weeks)

ii. Oncology/Orthopedics: Direct patient care experience (6 weeks)
iii. Cardiology: Direct patient care experience (6 weeks)

4. Residents will complete 1 of 2 non-direct patient care experiences based on their entering interest survey and scheduling availability:
    a. Informatics: Administrative learning experience (6 weeks)
    b. Pharmacy Administration: Administrative learning experience (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 Critical Care: Direct patient care experience (5 weeks)
    vi. Advanced Oncology: Direct patient care experience (5 weeks)
    vii. Others under development

- Staffing Hours
    a. Residents are required to staff a combination of operational and clinical shifts. The staffing commitment cannot be satisfied before the end of the residency year by working additional shifts early in the year. To fulfill this, residents will work one weekend every 3 weeks, one weekday shift every other week and work their required holidays. Residents are required to work one summer and one winter holiday. PGY1 residents will be scheduled in a variety of roles 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. The resident is responsible for tracking assigned staffing hours. The resident will notify their preceptor and RPD as soon as the resident identifies they have been scheduled in excess of the duty hours rules. Pharmacy leadership will proactively review the pharmacist schedule prior to publication to prevent scheduling beyond duty hour requirements.
    c. The A*SHP Duty Hour Requirements for Pharmacy Residency Programs* must be followed by the program and the residents. See ASHP website for complete duty hour definitions and requirements: ASHP Duty Hour Requirements for Pharmacy Residencies
    d. Moonlighting is defined as any voluntary, compensated, work performed outside the organization (external), or within the organization where the resident is in training (internal). These are compensated hours beyond the resident's salary and are not part of the scheduled duty periods of the residency program. External and internal moonlighting by residents is not allowed.
    e. Residents are required to complete the Duty hour Attestation monthly in PharmAcademic™. The RPD will review resident attestations to monitor compliance with duty hour requirements. Any instance of non-compliance will be addressed by the RPD and an action plan to prevent future instances will be developed.

f. 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.
g. Residents may trade assigned shifts under the following conditions:
    i. Duty hour agreement is not violated
    ii. The preceptor for the residents' current learning experience is notified and approves of the trade
    iii. The residency program director is notified and approves of the trade

- Administrative Time – It is expected that residents will be given time to work on administrative projects during clinical learning experiences per the learning experience preceptor's schedule.
- 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.
    c. Participation in and completion of a teaching certificate program through the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences is optional.
- Paid Time Off (PTO) and Time Away
    a. Time Away
        i. PTO 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 learning experience 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. Residents will staff one summer and one winter holiday. Residents will be given the remaining major holidays off without using PTO.
    g. Any remaining PTO at the end of the residency year will not be paid out.
    h. Residents dismissed from the program will receive pro-rated compensation for unused PTO.
- Orientation:

a. 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.
b. Standard training normally required to complete any staffing duties for residents may be customized and/or abbreviated if a specific resident enters the program with significant experience with pharmacy services and systems at BCH.

- Remediation and Dismissal:
  a. Residents are expected to complete all requirements of the Residency Program based on the ASHP Residency Standards and Competency Areas, Goals and Objectives for their specific program. Only those residents who complete the residency requirements set forth will receive their residency certificate. Evaluation of the resident's progress in completing the residency completion requirements is documented as part of the quarterly review process.
  b. The RPD, in conjunction with RAC, will continually assess the ability of the resident to meet the residency requirements by established deadlines. If a resident is failing to make progress in any aspect specific to the residency program completion requirements [e.g., “Needs Improvement” (NI) for the same objective on more than one summative evaluation, multiple NI’s for a single summative evaluation, not meeting progression expectations during a learning experience, not meeting deadlines], or if there is a concern with other behaviors related to performance (e.g., unprofessional behavior, plagiarism) the following steps shall be taken.
  c. The RPD will provide the resident verbal coaching for any initial issues identified. If the identified issues continue, the resident will be placed in a resident corrective action plan. The plan will provide specific action steps to address the behavior or performance concerns. The plan will indicate the criteria for successful remediation and will have a timeline for remediation of no longer than 4 weeks.
     i. If the resident meets the criteria for successful remediation, the resident must not regress for the duration of the residency to receive a certificate of completion.
     ii. If the resident is not successful in completing the action steps, yet makes progress, a second resident corrective action plan can be executed. The second resident corrective action plan will be no longer than 4 weeks.
     iii. If the resident does not meet the criteria for successful remediation in the second plan, the resident will be dismissed from the program and will not receive a certificate.
  d. Residency-related conduct or actions that may be grounds for immediate dismissal include, but are not limited to, plagiarism, inappropriate use of artificial intelligence, breach of confidentiality or violation of any rules and regulations of the Colorado State Board of Pharmacy.
  e. Residents also must abide by the organization’s code of conduct.
  f. If a resident completes 52 weeks of the residency but does not fulfill all residency completion requirements, a certificate will not be issued. No extensions will be granted for residents who have failed to meet residency completion requirements.

- 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. Status of salary and benefits during approved leave are determined by State, federal, and BCH policies.
        iii. 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.
    a. *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.
    b. *Professional Meetings* - Residents are expected to participate in professional meetings. Cost of these meetings will be the responsibility of the resident, but reimbursement funds may be available through BCH. 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.
    c. *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.
    *d. 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.
3. Pharmacy residents are encouraged to discuss potential (AI) use with preceptors prior to beginning course work to avoid potential misuse of the technology.
4. Pharmacy residents may not use AI to assist with topic discussion or journal club preparation.
5. Pharmacy residents may not use any confidential or patient information when using AI.

iv. Residency-related conduct or actions that may be grounds for immediate dismissal include, but are not limited to, plagiarism, inappropriate use of AI, breach of confidentiality or violation of any rules and regulations of the Colorado State Board of Pharmacy.

- 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.