Summary of Written Feedback Received Regarding CHPRB Accreditation Standards 2010, Draft Version 3 April 2008

Following are comments received from five sources prior to the submission deadline. Comments are reprinted below in no particular order. CHPRB disposition of the written submissions is indicated in ***bold***.

Submission A:

Congratulations on the excellent work done on revising the CHRPB Standards. The process used to develop, obtain wide-spread feedback, and refine the Standards has been impressive. We are pleased to see the broadening of the definition of pharmacy practice residencies to beyond the hospital domain and the recognition of joint offerings of residencies. As boundaries become less clear between different components within our health care system, our training programs need to reflect this change.

Line 205: Residencies offered in non-traditional settings may not have a Department and therefore, would have difficulty interpreting this section. Are we really asking that there be an organizational structure that oversees the pharmacy activities of the organization (within an amb care clinic this may be a practice committee for example)? ***Line 122 of the Standard defines "Department": "…the organizational structure for the provision of pharmacy services.". The definition has been amended to include oversight of pharmacy services.***

Line 223: Even in traditional settings, not all Departments are managed by pharmacists anymore. Are we accepting of this or is what we are asking that a pharmacist be involved in the decision making (not necessarily be the decision maker)? This also relates back to line 204 comment. ***The Canadian Society of Hospital Pharmacists has communicated its position regarding leadership of pharmacy services. With respect to this residency standard, the requirement that the department be led and managed by a professionally competent, legally qualified pharmacist(s) does not preclude having a person(s) other than a pharmacist as part of the departmental leadership and management team, nor does it preclude a non-pharmacist being the final authority for decisions at the department or organization level. The Board understands that some healthcare settings that wish to operate a pharmacy residency program (e.g., Family Health Teams, community pharmacies, health regions, etc) are likely to have a "department" leadership and management team comprised of persons with training in fields other than pharmacy, as well as at least one pharmacist. This Standard would require that oversight and provision of pharmacy services is led and managed by a pharmacist, even though that pharmacist might not have final authority for decision-making.***

Line 250 to 262: Many non-traditional settings do not have the majority of the drug distribution components listed. In an amb care setting is having a refill policy, sample closet distribution system etc acceptable or are we asking these residencies to link with a community pharmacy/hospital to provide this component of the residency? ***The Board strongly believes that pharmacy practice residencies should be offered in organizations that aspire to deliver a***

high standard of pharmacy care. Lines 250 to 262 describe major systems and service that are hallmarks of high quality pharmacy care. The Board is aware that not all systems or services are present in every organization due to the type of patients being served, or other organizational needs. If a particular system or standard does not apply to the organization, a program would identify this during the accreditation process. It is the experience of the Board that the CHPRB Accreditation Standard, the CSHP Standards of Practice, and the CHPRB Accreditation process prompts organizations to regularly assess whether existing services and systems continue to deliver a high standard of pharmacy care. Having policies in place, establishing procedures, or pursuing alternate ways of delivering services are quality initiatives that an organization might identify with respect to requirements in Line 250-262.

Line 668: With the increased focus on safe med practices, is a "working knowledge" adequate for a residency? ***In developing this first competency-based Accreditation Standard for pharmacy practice residencies, CHPRB has attempted to strike a balance between inclusion of established competencies, and competencies for which emphasis might increase or decrease within the effective period of a Standard (e.g., quality circles, pharmacy management, therapeutic drug monitoring, drug use evaluation, medication reconciliation, etc). The competencies as a whole must also be achievable within a one year period of training in a broad range of training environments. The Standard is revised every four years or earlier, if survey data and program feedback show that the requirements are inappropriately low or clearly unachievable at any future time in any setting.***

Line 714-718: Other areas here might include; giving and receiving constructive feedback, dealing with difficult teaching situations, developing clinical reasoning skills in others, teaching and role-modeling reflective practice, developing evaluation tools. ***The requirement speaks only to the instructional roles used in practice-based teaching, that a resident would be required to demonstrate if s/he has achieved the competency (direct instruction, modeling, coaching, and facilitation). The knowledge or skills (giving effective feedback; dealing with difficult situations; instructing to enhance critical thinking; asking beautiful questions, etc) that a program would augment in an individual resident, to assist them to achieve the competency, would be determined by the residency program.***

Submission B:

Line 1: add (CHPRB) after the title ***not revised (standard CHPRB masthead)***

Line 59: define the abbreviation "ASHP" to read "American Society of Health-System Pharmacists (ASHP)" ***Revised***

Line 99: define the abbreviation "CHPRB" the first time it appears in the body of the accreditation standards so sentence reads, "The Canadian Hospital Pharmacy Residency Board (CHPRB)...." ***Revised***

Line 109: delete "Canadian Hospital Pharmacy Residency Board" and the brackets around "CHPRB" ***Revised***

Line 141: define what you mean by "evidence-based"; this term has become popularized but the accreditation standards should provide clarity as to what this means ***Requirements defined in Standard 3.2***

Line 154 and 165: the term "compliance" infers an absolute term that should not be quantified by the adjective "substantial". If the term "substantial" must be included, then one needs to provide more clarity as to what this means (50% plus l%?) ***For Line 154 & 165, substantial compliance is defined by the accrediting bodies described in Requirement 1 (e.g., in the form of an accreditation award for a specified duration of time with or without conditions), not by CHPRB; therefore, a definition of "substantial" has not been added.***

Line 181: Consider providing more clarity regarding the term "routine" with regards to reports; this seems rather vague to me ***CHPRB requires routine reporting because it is a good practice of jointly operated programs; however, since definitions related to reporting (among other operational considerations) between joint programs are usually detailed in partnership or affiliation agreements or a Memorandum of Understanding, no change has been made to the Standard.***

Line 187: repeat the phrase "residency program" after "... jointly offered" ***Revised***

Line 226: Is there a need to include the bracketed word "(minimally)"? Consider deleting this term. ***Deleted***

Line 235: Is there a need to include the bracketed word "[improvement]"? Consider either deleting the term or remove the brackets. ***Revised***

Line 399: This is more of a comment directed at the accreditation board than at the standards themselves. There should be a national standard outlining formal criteria, policies and procedures for evaluation, ranking and admission of qualified applicants. Why is this important step in the process apparently left to individual residency programs? ***CHPRB does not prescribe the admissions process because some residents are considered students of a university or private school, others are employees, and yet others are classified as trainees (neither a student nor an employee). As such, federal and provincial statutes that apply to each resident at the point of application and admission to a residency program vary widely. CHPRB has further strengthened requirements related to admissions in the final version of the Standard, in the area of fair admission practices: "Residency applicants may be offered benefits (including awards, bursaries, and/or return of service contracts or agreements or equivalent); however, an applicant's acceptance or rejection of such benefits shall not influence the decision to admit a candidate to the residency program, nor have an influence on the decision regarding a resident's graduation from the residency program."***

Line 403: Again like line 399, who establishes the formal criteria-based process? ***Process established by the program and justified within their operating context.***

Line 407: In this day and age, are we still reliant on written letters for formal communications only? To speed up the process could the standards include some phrase indicating that other forms of communication (email/fax) may be used and followed up by a formal letter? ***Delivery method (electronic versus other) is defined by the program.***

Line 420: add a period at the end of the sentence ***Revised***

Line 521: Please consider providing more clarity/define the terms "formative and summative" ***Unchanged from 2006 Standard; add request to the list of learning needs associated with implementation of the 2010 Standard.***

Line 556: Provide more clarity regarding the term "timely"; perhaps within one week of completion of a rotation would be acceptable as noted on line 547 ***No change (program defined, due to wide variety of evaluation models used nation-wide)***

Line 560: same comment as for line 556 ***No change (program defined, due to wide variety of evaluation models used nation-wide)***

Lines 565 to 569: consider moving to line 553 to provide better flow of information; then renumber points 4, 5 and 6 ***No change***

Line 720: How do you determine this objectively? Perhaps you could consider adding the following, "Author of a paper suitable for publication in a peer-reviewed journal" ***No change (program defined due to the large range and number of written works required of residents in most programs nation-wide; see also line 735)***

Line 753: delete period after name of the journal ***Revised***

Line 780: add period at the end of the reference ***Revised***

Submission C

Overall, we support the revisions, and especially the use of a competency based model for the standards. The revised draft number three standards are well-written and provide a useful framework for residency practice in their current layout. However, our concerns revolve around the implementation of the new standards and we offer thoughts and suggestions to the Board regarding implementation of the new standards. A helpful step in the implementation process would be to release the proceedings of the recent PPC Accreditation Standards Workshop for general review by all residencies. Publication of an outline/ timeline of the Board's intentions around dissemination of the final standards, implementation deadlines of the new standards, and the documentation required by the residency programs for implementation would also be very helpful in this overall process. We are in agreement with the suggestion of the Board of having an

established national definition of minimum competency for graduation as a pharmacy resident, as has been done by the Association of Faculties of Pharmacy of Canada. Putting this definition and the process for generation of this definition forward will facilitate in the implementation of the new standards. ***Proceedings of past workshops and Standards 2010 implementation timelines are available:*** http://www.cshp.ca/programs/residencyTraining/CHPRBinfo_e.asp

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Submission D

Overall, we support the proposed standards, and especially the use of a competency based model for the standards. The revised draft number three standards are well-written and we feel provide a useful framework in their current layout for residency practice. However, our concerns and thoughts revolve around the implementation of the standards, i.e., practical definitions of minimum competency, timelines and documentation for implementation required. We have shared these concerns and suggestions with XXXXXX and have also chosen to forward them to XXXXXX in the hopes that this will initiate thought around a unified approach amongst all [province] Hospital Residency Programs regarding the standards implementation and minimum competency requirements.

We highlighted to XXXXX that the proceedings of the recent PPC Accreditation Standards Workshop should be released for general review by all residencies. We are in agreement with the suggestion of CHPRB of having an established national definition of minimum competency, as has been done by the Association of Faculties of Pharmacy of Canada. Putting this definition forward will facilitate in the implementation of the new standards. Finally, publication of an outline/ timeline of CHPRB's intentions around dissemination of the final standards, implementation deadlines of the new standards, and the subsequent documentation required by the residency programs would also be very helpful in this overall process.

However, we feel, as seen in the recent PPC Accreditation Standards Workshop, that the process of defining of competency standards is both a challenging and laborious process. Based on feedback from this workshop, a unified approach/ definitions to practice competencies would be logical for both programs and residents. Our thoughts are to suggest having this process done in a coordinated manner, through XXXXXX, in order to ensure this unified approach to competency standards. Having a consultant draft these standard definitions (e.g., range of situations, definition of levels, etc.) would be desirable as a one time expense. We offer these suggestions and potential solutions and hope that discussion around the process of drafting minimum competency standard definitions and implementing them can be brought up at the upcoming Annual General Meeting in XXXXX. ***Recommendation referred to CHPRB Strategic Planning committee***

Submission E

Congratulations to CHPRB on an excellent detailed tool to further pharmacy practice residency training!

Consider a more specific title "CHPRB Accreditation Standards for Pharmacy Practice Residencies"

We were looking for something about "adhering to the policies and procedures of CHPRB" (ie the RMS); did I miss it somewhere? ***Inserted in Section 2.1.1***

The board no longer specifies the amount of leave allowed within the 52 weeks; I thought it used to be 2 weeks paid leave (vacation) and anything beyond that needs to be "paid back" to make up the 52 week year. Was this omission deliberate, or will further clarification be forthcoming? ***No change (2002 and 2006 CHPRB Accreditation standards did not set limits for vacation leave)***

Line 665: in our region, pharmacists do not do order entry; thus line 665 is a problem for us ***No change. Transcription may include medication order entry, writing of prescriptions or prescription clarifications, etc., whether done by electronic or manual means.***

Line 337: will be a problem for us, as we're not a teaching hospital. however, as it says "should", I suppose we'll be OK. ***No change***

Line 312: is one that we have difficulty with; we consider it a "should" as well, in that if a skilled pharmacist with desire and aptitude becomes the coordinator one day (ie. without the admin background), we still think that we'd be compliant with the standard, given that all other requirements are met ***Unchanged since 1998 Standard***