

## CSHP 2015 STATUS: GOALS & OBJECTIVES (May 2011)

Note: Objectives with \*\* indicate a revised objective from 2007/08 to 2009/10

<b>GOAL 1: INCREASE THE EXTENT TO WHICH PHARMACISTS IN HOSPITALS AND RELATED HEALTHCARE SETTINGS HELP INDIVIDUAL HOSPITAL INPATIENTS ACHIEVE THE BEST USE OF MEDICATIONS.</b>			
<b>Objective Number</b>	<b>Objective Description</b>	<b>BASELINE</b>	<b>PROGRESS (2009/10)</b>
Objective 1.1**	In <b>100%</b> of hospitals <sup>1</sup> and related healthcare settings, pharmacists will ensure that medication reconciliation <sup>2</sup> occurs during transitions across the continuum of care (admission, transfer and discharge).	Admission 69% (2009/10)	
		Transfer 41% (2009/10)	
		Discharge 36% (2009/10)	
Objective 1.2	The medication therapy of <b>100%</b> of hospital inpatients with complex and high-risk medication regimens <sup>3</sup> will be monitored <sup>4</sup> by a pharmacist.	≤ 18% (2007/08)	5%
Objective 1.3**	In <b>90%</b> of hospitals, pharmacists manage medication therapy <sup>5</sup> for inpatients with complex and high-risk medication regimens in collaboration with other members of the healthcare team.	87% (2009/10)	
Objective 1.4	<b>75%</b> of hospital inpatients discharged with complex and high-risk medication regimens will receive medication counselling <sup>6</sup> managed by a pharmacist.	3% (2007/08)	2%
Objective 1.5	<b>50%</b> of recently hospitalized patients or their caregivers (family members for example) will recall speaking with a pharmacist while in the hospital.	<11% (2007/08)	<50%
<b>GOAL 2: INCREASE THE EXTENT TO WHICH PHARMACISTS HELP INDIVIDUAL NON-HOSPITALIZED PATIENTS ACHIEVE THE BEST USE OF MEDICATIONS.</b>			
<b>Objective Number</b>	<b>Objective Description</b>	<b>BASELINE</b>	<b>PROGRESS (2009/10)</b>
Objective 2.1**	In <b>70%</b> of ambulatory and specialized care clinics providing clinic care, pharmacists will manage medication therapy for clinic patients with complex and high-risk medication regimens, in collaboration with other members of the healthcare team.	11% (2009/10)	
Objective 2.2	In <b>95%</b> of ambulatory and specialized care clinics, pharmacists will counsel clinic patients with complex and high-risk medication regimens.	≤ 41% (2007/08)	12%

Objective Number	Objective Description	BASELINE	PROGRESS (2009/10)
Objective 2.3 **	In <b>85%</b> of home care services, pharmacists will manage medication therapy for patients with complex and high-risk medication regimens, in collaboration with other members of the healthcare team.	48% (2009/10)	
<b>GOAL 3: INCREASE THE EXTENT TO WHICH HOSPITAL AND RELATED HEALTHCARE SETTING PHARMACISTS ACTIVELY APPLY EVIDENCE-BASED METHODS TO THE IMPROVEMENT OF MEDICATION THERAPY.</b>			
Objective Number	Objective Description	BASELINE	PROGRESS (2009/10)
Objective 3.1**	In <b>100%</b> of hospitals and related healthcare settings, pharmacists will be actively involved in providing care to individual patients that is based on evidence, such as the use of quality drug information resources, published clinical studies or guidelines, and expert consensus advice.	90% (2009/10)	
Objective 3.2**	In <b>100%</b> of hospitals and related healthcare settings, pharmacists will be actively involved in the development and implementation of evidence-based <sup>7</sup> drug therapy protocols and/or order sets.	85% (2009/10)	
Objective 3.3	<b>90%</b> of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive angiotensin-converting enzyme inhibitors or angiotensin receptor blockers at discharge.	53% (2007/08)	59%
Objective 3.4	<b>90%</b> of hospital pharmacies will participate in ensuring that patients hospitalized for congestive heart failure will receive angiotensin-converting enzyme inhibitors or angiotensin receptor blockers at discharge.	50% (2007/08)	54%
Objective 3.5	<b>90%</b> of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive beta-blockers at discharge.	52% (2007/08)	59%
Objective 3.6	<b>90%</b> of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive aspirin at discharge.	52% (2007/08)	59%
Objective 3.7	<b>90%</b> of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive lipid-lowering therapy at discharge.	51% (2007/08)	59%
Objective 3.8	In <b>90%</b> of hospitals and related healthcare settings providing clinic care, pharmacists will participate in ensuring that non-hospitalized patients who are receiving medications to decrease blood glucose levels will be assessed at least annually with a HbA1c test.	23% (2007/08)	28%
Objective 3.9 (NEW)	In <b>70%</b> of hospitals and related healthcare settings, pharmacists will be actively involved in medication- and vaccination-related infection control programs <sup>8</sup> .	45% (2009/10)	

<b>GOAL 4: INCREASE THE EXTENT TO WHICH PHARMACY DEPARTMENTS IN HOSPITALS AND RELATED HEALTHCARE SETTINGS HAVE A SIGNIFICANT ROLE IN IMPROVING THE SAFETY OF MEDICATION USE.</b>			
<b>Objective Number</b>	<b>Objective Description</b>	<b>BASELINE</b>	<b>PROGRESS (2009/10)</b>
Objective 4.1	<b>90%</b> of hospitals and related healthcare settings will have an organizational program, with appropriate pharmacy involvement, to achieve significant annual, documented improvement in the safety of all steps in medication use.	64% (2007/08)	62%
Objective 4.2	<b>80%</b> of pharmacies in hospitals and related healthcare settings will conduct an annual assessment of the processes used for compounding sterile medications, consistent with established standards and best practices.	24% (2007/08)	29%
Objective 4.3	<b>80%</b> of hospitals have at least 95% of routine medication <sup>9</sup> orders reviewed for appropriateness by a pharmacist before administration of the first dose.	59% (2007/08)	61%
Objective 4.4	<b>100 %</b> of medication orders in a hospital's emergency department will be reviewed by hospital pharmacists within 24 hours.	≤ 51% (2007/08)	27%
Objective 4.5	<b>90%</b> of hospital pharmacies will participate in ensuring that patients receiving antibiotics as prophylaxis for surgical infections will have their prophylactic antibiotic therapy discontinued within 24 hours after the surgery end time.	39% (2007/08)	45%
Objective 4.6	<b>85%</b> of pharmacy technicians in hospitals and related healthcare settings will be certified by a clearly identifiable and recognized training program.	≤ 59% (2007/08)	63%
Objective 4.7	<b>75%</b> of pharmacies in hospitals utilize a unit-dose system <sup>10</sup> for drug distribution for 90% or more of their total beds.	62% (2007/08)	76%
Objective 4.8 <b>(NEW)</b>	<b>100%</b> of new pharmacists entering hospital and related healthcare setting practice will have completed a Canadian Hospital Pharmacy Residency Board-accredited residency.	29% (2009/10)	
<b>GOAL 5: INCREASE THE EXTENT TO WHICH HOSPITALS AND RELATED HEALTHCARE SETTINGS APPLY TECHNOLOGY EFFECTIVELY TO IMPROVE THE SAFETY OF MEDICATION USE.</b>			
<b>Objective Number</b>	<b>Objective Description</b>	<b>BASELINE</b>	<b>PROGRESS (2009/10)</b>
Objective 5.1	<b>75%</b> of hospitals will use machine-readable coding to verify medications before dispensing.	13% (2007/08)	17%
Objective 5.2	<b>75%</b> of hospitals will use machine-readable coding to verify all medications before administration to a patient.	1% (2007/08)	5%
Objective 5.3	For routine medication prescribing for inpatients, <b>75%</b> of hospitals will use computerized prescriber order entry systems that include clinical decision support <sup>11</sup> .	7% (2007/08)	6%
Objective 5.4	<b>100%</b> of hospital pharmacists will use computerized pharmacy order entry systems that include clinical decision support.	69% (2007/08)	77%

Objective 5.5	In <b>75%</b> of hospitals and related healthcare settings, pharmacists will use medication-relevant portions of patients' electronic medical records for managing patients' medication therapy.	81% (2007/08)	89%
Objective 5.6	In <b>75%</b> of hospitals and related healthcare settings, pharmacists will be able to electronically access pertinent patient information and communicate across settings of care (e.g. hospitals, clinics, home care operations, and chronic care operations) to ensure continuity of pharmaceutical care for patients with complex and high-risk medication regimens.	39% (2007/08)	37%
<b>GOAL 6: INCREASE THE EXTENT TO WHICH PHARMACY DEPARTMENTS IN HOSPITALS AND RELATED HEALTHCARE SETTINGS ENGAGE IN PUBLIC HEALTH INITIATIVES ON BEHALF OF THEIR COMMUNITIES.</b>			
<b>Objective Number</b>	<b>Objective Description</b>	<b>BASELINE</b>	<b>PROGRESS (2009/10)</b>
Objective 6.1	<b>60%</b> of pharmacies in hospitals and related healthcare settings will have specific ongoing initiatives that target community health <sup>12</sup> .	21% (2007/08)	17%
Objective 6.2	<b>85%</b> of hospital pharmacies will participate in ensuring that high risk patients in hospitals and related healthcare settings receive vaccinations for influenza and pneumococcus.	23% (2007/08)	30%
Objective 6.3	<b>80%</b> of hospital pharmacies will participate in ensuring that hospitalized patients who smoke receive smoking-cessation counselling.	19% (2007/08)	22%
Objective 6.4	<b>90%</b> of pharmacy departments in hospitals and related healthcare settings will have formal up-to-date emergency preparedness programs integrated with their hospitals and related healthcare settings' and their communities' emergency preparedness and response programs.	54% (2007/08)	78%

## DEFINITIONS

1. **Hospital:** Any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care; care for the mentally disordered; nursing home intermediate care service, adult residential care service, and comparable services for children. (Adapted from Section 2 of the Canada Health Act.)
2. **Medication reconciliation:** A process which ensures the collection and communication of accurate client/patient medication information. The ultimate goal of medication reconciliation is to facilitate continuity of pharmaceutical care for patients/clients at admission/beginning of services and/or at discharge/transition/end of service (e.g. from hospital to home or another level of care/service).
3. **Complex and high-risk medication regimens:** Medication regimens that are subject to potential danger or hazard (e.g. challenging dosing schedules or routes of administration, medications with documented and significant drug interactions, polypharmacy, and medications with a narrow therapeutic range, insulin, antithrombotics, chemotherapy). Lists are institution-specific.

4. **Monitoring:** An ongoing review of the whole patient, reviewing pertinent patient data (e.g. lab values, medications, patient parameters), speaking with other caregivers and/or the patient, and evaluating patient response to therapy. Monitoring is NOT the routine profile review that pharmacists perform at transcription/data entry.
5. **Managing medication therapy:** This encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's or other qualified health care provider's scope of practice. These services include but are not limited to the following, according to the individual needs of the patient:
  - a) Performing or obtaining necessary assessments of the patient's health status
  - b) Formulating a medication treatment plan
  - c) Selecting, initiating, modifying, or administering medication therapy
  - d) Monitoring and evaluating the patient's response to therapy, including safety and effectiveness
  - e) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
  - f) Documenting the care delivered and communicating essential information to the patient's other primary care providers
  - g) Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications
  - h) Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens
  - i) Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient
6. **Medication counselling:** A face-to-face and thorough review of patient medications and patient education.
7. **Evidence-based medicine:** The use of medication drawing on the results of clinical trials and consensus advice of best practices.
8. **Infection control programs:** For the purposes of this initiative, include all medication- or vaccination-related efforts related to minimizing infections in the hospital setting. This might include antimicrobial stewardship programs, efforts to increase vaccination rates, antibiotic surgical prophylaxis protocols, etc.
9. **Routine Medication Orders:** All medication orders with the exception of doses required for immediate procedures (such as in the operating room, labour and delivery, radiology, or cardiac catheterization) or in urgent situations when the resulting delay would harm the patient.
10. **Unit-dose system:** A hospital system of drug distribution in which medications are dispensed in a ready-to-administer form for a 24-hour period (i.e. no further dosage calculation or manipulation, or "note strength" label is required).
11. **Clinical decision support:** This **may** include medication interaction screening, dose checking, allergy checking, IV compatibility checking, and expert decision rules.
12. **Community health initiatives:** This could include health promotion and disease prevention, wellness programs, health reassessment, public health clinics, poison prevention education, community health fairs, brown bag sessions, school health nurse and teacher education.

## FOOTNOTES

**Original Objective 1.1:** Pharmacists will be involved in managing the acquisition, upon admission, of medication histories for 75% of hospital inpatients with complex and high risk medication regimens.

**Revised Objective 1.1:** In 100% of hospitals and related healthcare settings, pharmacists will ensure that medication reconciliation occurs during transitions across the continuum of care (admission, transfer and discharge).

**Original Objective 1.3:** In 90% of hospitals, pharmacists will have organizational authority to manage medication therapy in collaboration with other members of the healthcare team.

**Revised Objective 1.3:** In 90% of hospitals, pharmacists manage medication therapy for inpatients with complex and high-risk medication regimens in collaboration with other members of the healthcare team.

**Original Objective 2.1:** In 70% of ambulatory and specialized care clinics providing clinic care, pharmacists will have organizational authority for managing medication therapy for clinic patients with complex and high-risk medication regimens in collaboration with other members of the healthcare team.

**Revised Objective 2.1:** In 70% of ambulatory and specialized care clinics providing clinic care, pharmacists will manage medication therapy for clinic patients with complex and high-risk medication regimens, in collaboration with other members of the healthcare team.

**Original Objective 2.3:** In 85% of home care services, pharmacists will have organizational authority to manage medication therapy in collaboration with other members of the healthcare team.

**Revised Objective 2.3:** In 85% of home care services, pharmacists will manage medication therapy for patients with complex and high-risk medication regimens, in collaboration with other members of the healthcare team.

**Original Objective 3.1:** For 100% of hospital and related healthcare setting patients, pharmacists will be actively involved in ensuring that they receive evidence-based medication therapy.

**Revised Objective 3.1:** In 100% of hospitals and related healthcare settings, pharmacists will be actively involved in providing care to individual patients that is based on evidence, such as the use of quality drug information resources, published clinical studies or guidelines, and expert consensus advice.

**Original Objective 3.2:** In 100% of hospitals and related healthcare settings, pharmacists will be actively involved in the development and implementation of all evidence-based therapeutic protocols involving medication use.

**Revised Objective 3.2:** In 100% of hospitals and related healthcare settings, pharmacists will be actively involved in the development and implementation of evidence-based drug therapy protocols and/or order sets.

**New – Objective 3.9:** In 70% of hospitals and related healthcare settings, pharmacists will be actively involved in medication- and vaccination-related infection control programs.

**New – Objective 4.8:** 100% of new pharmacists entering hospital and related healthcare setting practice will have completed a Canadian Hospital Pharmacy Residency Board-accredited residency.

## BIBLIOGRAPHY

A crosswalk linking the goals and objectives of the ASHP Health-System Pharmacy 2015 Initiative to other health-care priorities. Bethesda (MD): American Society of Health-System Pharmacists; 2008 [cited 2008 May 30]. Available from: [http://www.ashp.org/s\\_ashp/docs/files/2015\\_Crosswalk\\_0508.pdf](http://www.ashp.org/s_ashp/docs/files/2015_Crosswalk_0508.pdf)

Canada Health Act: glossary of terms. Ottawa (ON): Health Canada; 2006 [cited 2008 May 30]. Available from: [www.hc-sc.gc.ca/hcs-sss/medi-assur/res/gloss\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/medi-assur/res/gloss_e.html)

Hospital Pharmacy in Canada Editorial Board. 2005/2006 Annual report – Hospital pharmacy in Canada: ethics in hospital pharmacy [Internet]. Vancouver (BC): Hospital Pharmacy in Canada Report; 2007 [cited 2008 May 30]. Available from: [http://www.lillyhospitalsurvey.ca/hpc2/content/rep\\_2006\\_toc.asp](http://www.lillyhospitalsurvey.ca/hpc2/content/rep_2006_toc.asp)

Patient safety: frequently asked questions [Internet]. Ottawa (ON): Accreditation Canada; 2008 [cited 2008 May 30]. Available from: <http://www.cchsa.ca/default.aspx?page=114&cat=30>

Pedersen CA, Schneider PJ, Scheckelhoff DJ. ASHP national survey of pharmacy practice in hospital settings: dispensing and administration – 2005. *Am J Health-Syst Pharm* 2006; 63:327-45

Pedersen CA, Schneider PJ, Scheckelhoff DJ. ASHP national survey of pharmacy practice in hospital settings: monitoring and patient education – 2006. *Am J Health-Syst Pharm* 2007; 64:507-20

Pedersen CA, Schneider PJ, Scheckelhoff DJ. ASHP national survey of pharmacy practice in hospital settings: prescribing and transcribing – 2007. *Am J Health-Syst Pharm* 2008; 65:827-43

Statement on unit-dose and intravenous admixture drug distribution. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2008 [cited 2008 May 30]. Available from: [http://www.cshp.ca/productsServices/officialPublications/index\\_e.asp](http://www.cshp.ca/productsServices/officialPublications/index_e.asp)

Top patient concerns 2002: omnibus survey results. Bethesda (MD): American Society of Health-System Pharmacists; 2002 [cited 2008 May 30]. Available from: [http://www.ashp.org/s\\_ashp/docs/files/PR\\_ResearchReport.pdf](http://www.ashp.org/s_ashp/docs/files/PR_ResearchReport.pdf)

CSHP 2015 was approved by CSHP Council: February 25, 2007 and the CSHP 2015 document was revised: May 19, 2008