May 1, 2017

Ontario College of Pharmacists
483 Huron Street
Toronto, Ontario
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Via email: consultations@ocpinfo.com

RE: Open consultation feedback on a standardized continuous quality assurance program for medication safety

United Pharma Group (UPG) welcomes the opportunity to provide comments on the proposed implementation of a Continuous Quality Assurance (CQA) program for Medication Safety, including the reporting of anonymous medication incident data to a third party.

UPG represents the interests of more than 90 independent pharmacy owners across Ontario. Our members and their pharmacy teams are committed to patient safety and to providing optimal, effective care to their patients in their everyday practice.

Medication incidents are the single most preventable cause of patient harm. Furthermore, the occurrence of medication incidents compromises patients' confidence in the healthcare system, in addition to increasing overall healthcare costs. It is important to note though that a significant number of these incidents arise in prescribing and it is often the pharmacist that plays a key role in intervening to prevent such errors from reaching the patient. In fact, the causes of many medication incidents are multifactorial.

> *Hence, while we applaud the proposed CQA program to standardize incidents' reporting and enhance learnings from them within the pharmacy sector, we strongly advise that the CQA program, through its continuous quality improvement (CQI) process, adopts a multi-disciplinary approach to collect and share the learnings arising from medication incidents between various healthcare professionals, locally, provincially and nationally, in order to truly create a collaborative culture that promotes and enables learnings from medication incidents to minimize and ultimately prevent their recurrence.*

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UPG supports having a mandatory consistent standard for medication incidents reporting for all pharmacies, with the goal to help pharmacy professionals to learn from those incidents, and to enhance their practice accordingly. To achieve this goal, pharmacy team members would need to embrace a 'culture of safety' where there is an understanding and appreciation of the value of collaborative learning from an incident that occurred, rather than a focus on placing or exchanging blame. This shift from 'who' to 'what', 'how' and 'why' would ultimately need to be supported by the designated manager and/or pharmacy owner to constantly drive and foster a 'culture of safety', a 'culture of learning' and a 'culture of continuous improvement' rather than a 'culture of fear', a 'culture of blame' or a 'culture of punishment'.

> *To enable this shift, the reported incidents should not carry direct or indirect penalties or punitive actions either from employers or the College. Furthermore, the College should facilitate online and on-site continuing education, training and coaching to effectively address any cynical concerns prior to the full implementation of the CQA program, and to provide the necessary reassurance to members on how the data collected will be utilized.*

To that end, UPG supports that the proposed reporting is anonymous, is made to an independent objective third party and is distinct from College processes. The fact that individual medication incidents reported will not be received by the College is paramount to encourage increased timely reporting and to mitigate any concerns of potential blame or disciplinary measures.

> *Since the purpose of the data collection is to support practice improvements and learnings, it is important that the College implements a mechanism to share on a regular basis with pharmacy professionals the identified common areas, trends and patterns of risk and provide accordingly, in collaboration with the independent third party or the Ontario Pharmacists Association, appropriate training, coaching, continuing education programs, practice resources and/or guidance documents.*

A key barrier to reporting medication incidents is the fact that it could be too time consuming. Therefore, to ensure standardized, accurate, timely and complete reporting, the process of report submission would need to be streamlined.

> *UPG hence proposes the following measures for consideration:*
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> - *Since medication incidents do also include 'near misses' and 'no harm events' that could have resulted in unwanted consequences but were addressed before*

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reaching the patient, it would be important to clearly outline and define what needs to be reported and what doesn't.

- *Since 'near misses' and 'no harm events' are typically addressed at the pharmacy level through making the necessary changes to a patient's prescription in the dispensing software to reprint/re-adjudicate, it would certainly be very helpful if there is coordination in place between the pharmacy dispensing software and the independent third party which would allow for seamless flow of information in such situations without having to duplicate documentation. For instance, if the dispensing software captures the reason a prescription was edited or cancelled (ex. Wrong directions), then ideally that information should directly flow anonymously to the independent third party as a 'near miss' or 'no harm event' without requiring the pharmacy professional to re-enter that information into the independent third party's reporting system. This would certainly facilitate the reporting process and positively impact workflow and time management.*
- *Since incidents can be caused by a variety of causes and factors at various stages of the prescription prescribing and dispensing processes (ex. Wrong drug, dose, quantity prescribed or dispensed, etc.), it would be very helpful to have a drop-down menu and/or check-boxes for the common categories (which could be identified based on learnings from other jurisdictions that currently require mandatory incidents reporting). This would minimize the amount of time for report completion.*
- *To ensure accurate submission of completed incident reports, it would also be helpful to clearly identify the fields that are mandatory, which will prevent unintentional submission of incomplete reports.*

Recognizing the value of measuring the aggregate data collected in order to qualify the progress achieved from this initiative, UPG is inquiring on what metrics and benchmarks will be used if any. Furthermore, should certain target reporting rates be set, would some pharmacies be identified as 'under-reporting' or would the process be completely anonymous? In addition, there are many factors why a pharmacy could be reporting more than another (based on prescriptions volume, complexity of patients mix or practice, etc.). Hence, if certain metrics would be adopted, how would those other factors be assessed? If the program is completely anonymous, are there any measures the College would be implementing to evaluate the success of the CQA program? To that end, further clarity is required on how the anonymous mandatory reporting will be enforced and inspected.

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UPG therefore supports the College's proposed two phased approach for implementation, with the first phase involving volunteer pharmacies that would help assess the program requirements. As there are many unique pharmacy practice settings, it would be prudent to ensure that there are pharmacies representative of those various settings, volumes, workflows and locations in the pilot phase, which would help mitigate any unforeseen challenges in the implementation of the second phase. While full implementation in all pharmacies is expected by December 2018, we recommend that there would be flexibility in potentially amending that date depending on the outcome and findings from the first phase.

United Pharma Group appreciates the opportunity to provide commentary on the College's consultation on the proposed implementation of a Continuous Quality Assurance program for Medication Safety. We strongly believe in the value of implementing such program which promotes sharing the learning from medication incidents and appreciate the positive impact it would have on advancing patient safety.

Yours truly,

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