August 6, 2018

Re: CSHP Ontario Branch Response to Consultation – *Supplemental Standard of Practice: Mandatory Standardized Medication Safety Program in Ontario Pharmacies*

Dear colleagues at the Ontario College of Pharmacists:

The Canadian Society of Hospital Pharmacists (CSHP) is a national voluntary organization of pharmacists committed to patient care through the advancement of safe, effective medication use in hospitals and other collaborative healthcare settings.

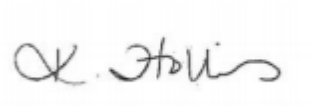
Members of CSHP Ontario Branch (CSHP OB) have reviewed the *Supplemental Standards of Practice: Mandatory Standardized Medication Safety Program in Ontario Pharmacies,* the following feedback was received and collated for your review and consideration:

- While the OCP Supplemental Standard of Practice recommend that each instance of reporting be ***anonymous,*** hospitals have had success with incident reporting systems that are not anonymous. In fact, the anonymity would hinder any attempts for follow-up and additional investigation required to determine the root cause of an incident. This process is described in the ***"Analyze" step***. Please give some consideration that anonymity of incident reporting may hinder the ability to determine ***causal factors*** and identification of root cause flaws in the systems/processes.
- Given that most hospitals have established electronic incident reporting systems that are not anonymous, will the anonymity be solely at the level of the third-party incident reporting system for the purposes of the College's Medication Safety Program?
- Will the third-party incident reporting system accept aggregate reports from hospitals? Hospital electronic incident reporting systems contain patient and staff confidential information. How will this information be handled by the third-party incident reporting system?
- There is concern on behalf of hospital Pharmacists for the requirement of double-reporting (documenting in 2 separate systems: the hospital's incident reporting system and the College's third-party incident reporting system). Is the College/third-party incident reporting system working with electronic reporting vendors to have data from the current programs interface/send-receive data to the third-party vendor's system? Or will Pharmacists have to enter the incident into 2 separate systems in order to fulfill the reporting requirement? Challenges with dual reporting have already been encountered since the Ontario Hospital's Association mandate in 2011 to report critical incidents into CIHI's National System for Incident Reporting (NSIR). The specific challenges encountered from dual reporting are:
    - Finding the time for the dual reporting. The burden will be significant if all near misses and incidents are to be reporting in the College's third-party incident reporting system.
    - Ensuring any and all organization/unit/patient identifying information from any free-text fields is deleted prior to submission.
- What are the capabilities of the third-party incident reporting system? Will hospital pharmacies be able to view aggregate data for all hospitals across the province?
- Will collaborative care settings Pharmacists be able to review aggregate medication incident reporting data specific to their practice settings?

- Will specific guidelines for reporting be developed? Hospitals use many acronyms (ie: MD, RN, RPN, ER, ID) that are not accepted by NSIR and are therefore sent back to the organization for correction. The development of specific guidelines and acceptable reporting practices will be valuable to minimize the requirement to correct reports and this in turn will increase reporting compliance.
- How will the College ensure that work will not have to be duplicated for hospital and collaborative care setting Pharmacists where adequate medication safety governance has been established? As per the Medication Management Standards of Health Services Organization (previously Accreditation Canada), all institutions must establish an interdisciplinary committee that oversees medication safety within the institution. Will hospitals be able to leverage this governance over medication safety for the purposes of this program?
- Will the requirement include the mandatory of reporting all medication related incidents? Hospitals have many medication related incidents that are not directly related to Pharmacy processes (i.e.: delayed administration of a medication – due to factors not within the control of the Pharmacy department). Will these incidents have to be reported to meet the College's requirements?

Please contact me if you have any questions or would like CSHP OB to provide more information on this feedback. Thank you for the opportunity to provide this feedback.

Sincerely,



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