



April 27, 2017

Nancy Lum-Wilson
Registrar & CEO
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Dear Ms. Lum-Wilson:

**RE: CSHP-OB RESPONSE – IMPLEMENTATION OF CONTINUOUS QUALITY ASSURANCE FOR
MEDICATION SAFETY**

The Ontario Branch of the Canadian Society of Hospital Pharmacists (CSHP-OB) thanks you for the opportunity to provide feedback on the 'Implementation of Continuous Quality Assurance for Medication Safety' Program. The Ontario College of Pharmacists (OCP) should be commended for the efforts to ensure safe, effective and ethical pharmacy services in Ontario.

The Canadian Society of Hospital Pharmacists (CSHP) is the national voluntary organization of pharmacists committed to patient care through the advancement of safe, effective medication use in hospitals and other collaborative healthcare settings. As such, CSHP-OB is supportive of ensuring processes are in place to report incidents, to review and disclose these incidents to patients/families and to share learnings gained from incidents.

As the provincial branch of a national organization, we encourage the Ontario College of Pharmacists to lead the development of a national, comprehensive program for continuous quality assurance for medication safety. An effort on a national scale would provide benefit and build upon successes made by organizations such as the Institute for Safe Medication Practices Canada. A national program may also help establish standards for reporting and benchmarking.

To provide feedback we have listed CSHP-OB responses to the questions posed on the OCP website:

1. Do you see the CQA program benefiting practice in your own pharmacy?

Response:



Yes, CSHP-OB believes the CQA program will benefit practice in hospital and other collaborative healthcare settings. The majority of hospital pharmacy departments already have varying levels of CQA programs for medication events in place; therefore it is expected that implementation of the OCP CQA program will help drive consistency, enhance existing CQA programs and assist care providers share best practices and lessons learned from medication events. In addition, for hospitals that do not have an appropriate medication event reporting system, the requirement from OCP will ensure this occurs.

2. What would support successful implementation?

Response:

- Trial sites; in particular sites located in hospitals and other collaborative healthcare settings with varying sizes, governance structures and levels of current CQA programs.
- Clearly defined standard fields for medication event reporting submissions; Suggest that this be developed by a working group that would include key stakeholders, software vendors, as well as hospital and community pharmacy participants. A key outcome of this work would be to enable ease of reporting and the ability for interface between different systems.
- Interfaces to existing medication event reporting software to reduce the need for manual or duplicate reporting of medication events.
- One time funding to support the cost of hospitals and other collaborative care settings to transition from existing systems to systems that conform to the requirements of the OCP CQA program.
- A focus on sharing of information and best practices that can be obtained from the medication event database. Ideally the database should enable proactive review of trends and provide summaries of key findings. This information should be made available to all pharmacies.
- Collaboration with organizations and jurisdictions that have implemented medication reporting systems such as the Institute for Safe Medication Practices, Nova Scotia, National System for Incident Reporting.
- Develop metrics and benchmarks to enhance the ability for participating organizations to strive for excellence and understand strengths and areas for improvement in relation to peer organizations. Again, this information should be made available to all pharmacies.

3. How could the College help with the implementation?

Response:

- Refer to response to Question 2
4. What are you are already doing in your pharmacy around CQI and continuing quality assurance?

Response:

- The majority of hospital pharmacy departments already have varying levels of CQA programs for medication events in place. It is recommended that OCP work closely with hospitals and other collaborative healthcare settings and CSHP-OB to harvest the experience gained from the use of these systems to help drive the design and implementation of the OCP CQA Program.

5. Is it reasonable to implement the CQA program in two phases?

- Yes, it is reasonable to implement the CQA program in two phases. CSHP-OB recommends that hospital pharmacies of varying sizes, structures and maturity levels of medication event reporting participate in the first phase of CQA program implementation. The benefit of this approach will be to help ensure key success factors, challenges and opportunities that are unique to the hospital setting are identified in the first phase of implementation, prior to full program implementation.

CSHP-OB would also like to provide some additional recommendations and considerations related to the proposed CQA program:

- Recommend 'Near Miss' events be included as reportable medication events.
- Recommend that medication events can be reported by any staff member of an organization to which the program applies, i.e., do not limit ability to report medication events to registrants of the Ontario College of Pharmacists.
- Recommend inclusion of additional elements in the procurement process for the CQA database vendor; specifically elements that could be used to streamline and allow for analysis and benchmarking of hospital assessment criteria with a potential link back to medication event reporting.
- Consideration be given to a CQA program whereby members of the public could submit a medication event and receive a follow-up report specific to that medication event.

- Consideration be given to transparency and public access to the medication event database.
- Consideration be given to the reality that reporting a medication event is only one aspect of a CQA program; careful review, discussion with team members, root cause analysis and process improvements will also need to be incorporated into a CQA program to maximize impact on safety.
- Consideration be given to the potential unintended consequence of shifting pharmacists and pharmacy technicians from value add patient care activities to workload related to the need to transcribe and/or duplicate medication event reporting due to system design or lack of interface ability of event reporting systems.

Thank you for the opportunity to provide feedback and note that CSHP-OB executive is available to discuss any of the points raised in this submission in more detail.

Respectfully submitted on behalf of CSHP-OB executive and council,



Ryan Itterman

President, Canadian Society of Hospital Pharmacists – Ontario Branch