Ontario College of Pharmacists
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Agenda

ONTARIO COLLEGE OF PHARMACISTS

COUNCIL MEETING AGENDA

MONDAY, DECEMBER 12, 2016 – 9:00 A.M.

OCP COUNCIL CHAMBERS

1. Noting Members Present

2. Declaration of Conflict

3. Approval of Agenda

4. President's Opening Remarks

4.1 Briefing Note - President's Report to December 2016 Council ..... Appendix 1

4.2 Briefing Note - September 2016 Council Meeting Evaluation ..... Appendix 2

5. Approval of Minutes of Previous Meeting

5.1 Minutes of Special Meeting of Council (November 24, 2016) ..... Appendix 3

5.2 Minutes of September 2016 Council Meeting ..... Appendix 4

6. Notice of Motions Intended to be Introduced

7. Motions, Notice of Which Had Previously Been Given

8. Inquiries

9. Matters Arising from Previous Meetings

9.1 Briefing Note – Acting Registrar's Report to December 2016 Council ..... Appendix 5

- Ministry/Legislative Initiatives
- *Patients First Act*
- Sexual Abuse Task Force
- Digital Health
- Opioid Abuse
- Medication Error Reporting
- Federation of Health Regulatory Colleges of Ontario
- National Association of Pharmacy Regulatory Authorities
- Ontario Pharmacists Association
- Strategic Priorities Progress Update
- Quality Assurance and Registration Regulation Update
- Appointment of Inspectors
- Program Updates/Presentations

10. Discussion and Decision

10.1 Briefing Note – Executive Committee (Continuous Quality Improvement for Medication Safety) ..... Appendix 6

11. For Information

None

12. Other Matters

12.1 Presentation by Drs. Zubin Austin and Heather Boon, Leslie Dan Faculty of Pharmacy, University of Toronto
Time: 1:30 – 2:00 p.m.

13. Unfinished Business

14. Motion of Adjournment

As a courtesy to other Council Members, you are requested to please turn off any devices that may cause disruption during the Council Meeting. There are breaks scheduled throughout the day in order to allow members the opportunity to retrieve and respond to messages.

Please note: *The College is a scent free environment. Scented products such as hairsprays, perfume, and scented deodorants may trigger reactions such as respiratory distress and headaches. In consideration of others, people attending the College are asked to limit or refrain from using scented products. Your co-operation is appreciated.*

Thank you.

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COUNCIL BRIEFING NOTE
MEETING DATE: DECEMBER 2016

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Régis Vaillancourt, President

TOPIC: President's Report to December 2016 Council

ISSUE: As set out in the Governance Manual, the President is required to submit a report of activities at each Council meeting.

BACKGROUND: I respectfully submit a report on my activities since the September 2016 Council Meeting. In addition to regular meetings and phone calls with the interim Registrar and the Vice President, listed below are the meetings, conferences or presentations I attended on behalf of the College during the reporting period. Where applicable, meetings have been categorized into general topics or groups.

Other Stakeholder Meetings:

November 19th	Ontario Branch – CSHP Annual General Meeting

College Meetings:

September 22nd	Conference call – discuss Executive and Council meetings for 2016/2017
September 26th	Search Committee Meeting - Review Long List
September 27th	Hospital Advisory Group Meeting
October 5th	Registrar/CEO Candidate Interviews
October 6th	Registrar/CEO Candidate Interviews
October 18th	Conference call - Search Committee
October 26th	Accreditation Committee Meeting
October 27th	Conference call - New Council Member Orientation
October 28th	Search Committee Meeting - Second Round of Interviews
November 4th	Discipline Committee Meeting
November 10th	Conference call - Search Committee
November 18th	Conference call with ISMP re Medication Errors Reporting
November 24th	Executive Committee Meeting and Special Meeting of Council

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COUNCIL BRIEFING NOTE
MEETING DATE: DECEMBER 2016

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Regis Vaillancourt, President

TOPIC: September 2016 Council Evaluation Report to December 2016 Council

ISSUE: As set out in the Governance Manual, after each Council meeting, Council performs an evaluation of the effectiveness of the meeting and provides suggestions for improvement.

BACKGROUND: At the September 2016 Council meeting, we again provided Council members with the opportunity to provide their feedback. 21 Council members responded to the survey. A summary of the input is being provided to Council for information.

1. Governance philosophy Council and staff work collaboratively, each in distinct roles, to carry out self-regulation of the pharmacy profession in the interest of the public and in the context of our mission statement and legislated mandate. How would you evaluate the meeting overall?

Answer Options	Always	Frequently	Often	Occasionally	Never	Response Count
1. In accordance with the governance philosophy, topics were related to the interest of the public and the purpose of OCP	20	1	0	0	0	21
2. Members were well prepared to participate effectively in discussion and decision making	10	10	1	0	0	21
3. In accordance with the governance philosophy, Council worked interdependently with staff	17	4	0	0	0	21
4. There was effective use of time	13	6	2	0	0	21
5. There was an appropriate level of discussion of issues	15	3	3	0	0	21
6. The discussion was focused, clear, concise, and on topic	11	6	4	0	0	21

2. Did the meeting further the public interest?

YES = 100%
NO = 0%

3. Identify the issue for which you felt the discussion and decision-making process worked best, and why.

- Police clearance - good discussion and resolution
- Adoption of the Model Standards for Pharmacy Compounding for Sterile Preparations (NAPRA 2016) and inclusion of DPP to follow same standards. Excellent and constructive input from the PPC, (Compounding Working Group) and the OCP staff
- Presentation on governance process
- Changes proposed in the quality assurance committee
- Managing the discussion by having everyone speak before any one could speak again, gives more order to the meeting and gives everyone a chance to speak.
- In general all the discussions and decision-making process worked well.

- The discussion on proposed changes to the registration process was excellent.
- I believe that the discussion surrounding the reports and the discussions of their contents was appropriate.
- discussion about registration and QA changes

4. Identify the issue(s) for which you have felt the discussion and decision-making process was not effective, and why. Note any areas where the distinction between governance and operations was unclear

- None
- We should consider the Canadian guide to good governance by Kerr & King as opposed to the American Robert's Rules
- Registration committee discussion about criminal/police check for licensing.
- Even with the above process, some issues are misunderstood by a few members
- I do not have a comment

5. Using the Code of Conduct and Procedures for Council and Committee Members as your guide, in general, how satisfied are you with Council members' ability to demonstrate the principles of accountability, respect, integrity and openness?

Answer Choices	Responses
Completely Satisfied	14
Mostly Satisfied	7
Neither Satisfied Nor Dissatisfied	0
Mostly Dissatisfied	0
Completely Dissatisfied	0
Total Responses	0

6. Suggestions for improvement and General Comments (name of respondent - optional)

- The meeting was nicely paced and all points of view considered in a fair way.
- Need to include medical/personal LOA when presenting Council and committee attendance in past year For finance report - need to have PowerPoint of budget details (excel sheets are too detailed) C. Donaldson
- None
- I look forward to having Regis as the president. He demonstrates both effective leadership skills and timeliness. Karen Riley
- Good meeting. Sylvia Moustacalis
- Great meeting. Good discussion and involvement of all. Good application of the rules of order to keep us focused.
- Just my first meeting and still new to the process! Overall, meeting was good. First day was not typical from my understanding - and the second day was definitely more interactive with discussion of issues. Looking forward to more discussion - however, ones which ensure efficient use of words and time. Will have more feedback next time I'm sure! Billy Cheung

Respectfully submitted,

Regis Vaillancourt, President

Ontario College of Pharmacists

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MINUTES OF SPECIAL MEETING

OF COUNCIL

NOVEMBER 24, 2016

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THURSDAY, NOVEMBER 24, 2016 – 11:01 A.M.

VIA CONFERENCE CALL/IN-PERSON
&
COUNCIL CHAMBERS SOUTH, ONTARIO COLLEGE OF PHARMACISTS

Elected Members

District H	Dr. Régis Vaillancourt, Ottawa – In person
District H	Ms. Christine Donaldson, Windsor – Via conference call
District K	Dr. Esmail Merani, Carleton Place – In person
District K	Ms. Tracey Phillips, Westport – Via conference call
District L	Mr. Billy Cheung, Markham – Via conference call
District L	Mr. James Morrison, Burlington – In person
District L	Dr. Sony Poulose, Hamilton – Via conference call
District M	Mr. Fayez Kosa, Toronto - Regrets
District M	Mr. Don Organ, Toronto – In person
District M	Ms. Laura Weyland, Toronto – Via conference call
District N	Mr. Gerry Cook, London – In person
District N	Mr. Chris Leung, Windsor – Via conference call
District N	Dr. Karen Riley, Sarnia - Regrets
District P	Mr. Jon MacDonald, Sault Ste. Marie – Via conference call
District P	Mr. Douglas Stewart, Sudbury - Regrets
District T	Ms. Michelle Filo, Sudbury - Regrets
District TH	Mr. Goran Petrovic, Kitchener – Via conference call

Dr. Heather Boon, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto - Regrets
Dr. David Edwards, Hallman Director, School of Pharmacy, University of Waterloo – Via conference call

Members Appointed by the Lieutenant-Governor-in-Council

Ms. Kathleen Al-Zand, Ottawa – Via conference call
Ms. Linda Bracken, Marmora – Via conference call
Ms. Carol-Ann Cushnie, Toronto - Via conference call
Mr. Ronald Farrell, Sundridge - Via conference call
Mr. Naj Hassam, North York - Regrets
Mr. Javaid Khan, Markham - Via conference call
Mr. John Laframboise, Ottawa - In person
Mr. James MacLaggan, Bowmanville - Via conference call
Ms. Sylvia Moustacalis, Toronto – In person
Mr. Shahid Rashdi, Mississauga - Via conference call
Ms. Joy Sommerfreund, London - Via conference call
Mr. Ravil Veli, North Bay - Via conference call
Mr. Wes Vickers, LaSalle - Regrets

Staff present

Ms. Connie Campbell, Director, Finance and Administration
Ms. Ushma Rajdev, Council and Executive Liaison

1. Noting Members Present

The President thanked the Council members for attending this Special Meeting of Council and after establishing that all members participating in the conference call were able to hear the proceedings and each other, Council member attendance was determined through a roll-call.

2. President's Opening Remarks

Dr. Vaillancourt explained that while some of the meeting material was distributed ahead of time, due to the nature of the discussion, there were certain documents that would be made available to Council members once the meeting moved *in camera*.

3. Declaration of Conflict

There were no conflicts declared.

4. Approval of Agenda

It was moved and seconded that the Agenda be approved. CARRIED.

5. Motions respecting Committee-of-the-Whole

Since this issue pertained to a personnel matter, and accordingly met the requirements for having an in-camera session under section 7 of the Health Professions Procedural Code**, it was moved and seconded that Council do now, at 11:06 a.m., move into Committee-of-the-whole. CARRIED.**

Council discussed the appointment of the Registrar and CEO.

It was moved and seconded that at 11:55 a.m., Council do now rise from Committee of-the-Whole. CARRIED.

6. Motion respecting Appointment of CEO and Registrar

It was moved and seconded that Council approve the appointment of Ms. Nancy Lum-Wilson as CEO and Registrar of the Ontario College of Pharmacists effective January 9, 2017. Council members voted unanimously in favour of the motion. **CARRIED.**

7. Other Matters/Unfinished Business

7.1 Motion respecting Dissolution on the Search Committee

With the mandate of the Search Committee fulfilled, **it was moved and seconded that the Search Committee be dissolved. CARRIED.**

8. Motion respecting Circulation of Minutes of Special Meeting of Council

A motion to approve the circulation of the draft minutes of this Special Meeting of Council to Council members was moved and seconded. CARRIED.

9. Motion of Adjournment

It was moved and seconded that the Council meeting be adjourned at 11:56 a.m. and to reconvene on Monday December 12, 2016, or at the call of the President. CARRIED.

Ushma Rajdev
Council and Executive Liaison

Régis Vaillancourt
President

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Ontario College of Pharmacists

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MINUTES OF MEETING

OF COUNCIL

SEPTEMBER 19 AND 20, 2016

Page

MONDAY, SEPTEMBER 19, 2016 – 9:04 A.M.

COUNCIL CHAMBERS, ONTARIO COLLEGE OF PHARMACISTS

Elected Members

District H	Dr. Regis Vaillancourt, Ottawa
District H	Ms. Christine Donaldson, Windsor
District K	Dr. Esmail Merani, Carleton Place
District K	Ms. Tracey Phillips, Westport
District L	Mr. Billy Cheung, Markham
District L	Mr. James Morrison, Burlington
District L	Dr. Sony Poulose, Hamilton
District M	Mr. Fayez Kosa, Toronto
District M	Mr. Don Organ, Toronto
District M	Ms. Laura Weyland, Toronto
District N	Mr. Gerry Cook, London
District N	Mr. Chris Leung, Windsor
District N	Dr. Karen Riley, Sarnia
District P	Mr. Jon MacDonald, Sault Ste. Marie
District P	Mr. Douglas Stewart, Sudbury
District T	Ms. Michelle Filo, Sudbury
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Dr. Heather Boon, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto
Dr. David Edwards, Hallman Director, School of Pharmacy, University of Waterloo

Members Appointed by the Lieutenant-Governor-in-Council

Ms. Kathleen Al-Zand, Ottawa
Ms. Linda Bracken, Marmora
Ms. Carol-Ann Cushnie, Toronto
Mr. Ronald Farrell, Sundridge
Mr. Javaid Khan, Markham
Mr. John Laframboise, Ottawa
Mr. James MacLaggan, Bowmanville
Ms. Sylvia Moustacalis, Toronto
Mr. Shahid Rashdi, Mississauga - **Regrets**
Ms. Joy Sommerfreund, London
Mr. Ravil Veli, North Bay
Mr. Wes Vickers, LaSalle

Staff present

Ms. Connie Campbell, Director, Finance and Administration
Ms. Susan James, Director, Competence
Mr. Marshall Moleschi, CEO and Registrar
Ms. Ushma Rajdev, Council and Executive Liaison
Ms. Anne Resnick, Deputy Registrar/Director, Conduct

Invited Guest

Mr. Richard Steniecke, Partner, Steinecke Maciura LeBlanc

1. Noting Members Present

Member attendance was noted.

2 Declaration of Conflict

There were no conflicts declared.

3. Approval of Agenda

It was moved and seconded that the Agenda be approved. CARRIED.

4. President's Opening Remarks

For the benefit of Council members not in attendance at the previous evening's Farewell Reception for Registrar Moleschi, President Merani provided a brief summary of the event.

He welcomed new members, Ms. Tracey Phillips from District K, Mr. Billy Cheung, Mr. James Morrison and Dr. Sony Poulose from District L to the Council table. Also welcomed was recently appointed public member, Ms. Carol-Ann Cushnie (Toronto). Mr. James MacLaggan, public member from Bowmanville, was also welcomed to the Council table (appointed in April but was unable to attend the June Council meeting due to prior commitments). Council also noted returning members from District K, Dr. Merani, Ms. Michelle Filo from District T, and Mr. Goran Petrovic from District Th.

All new members were requested to briefly introduce themselves to Council and the President advised that as is customary, they had been paired with a more senior Council member for informal mentoring.

4.1 Briefing Note - President's Report to September 2016 Council

Dr. Merani referred to his report which summarized his activities since the previous Council meeting. These included attending various committee meetings at the College and various phone calls and meetings with the Registrar and the Vice President. Referencing the Governance Manual, Dr. Merani advised that meeting attendance was required to be recorded and reported annually and that this information was attached to his report.

A correction was noted to the September 18, 2015 Council meeting attendance (Mr. MacDonald was present, Mr. Stewart was not).

4.2 Briefing Note - June 2016 Council Meeting Evaluation

The President referred Council members to the June 2016 Council meeting evaluation and noted that although the number of respondents had dropped, the feedback on the whole had been positive. Council members were encouraged to continue to provide feedback which will serve to ensure efficiency and enhance Council members' participation at these meetings.

5. Annual Council Member Orientation and Committee Chair Training

Next, Dr. Merani introduced Mr. Richard Steinecke and invited him to conduct this annual quarter day education session. Mr. Steinecke presented an overview of the Governance Model adopted by the College, after which Council members participated in several governance scenarios.

6. Approval of Minutes of Previous Meeting

6.1 Minutes of June 2016 Council Meeting

It was moved and seconded that the Minutes of the June 2016 meeting be approved. CARRIED.

7. Notice of Motions Intended to be Introduced

There were none.

8. Motions, Notice of Which Had Previously Been Given

There were none.

9. Inquiries

There were none.

10. Briefing Note - Registrar's Report on Election of Members to Council

Mr. Moleschi reported that elections were held in Districts K, L, T and TH and his Report on Elections was received for information by Council.

11. Briefing Note - Elections Committee

A motion to receive the Elections Committee Report was moved and seconded. CARRIED.

Dr. Merani, Chair of the Elections Committee, presented the report to Council. He advised that the Elections Committee was appointed at the June 2016 Council meeting and the Committee met on August 25, 2016 to put together the slate of members being presented in the Report. He advised that the slate was based on preferences indicated by the Council members and that during the elections process, in addition to the slate being presented, names could be withdrawn or members nominated from the floor.

Council members also noted for information that after the election of President, Vice President, Executive Committee and Committee Chairs had been conducted, Council would continue with the remainder of the items on the agenda and that upon adjournment later that afternoon, the Nominating Committee, together with the new Chairs of the Statutory and Standing Committees, would convene to discuss the appointments. He noted that while every effort will be made to appoint members according to their preferences, Council members needed to be cognizant that there will also be appointments to committees in order to meet composition and workload requirements. The finalized slate would be presented to Council for approval the following day.

12. Appointment of Tellers

Ms. Campbell and Ms. James were appointed as tellers for the upcoming Council elections.

13. Election of President

It was noted that there was one candidate (Dr. Vaillancourt) nominated for the position of President. No further nominations were received from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Dr. Vaillancourt was declared President for the 2016/2017 term after which he delivered brief remarks to Council.

14. Election of Vice President

Council noted that there was one candidate (Ms. Donaldson) for the position of Vice President. No further nominations were received from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Donaldson was declared Vice President of the College for the 2016/2017 term and she delivered brief remarks to Council.

15. Past President Award

On behalf of Council, Past President Merani was recognized and presented with gifts by President Vaillancourt. Dr. Edwards, President of the Canadian Foundation for Pharmacy, also presented Dr. Merani with the Past President's award on behalf of the Foundation.

16. Appointment of Nominating Committee

It was moved and seconded that together with newly elected President, Dr. Vaillancourt and Vice President, Ms. Donaldson, Dr. Merani and Ms. Sommerfreund be appointed to serve on the Nominating Committee. The motion CARRIED.

17. Election of Executive Committee Members

Elections were held for the elected member position on the Executive Committee. Council noted that Mr. Organ and Ms. Weyland had expressed an interest in serving on the Executive Committee. No further nominations were received from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

The President invited both candidates to briefly address Council. Mr. Organ spoke first, followed by Ms. Weyland. Following the speeches, Council members were requested to cast their ballots and the tellers collected the ballots and left the chambers to count the votes. It was noted that the result would be announced after the election of public members had occurred.

Council next noted that Ms. Al-Zand, Ms. Bracken, Mr. Farrell, Ms. Moustacalis and Ms. Sommerfreund had all expressed an interest in serving on the Executive Committee. No further nominations were received from the floor. **A motion to close the nominations was moved and seconded. The motion CARRIED.** All five candidates were invited to provide brief remarks to Council and Council members were required to cast their votes (i.e. mark their ballots for up to three candidates). Dr. Vaillancourt explained that the candidate receiving the fewest votes would be removed from the ballot and the voting would continue until such time as there were three candidates remaining.

Following the voting and counting of ballots, Ms. Campbell announced that ballots would need to be re-cast for the remaining candidates - Ms. Al-Zand, Mr. Farrell, Ms. Moustacalis and Ms. Sommerfreund. Council members cast their ballots a second time and following the count, Ms. Campbell announced all four public members had received an equal number of votes. It was agreed by Council that the tie be broken by lot to determine the successful candidates. Accordingly, Dr. Merani was invited to draw the names and he announced that Ms. Moustacalis, Ms. Sommerfreund and Mr. Farrell would be serving on the Executive Committee for the 2016/2017 term.

Ms. Campbell next announced that Ms. Weyland had been elected to serve on the Executive Committee.

18. Election of Committee Chairs

Accreditation and Drug Preparation Premises Committees (DPP)

The President noted that Ms. Philips had been nominated for the position of Chair of the Accreditation and DPP Committees. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Phillips was declared Chair of the Accreditation and DPP Committees.

Discipline Committee

The President noted that Mr. Stewart had been nominated for the position of Chair of the Discipline Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Mr. Stewart was declared Chair of the Discipline Committee.

Finance and Audit Committee

The President noted that Mr. Khan had been nominated for the position of Chair of the Finance and Audit Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Mr. Khan was declared Chair of the Finance and Audit Committee.

Fitness to Practise Committee

The President noted that Ms. Al-Zand had been nominated for the position of Chair of the Fitness to Practise Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Al-Zand was declared Chair of the Fitness to Practise Committee.

Inquiries, Complaints and Reports Committee (ICRC)

The President noted that Ms. Weyland had been nominated to serve as Chair of the ICRC. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Weyland was declared Chair of the Inquiries, Complaints and Reports Committee.

Patient Relations Committee

The President noted that Ms. Sommerfreund had been nominated to serve as Chair of the Patient Relations Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Sommerfreund was declared Chair of the Patient Relations Committee.

Professional Practice Committee

The President noted that Mr. Leung had been nominated to serve as Chair of the Professional Practice Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Mr. Leung was declared Chair of the Professional Practice Committee.

Quality Assurance Committee

The President noted that Mr. MacDonald had been nominated to serve as Chair of the Quality Assurance Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Mr. MacDonald was declared Chair of the Quality Assurance Committee.

Registration Committee

The President noted that Ms. Donaldson had been nominated to serve as Chair of the Registration Committee. There were no further nominations from the floor and **a motion to close the nominations was moved and seconded. The motion CARRIED.**

Ms. Donaldson was declared Chair of the Registration Committee.

Motion respecting destruction of ballots

A motion to destroy the ballots was moved and seconded. The motion CARRIED.

19. Matters Arising from Previous Meetings

19.1 Briefing Note - Registrar's Report to September 2016 Council

Mr. Moleschi highlighted the salient points from his report and responded to questions from the floor.

Regarding Bill 21 *Safeguarding Health Care Integrity Act/Drug and Pharmacies Regulation Act (DPRA)*, Mr. Moleschi reported that, the amendments to the regulation to the DPRA which, among others, add provisions for the inspection of pharmacies within public and private hospitals, had been approved by cabinet on July 20, 2016 and the Bill came into force on August 1, 2016.

As part of Bill 21, changes were also made to the *Regulated Health Professions Act (RHPA),* which are intended, among other things, to improve information-sharing between health regulatory colleges and other healthcare organizations such as public health authorities and public hospitals. The Lieutenant Governor in Council approved August 1, 2016 as the date on which these changes, and corresponding changes to the *Public Hospitals Act*, will come into force.

Registrar Moleschi then provided an update on Bill 119, *The Health Information Protection Act*, which contains provisions to amend the *Narcotics Safety and Awareness Act, 2010* (NSAA), noting that the Act was proclaimed into force on June 3, 2016. These amendments support more informed health care decisions by permitting the ministry's disclosure of monitored drug dispensing data to other health care providers rather than just the original prescriber and dispenser, and also permitting disclosure to new prescribers, when deciding whether or not to prescribe a monitored drug.

As shared with Council on September 9, 2016, the Report from the Minister's Task Force on Prevention of Sexual Abuse of Patients was released and the Registrar advised Council that it is expected that the Government will base its actions on the Task Force's recommendations from this Report. In fall 2016, it is expected that legislative amendments will be brought forward that will: (1) add to the expanded list of acts that will result in the mandatory revocation of a regulated health professional's license, (2) remove the ability of a college to allow a regulated health professional to continue to practice on patients of one gender after an allegation or finding of sexual abuse, (3) increase fines for health professionals and organizations that fail to report a suspected case of patient sexual abuse to a college, (4) increase transparency by adding to what colleges must report on their public register and website, (5) clarify the time period after the end of a patient-provider relationship in which sexual relations are prohibited, and (6), fund patient therapy and counselling from the moment a complaint of sexual abuse is made.

This College is committed to supporting and protecting patients from sexual abuse by pharmacy professionals and will work with the government to build on current college processes to ensure patient protection.

Registrar Moleschi next reported that together with the President, on August 25th, he signed the sealed regulation regarding amendments to the *Pharmacy Act* regulations which will authorize pharmacists to administer select vaccines. The proposed amendments will further authorize pharmacy students and interns to administer injections — both those under the Universal Influenza Immunization Program and the selected vaccines — subject to the terms, limits and conditions imposed on their certificate of registration. Proclamation of this regulatory amendment is expected this fall.

Referring to the issue of opioid abuse, the Registrar explained that in June 2015, the Government of Ontario joined other provinces and territories in calling for Health Canada to

remove the prescription status of naloxone. The change in status was finalized by Health Canada in March of 2016. On June 24, 2016, the National Association of Pharmacy Regulatory Authorities' (NAPRA) scheduling change for naloxone hydrochloride injection (naloxone) was finalized. Naloxone, when indicated for emergency use for opioid overdose outside hospital settings, was listed as a Schedule II drug, and as a result, effective June 24, 2016, does not require a prescription to be sold in Ontario pharmacies if it meets that criteria. In response to questions from the floor, the Registrar explained that as with any drug, in addition to using professional judgement, members are expected to apply standards of practice, guidelines and the code of ethics when making clinical decisions, and to document all actions.

The Registrar next advised that following the passage of Medical Assistance in Dying (MAID) legislation on June 17, 2016, pharmacists and pharmacy technicians are now exempted from criminal liability when dispensing a prescription that is written by a medical or nurse practitioner in providing medical assistance in dying. The College has developed a Guidance Document on this issue. As well, the Ministry of Health and Long-Term Care has a webpage designed to provide the general public, patients and providers with MAID-specific information, guidance and resources. The Ministry, specifically the Ontario Public Drug Programs Division, has also developed more resources for pharmacies and dispensing physicians.

The Registrar reported that on July 13th, together with Ms. Campbell and Ms. James, he met with Minister Hoskins and reported that the Minister recognized the great number of accomplishments that this College has achieved in working collaboratively with his staff and ministry officials. Mr. Moleschi added that the meeting was very positive and resulted in a commitment from the Minister to continue to work on a few outstanding issues and regulation approvals and further, that he will be looking to work with the College in the fall to implement common ailments as part of pharmacist's scope of practice.

Council also noted for information that the Federation of Health Regulatory Colleges of Ontario (FHRCO), of which this College is a member, has embarked upon a multi-year, multi-faceted project to inform the public about regulation and specifically about Ontario's health regulatory system. Year one of the project includes the development of a strategic communications plan and website, with a staged approach, and beginning with a comprehensive research phase. A public-facing website will be the first output of this collaborative work.

Next, Ms. Campbell was invited to provide a brief overview of the College's Operational Plan. Council members were referred to the framework which demonstrates the noteworthy accomplishments for the quarter. It was noted that this reporting enables Council to better monitor the progress of the goals and priorities set by Council in March 2015, and the Registrar reminded Council that while it does not get involved in operational matters, it does hold the Registrar accountable for operational performance outcomes (including implementing the operational aspects of the Council's strategic plan).

20. For Decision

20.1 Briefing Note – Finance and Audit Committee

A motion to receive the Briefing Note from the Finance and Audit Committee was moved and seconded. CARRIED.

Mr. Khan, Chair of the Finance and Audit Committee, presented the Briefing Note to Council. The document outlined the operating and capital budget for 2017, which supports the Strategic Plan developed by Council in March 2015 and the Operational Plan presented to Council in June 2015.

Together with Ms. Campbell, Director of Finance and Administration, Mr. Khan responded to questions from the floor and provided clarification where necessary.

Council noted that as a result of continued growth in membership and moderate increases in expenses for 2017, no fee increases are required. Operating expenses are budgeted to equal revenue; capital expenditures will be funded by reserves if no operating surplus materializes throughout 2017.

A motion to approve the 2017 Operating and Capital Budget was moved and seconded. CARRIED.

20.2 Briefing Note – Finance and Audit Committee

A motion to receive the Briefing Note from the Finance and Audit Committee was moved and seconded. CARRIED.

Mr. Khan advised that the Finance and Audit Committee had recommended the reappointment of Clarke Henning LLP Chartered Accountants as Auditors for the College for the 2016 fiscal year.

The auditors were selected in 2014 following an external review of the College's auditing and financial services and the Finance and Audit Committee is satisfied that the firm continues to meet the College's requirements. **A motion to approve the appointment of Clarke Henning LLP as Auditors for the College for the fiscal year 2016 was moved and seconded. CARRIED.**

Adjournment

At 2:59 p.m. the President declared the meeting adjourned and advised Council members that the Nominating Committee and the newly elected Chairs would now meet to discuss the appointment of members to the Statutory and Standing Committees.

TUESDAY, SEPTEMBER 20, 2016 – 9:00 A.M.

COUNCIL CHAMBERS, ONTARIO COLLEGE OF PHARMACISTS

Elected Members

District H	Dr. Regis Vaillancourt, Ottawa
District H	Ms. Christine Donaldson, Windsor
District K	Dr. Esmail Merani, Carleton Place
District K	Ms. Tracey Phillips, Westport
District L	Mr. Billy Cheung, Markham
District L	Mr. James Morrison, Burlington
District L	Dr. Sony Poulose, Hamilton
District M	Mr. Fayez Kosa, Toronto
District M	Mr. Don Organ, Toronto
District M	Ms. Laura Weyland, Toronto
District N	Mr. Gerry Cook, London - **Regrets**
District N	Mr. Chris Leung, Windsor
District N	Dr. Karen Riley, Sarnia
District P	Mr. Jon MacDonald, Sault Ste. Marie
District P	Mr. Douglas Stewart, Sudbury
District T	Ms. Michelle Filo, Sudbury
District TH	Mr. Goran Petrovic, Kitchener

Dr. Heather Boon, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto
Dr. David Edwards, Hallman Director, School of Pharmacy, University of Waterloo

Members Appointed by the Lieutenant-Governor-in-Council

Ms. Kathleen Al-Zand, Ottawa
Ms. Linda Bracken, Marmora
Ms. Carol-Ann Cushnie, Toronto
Mr. Ronald Farrell, Sundridge
Mr. Javaid Khan, Markham
Mr. John Laframboise, Ottawa
Mr. James MacLaggan, Bowmanville
Ms. Sylvia Moustacalis, Toronto
Mr. Shahid Rashdi, Mississauga - **Regrets**
Ms. Joy Sommerfreund, London
Mr. Ravil Veli, North Bay
Mr. Wes Vickers, LaSalle

Staff present

Ms. Connie Campbell, Director, Finance and Administration
Ms. Susan James, Director, Competence
Mr. Marshall Moleschi, CEO and Registrar
Ms. Ushma Rajdev, Council and Executive Liaison
Ms. Anne Resnick, Deputy Registrar/Director, Conduct

22. Other Matters

22.1 Approval of Appointments to Statutory and Standing Committees

The President referred Council to the Committee appointments list distributed earlier in the day and thanked the Nominating Committee and the newly-elected Chairs of the statutory and standing committees, who had met the previous afternoon, for their work in this appointment process.

A motion to approve the appointments to the Statutory and Standing Committees was moved and seconded. CARRIED.

20. For Decision

20.4 Briefing Note - Quality Assurance Committee

A motion to receive the Briefing Note from the Quality Assurance Committee was moved and seconded. CARRIED.

Mr. MacDonald, Chair of the Quality Assurance (QA) Committee presented the briefing note to Council. Noting that the Quality Assurance Regulations will require amendments to incorporate pharmacy technicians, the QA Committee requested Council to: (1) consider the two-part register for both pharmacy technicians and pharmacists; and (2) shift from hourly reporting of practice to confirmation of competence.

Mr. MacDonald set out the benefits of maintaining the two-part register and to incorporate pharmacy technicians to align with the current register of pharmacists (part A for those engaged in patient care; and part B for those in non-patient care practice). Council members were referred to the framework which provided the rationale for the proposed approach, along with the suggested timeline.

A motion to approve the continuation of a two-part register to include both pharmacists and technicians was moved and seconded. CARRIED.

Council was next requested to consider moving to a requirement that members declare that they have completed sufficient practice to maintain competence in patient care within the member's area of practice, in place of the current hourly practice requirement.

Mr. MacDonald explained that in making this recommendation, the QA Committee had considered the lack of evidence among health professions correlating minimum practice hours to competence. Thus, the Committee considered that a practice hour requirement as a measure of competence was not defensible, and may lead to a false sense of assurance that a member was meeting the standards of the profession. He added that the proposed amendments to the regulations will remove the requirement of attaining a minimum number of practice hours for members in Part A. On an annual basis, instead of reporting hours, a member would declare they are maintaining the competence necessary to provide patient care.

As well, the approach to Quality Assurance is evolving from applying a standardized competence assessment in a test environment to evaluating actual performance at a member's practice site, focusing on the areas of patient assessment, decision-making, communication and education/documentation. This approach provides a better measure of competence than reporting hours and can be administered in conjunction with pharmacy assessments, such that at least 10% of member's can be assessed each year, instead of less than 2% in the current model. Council further noted that the completion of a declaration supports transparency and aligns with the notion of placing the patient at the centre of the model and furthermore, will allow competent practitioners who do not meet the minimum hours' requirements in the current model, to be able to provide patient care.

It was noted that the regulations will be outcomes-based, supported by standards, policies and guidelines which can change over time to enable practice evolution. Questions respecting specifics were asked and it was noted that a lot of the operational and language details would be examined over the next few months. Following lengthy debate on this recommendation, **it was moved and seconded that Council approve the replacement of the practice declaration of '600 hours over three years' with a practice declaration that the member has completed sufficient practice to maintain competence in patient care within the member's area of practice.** With the exception of one abstention (Mr. Kosa), Council members voted in favour of the motion. There were no negative votes. **The motion CARRIED.**

20.3 Briefing Note – Registration Committee

A motion to receive the Briefing Note from the Registration Committee was moved and seconded. CARRIED.

Ms. Donaldson, Chair of Registration Committee, presented the briefing note to Council. The Registration Committee, it was noted, made two recommendations for Council's consideration: (1) consider implementing a single provisional class of registration for Pharmacists and Pharmacy Technicians (i.e. combining Student and Intern class for Pharmacists and adding Pharmacy Technicians); and (2) adding a requirement for registration candidates to complete police background checks.

As with the previous briefing note, Council noted that proposed amendments to the Registration Regulation will be outcomes-based and high level rather than specific, and that approved standards, policies and guidelines will be utilized to address issues wherever possible.

Ms. Donaldson provided the rationale for the first recommendation, noting that current registration regulations do not include a mechanism to register pharmacy technicians post-graduation while other registration requirements are being completed. As well, many requirements for students and interns are duplicated throughout the registration process and the proposed amendments will ensure a more streamlined registration process that will be compliant with the *Fair Access to Regulated Professions and Compulsory Trades Act* and with the recommendations of the Office of the Fairness Commissioner.

Following discussion, **a motion was moved and seconded that Council approve the establishment of a single provisional class of registration for Pharmacists and Pharmacy Technicians (i.e. combining Student and Intern class for Pharmacists; adding provisional class for Pharmacy Technicians). The motion CARRIED.**

Referring to the second recommendation, Council noted that the current Registration Regulation does not have a mechanism to require applicants to provide police background checks, and while the declaration of good character is required to be updated upon annual renewal, or in the event of new character-related incidents, there have been instances where the College has learnt of applicant or member conduct that has not been disclosed to the College voluntarily through other means (e.g. anonymous tips, news items, complaints).

It was moved and seconded that Council approves the addition of Police Background Checks as a requirement for registration (any class) with the College. In discussing this recommendation, there were several questions relating to operational and language application, the type of conduct that would be covered, and staff explained that the Registration Committee will be developing standards, policies and guidelines to address these issues.

Ms. Phillips noted that while she was fully in support of the recommendation, the requirement for a “police background check” was one of many means to obtain information, and suggested that it may be more appropriate to use broader language, such as a “criminal record check” which could provide a different level of investigation. Discussion ensued on the type of investigation the various “checks” provided, what this would mean for an out-of-province or out-of-country registrant, and while it was noted that Council was committing to high-level principles at this time, **a motion to amend the language to approve the requirement of the addition of a “criminal record check” instead of a “police background check” was moved and seconded.** Following discussion, the President called for a vote on the amendment. 12 members voted in favour of the amendment and 15 members voted against. The motion to amend was defeated.

Ms. Donaldson re-read the original motion**: that Council approve the addition of Police Background Checks as a requirement for registration (any class) with the College.** Council members voted in favour of the motion, Mr. Kosa voted against the motion, and there were no abstentions. **CARRIED.**

20.5 Briefing Note – Sterile Compounding Working Group

Mr. Leung, Chair of the Sterile Compounding Working Group, was invited to address Council. **A motion to receive the Briefing Note for discussion was moved and seconded. CARRIED.**

Following an extensive consultation process, the National Association of Pharmacy Regulatory Authorities (NAPRA), approved national standards for pharmacy compounding of hazardous and non-hazardous sterile preparations. This College established a working group comprised of pharmacy professionals currently working within the area of compounding to consider these standards. The working group proposed that the NAPRA standards be adopted and implemented in Ontario, in parallel with the official implementation of USP 800 in the United States. However, the group also completed a consultation with pharmacy professionals and stakeholders from May 13, 2016 to June 30, 2016 on the length of time required to implement the standards. Specifically, feedback was sought on the challenges members would face in order to meet the proposed implementation date; and the time period required to conduct a gap-analysis against the standards and create an action plan leading to implementation. Although 65% of the 52 respondents opposed the two year implementation timeline, the working group noted that the preparation of medications (pharmacy compounding) has always been an integral part of the practice of pharmacy and current pharmacy practice for the preparation of sterile products in Canada already incorporates many of the patient safety and quality assurance requirements of these new standards.

Council noted the key comments set out in the briefing note, in particular the summary of feedback from the consultation, and following discussion**, a motion was moved and seconded that Council approve the adoption of the *Model Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations (NAPRA, 2016)* and the *Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations (NAPRA, 2016)* and approved implementation by January 1, 2019. CARRIED.**

21. For Information

21.1 Briefing Note – Statutory and Standing Committee Reports

President Vaillancourt next advised Council that as required in the *Regulated Health Professions Act* and the College by-laws, all statutory committees are required to submit an annual report to Council. He added that the reports were provided for information only and that none of the material in the reports was new but essentially a re-cap of what had occurred and reported during the previous Council year.

21.2 Briefing Note – Patch for Patch Working Group

Council was next referred to an informational item from the Patch for Patch Working Group. Dr. Vaillancourt noted that this working group was chaired by Dr. Nashat who is no longer on Council. As staff support to this working group, Ms. Tina Perlman, Manager, Community Practice, was invited to address Council.

In an effort to combat the abuse, misuse, and diversion of prescription fentanyl, the provincial government passed new legislation which requires patients who receive a prescription for fentanyl to return their used patches to a pharmacy before receiving new ones. Ms. Perlman advised Council that this College and the College of Physicians and Surgeons of Ontario (CPSO) both strongly support this new legislation, as well as the government's approach to delineate specific roles and responsibilities for physicians and pharmacists when prescribing and dispensing fentanyl.

As a result, both Colleges have been working together with the Ministry of Health and Long-Term Care and have created a joint Fact Sheet which outlines the specific roles and responsibilities for physicians and pharmacists when prescribing and dispensing fentanyl. Council noted that the regulations under *the Safeguarding our Communities Act (Patch for Patch Return Policy)* will take effect on October 1, 2016

The Fact Sheet was received for information by Council.

22. Other Matters

22.2 Appointment of Interim Acting Registrar

President Vaillancourt advised that before adjourning, and saying farewell to Registrar Moleschi, Council would need to appoint an Interim Acting Registrar.

It was moved and seconded that as of October 1, 2016, Ms. Anne Resnick, Deputy Registrar, be appointed Interim Acting Registrar until such time as a new Registrar is in place. Council members voted unanimously in favour of the motion. **The motion CARRIED.**

Motion respecting Circulation of Minutes

A motion to approve the circulation of the draft minutes of this Council Meeting to Council members was moved and seconded. The motion CARRIED.

23. Unfinished Business

Mr. Moleschi took the opportunity to say his farewell to Council members.

Dr. Vaillancourt then requested Ms. Campbell to provide a brief update from the Search Committee. Council noted that following the retention of Ms. Heather Connelly of Phelps group to recruit and assist the Search Committee in selecting a new Registrar and CEO, Council, staff and college stakeholders were invited to provide input on the mandate for the new Registrar.

From this input, a Candidate profile was created and the Search Committee met in early August to confirm the profile. Over the summer, emails were sent to various stakeholders (pharmacy regulatory authorities, government, pharmacy networks, etc.) to seek a suitable candidate. She added that the Search Committee will be meeting in a few weeks to review the long list of applicants, from which a shorter list of candidates for interviews will be compiled. Ms. Campbell

advised that in the event that the Search Committee was successful in selecting a candidate by mid-October, a Special Meeting of Council will be called in order to ratify the Search Committee's recommended candidate.

25. Motion of Adjournment

It was moved and seconded that the Council meeting be adjourned at 11:55 a.m. and to reconvene on Monday December 12, 2016, or at the call of the President. The motion CARRIED.

Ushma Rajdev
Council and Executive Liaison

Regis Vaillancourt
President

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Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: DECEMBER 2016

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Anne Resnick, Interim Acting Registrar

TOPIC: Report to December 2016 Council

ISSUE: As set out in the Governance Manual, Council holds the Registrar accountable for the operational performance of the organization. As well, the Registrar is responsible for reviewing the effectiveness of the College in achieving its public interest mandate and the implementation of the Council's strategic plan and directional policies. As such, the Registrar is expected to report on these activities at every Council meeting.

BACKGROUND: As the Interim Acting Registrar, I respectfully submit a report on the activities since the September 2016 Council Meeting. In addition to various internal meetings with staff and regular meetings and phone calls with the President and the Vice President, summarized below are some of the meetings I attended and matters that I dealt with on behalf of the College during the reporting period.

Ministry/Legislative Initiatives

On September 23, 2016, the Ontario's Premier provided the Minister of Health and Long-Term Care with a mandate letter (attached) on the priorities for his ministry.

Of note is that all pieces of legislation that were introduced, but had not passed the previous legislature, effectively died when the legislature was prorogued. However, the Premier is committed to re-introducing all of them during the fall sitting. The *Patients First Act* was re-introduced on October 6, 2016 and is currently in second reading. If passed, the government's expectations are that the *Patients First Act* will improve access to health care for patients and their families by various mechanisms, of which the following may impact OCP:

- Improving local connections and communication between family doctors, nurse practitioners, inter-professional health care teams, hospitals, and home and community care;
- Ensuring that patients only have to tell their story once, by enabling health care providers to share and update their health care plans;
- Providing better patient transitions between acute, primary, home and community, mental health and addictions, and long-term care;
- Improving consistency of home and community care across the province; and
- Strengthening health planning and accountability by monitoring performance and outcomes

On October 31, 2016, along with Ms. Judy Chong and Ms. Susan James, at the invitation of the Ministry of Health and Long-Term Care, I met with Assistant Deputy Ministers and Directors of Health Capital, Delivery and Implementation, and Health System Accountability and Performance. The purpose of the meeting was to give an update on College efforts to protect the public and ensure high quality hospital based pharmacy services, consistent with our new oversight responsibilities.

Sexual Abuse Task Force

In December of 2014, Minister Hoskins launched a task force to review and modernize laws that deal with sexual abuse of patients by health professionals. On September 9, 2016, the government publicly released the task force's report entitled "To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991". In response to the report, Minister Hoskins announced the government's intention to bring forward legislative changes in the fall of 2016 that would:

- Add to the expanded list of acts that will result in the mandatory revocation of a regulated health professional's license;
- Remove the ability of a college to allow a regulated health professional to continue to practice on patients of one gender after an allegation or finding of sexual abuse;
- Increase fines for health professionals and organizations that fail to report a suspected case of patient sexual abuse to a college;
- Increase transparency by adding to what colleges must report on their public register and website;
- Clarify the time period after the end of a patient-provider relationship in which sexual relations are prohibited; and
- Fund patient therapy and counselling from the moment a complaint of sexual abuse is made.

Furthermore, the Minister committed to working with an expert to improve the processes that health regulatory colleges must follow when dealing with sexual abuse complaints, investigations and disciplinary measures and plans to bring forward further measures by winter 2017 to:

- Identify more ways for patients to participate in the complaints, investigation and discipline processes at health regulatory colleges; and
- Enhance knowledge and education among the public, patients and health professionals.

Digital Health

On October 7, 2016, Minister Hoskins released a letter (attached) he wrote to Ed Clark, the Premier's Business Advisor and Chair of the Advisory Council on Government Assets. In his letter, Minister Hoskins requests Mr. Clark's expert advice in valuing public and private assets with respect to Ontario's digital health strategy. eHealth was established in 2008 with a mandate to establish and maintain electronic health records for all Ontario's residents. The mandate of eHealth Ontario expires at the end of December 2017 and Minister Hoskins is looking for an assessment on the province's existing digital health assets before establishing a new digital health strategy. Specifically, Mr. Clark has been asked to provide the following:

- A value assessment of Ontario's digital health assets and all related intellectual property and infrastructure; and
- Recommendations related to how to maximize the value of these assets for Ontarians by improving how care is delivered, the patient experience in interacting with the health care system and, indirectly, through the economic value that is created for Ontario's economy.

Currently, most family physicians in Ontario have electronic medical records in their practice and nearly all hospital-based diagnostic imaging is digital and key lab results are available through a provincial information system. However, there remains much work to be done to fulfill the digital health mandate. Minister Hoskins has indicated that patients should be able to access their own health records, book physician appointments online, keep track of medicines, renew

prescriptions electronically and access services and advice remotely.

Opioid Abuse
On October 12, 2016, Minister Hoskins announced an Opioid strategy that focuses on enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services. The strategy was supported by the recommendations of the Methadone Treatment and Services Advisory Committee, which was established by the province to advise on strengthening Ontario's methadone treatment and related services. Ontario's strategy to prevent addiction and overdose includes:

- Designating Dr. David Williams, Ontario's Chief Medical Officer of Health, as Ontario's first-ever Provincial Overdose Coordinator to launch a new surveillance and reporting system to better respond to opioid overdoses in a timely manner and inform how best to direct care.
- Developing evidence-based standards for health care providers on appropriate opioid prescribing that will be released by end of 2017-18 to help prevent the unnecessary dispensing and over-prescribing of pain killers.
- Delisting high-strength formulations of long-acting opioids from the Ontario Drug Benefit Formulary starting January 1, 2017 to help prevent addiction and support appropriate prescribing.
- Investing $17 million annually in Ontario's Chronic Pain Network to create or enhance 17 chronic pain clinics across the province, ensuring that patients receive timely and appropriate care.
- Expanding access to naloxone overdose medication, available free of charge for patients and their families through pharmacies and eligible organizations to prevent overdose deaths.
- Increasing access to Suboxone addiction treatment and improving patient outcomes and integration of care for those using this treatment.
- Beginning October 1, 2016, stricter controls on the prescribing and dispensing of fentanyl patches took effect. Patients are now required to return used fentanyl patches to their pharmacy before more patches can be dispensed.

A letter from Minister Hoskins and Dr. Williams is attached for Council's information. In addition, following a recent national meeting, the Federal Minister of Health, the honourable Jane Philpott, and Minister Hoskins, issued a "Joint Statement of Action to Address the Opioid Crisis". To read more, click on http://www.healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/opioids-opioides/conference-cadre/statement-declaration-eng.php.

Medication Error Reporting
On October 20, 2016, media reports surfaced concerning an eight-year-old boy named Andrew Sheldrick, who had died in the spring of 2016, as a result of a medication error. A coroner's report concluded that the pharmacist mistakenly gave Andrew a muscle relaxant drug used to treat muscle spasms caused by conditions such as multiple sclerosis and Andrew had three times the toxic dose in his system. Andrew's mother is calling on the provincial government to implement a mandatory medication error reporting system and to date, has collected over 2,000 signatures on a petition.

In response to the incident, Minister Hoskins stated "I will be looking specifically, in light of this tragic situation, to see if there's more that can be done in a transparent and accountable way," he said. "I will be working with the Ontario College of Pharmacists to see if there's more that can and should be done." The Minister added that he would also look into the process in Nova Scotia, the only province that requires the reporting and public notification of pharmacy errors, and said he would examine its experience with the issue. A briefing note on this matter is

included in this Council agenda.

Inter-Professional Relationships

Federation of Health Regulatory Colleges of Ontario (FHRCO) Update

The Federation of Health Regulatory College of Ontario (FHRCO) maintains a strategic focus on regulatory matters while promoting effective communication and cooperation among its members. During this reporting period, and as previously reported, the Federation continued its work on the development of a website focused on the public. Further information, as it becomes available, will be provided to Council.

The Federation also provided some preliminary feedback to the Minister's Sexual Abuse Task Force Report and Recommendations, as well as to the proposed amendments to the *Regulated Health Professions Act*. In general, the high level remarks and feedback express strong support for the intent and spirit of the recommendations and ask for further exploration and consultation by the Registrars of all FHRCO members.

Presentations/Other Stakeholder Meetings

National Association of Pharmacy Regulatory Authorities (NAPRA) Update

NAPRA is continuing to move forward on all the initiatives identified in its Strategic Plan for 2016-2017. The Registrars' group met in Saskatoon November 8, followed by the NAPRA Board meeting on November 9 and 10. Attached is a memorandum respecting the issues discussed at that meeting from Mr. Mark Scanlon, the College representative on NAPRA. Mr. Scanlon's memo also refers to proposed amendments to NAPRA's governance model, and a communication from NAPRA to the member organizations is attached for Council's consideration.

NAPRA recently provided the College with the Draft Model Standards for Pharmacy Compounding of Non-Sterile Preparations and requested feedback from the each of the Regulatory Authorities by early December. Given the broad application of these Standards to pharmacy practice, the College completed a 30-day consultation with pharmacists and pharmacy technicians, to help inform our feedback to NAPRA (a summary of the consultation is attached). The College's Compounding Working Group will also assist in preparation of the College's submission. Once finalized by NAPRA, the Standards will be presented to Council for consideration of their implementation.

Ontario Pharmacists Association (OPA)

As in previous years, the College was invited by the OPA to provide input on their updated Fee Guide. The College reiterated our position that the Guide should be considered in tandem with the College Policy on Fees for Professional Pharmacy Services and the Guideline on Dispensing Components Included in the Usual and Customary Fee, as well as in the context of the recently amended Code of Ethics, and that although the College does not have the authority to determine or establish fees, it does have the responsibility to investigate allegations that a fee is excessive in relation to the service provided. We also suggested that pharmacists be reminded of the rules related to disclosure, posting and filing of dispensing fees and the need for the patient to understand why a different fee is being charged and importantly, to agree to it.

Strategic Priorities Progress Update
A key part of the Registrar's performance is to regularly provide an update to Council on the College's Operational Plan. The program activities and intended outcomes support the priorities outlined in the Strategic Framework developed by Council in March 2015. Attached for Council's information is an update of progress made on the various strategic directions since the September 2016 Council meeting.

Quality Assurance and Registration Regulation Update
Drafting of the revised Quality Assurance and Registration Regulations has been initiated to reflect the changes discussed at September Council. The next step in our regulation development process is to share our regulatory position/framework with the Ministry so that any issues or concerns can be considered in the drafting. This is expected to occur early in the New Year. Accordingly, draft regulations should be ready for presentation to Council in March after which we will undertake broad stakeholder consultation as required.

Appointment of Inspectors
Attached for Council's information, and as required under by bylaws, is a memorandum on the Appointment of Inspectors.

Program Updates/Presentations
This reporting activity also includes regular program updates/presentations from the program managers. At this December Council meeting, I will invite Ms. Judy Chong, Manager, Hospital Practice, as well as Ms. Maryan Gemus, Manager, Investigations and Resolutions, to present to Council.

September 2016 Mandate letter: Health and Long-Term Care

Premier's instructions to the Minister on priorities.

Ontario

On this page

September 23, 2016
The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
80 Grosvenor Street
10th Floor, Hepburn Block
Toronto, Ontario
M7A 2C4
Dear Minister Hoskins:
Welcome back to your role as Minister of Health and Long-Term Care. As we mark the mid-point of our mandate, we have a strong and new Cabinet, and are poised to redouble our efforts to deliver on our top priority — creating jobs and growth. Guided by our balanced plan to build Ontario up for everyone, we will continue to work together to deliver real benefits and more inclusive growth that will help people in their everyday lives.
We embark on this important part of our mandate knowing that our four-part economic plan is working — we are making the largest investment in public infrastructure in Ontario's history, making postsecondary education

more affordable and accessible, leading the transition to a low-carbon economy and the fight against climate change, and building retirement security for workers.

Building on our ambitious and activist agenda, and with a focus on implementing our economic plan, we will continue to forge partnerships with businesses, educators, labour, communities, the not-for-profit sector and with all Ontarians to foster economic growth and to make a genuine, positive difference in people's lives. Collaboration and active listening remain at the heart of the work we undertake on behalf of the people of Ontario — these are values that ensure a common purpose, stimulate positive change and help achieve desired outcomes. With this in mind, I ask that you work closely with your Cabinet colleagues to deliver positive results on initiatives that cut across several ministries, such as our Climate Change Action Plan, Business Growth Initiative, and the Highly Skilled Workforce Strategy. I also ask you to collaborate with the Minister Responsible for Digital Government to drive digital transformation across government and modernize public service delivery.

We have made tangible progress, and we have achieved the following key results:

- Delivered Patients First: Action Plan for Health Care: the next phase of Ontario's plan for building a health care system that puts patients first, enabling us to deliver better, easier access to care.
- Introduced new legislation that would, if passed, provide Local Health Integration Networks an expanded role including in primary care, home and community care and public health in order to improve access and integrated service for patients.
- Launched a Roadmap to Strengthen Home and Community Care to help keep Ontarians safe and healthy in their communities as they age, including an investment of $750 million over three years that supports improved access to care and better consistency and quality of care.
- Improved access to fertility treatments for Ontario families and to sex reassignment surgery for transgender people.
- Completed a series of provincial stakeholder engagement sessions as part of a palliative care consultation and announced a new investment of $75 million over three years to improve access to community-based hospice and palliative care.
- Increased safety in long-term care homes with continued investments for resident care, specialized investments for behavioural supports, and an ongoing commitment to annual inspections of every long-term care home in the province.
- Worked with patients, patient advocacy groups and hospitals to develop a provincial approach to hospital parking pricing that is making hospital parking more affordable.
- Launched the next phase of the Mental Health and Addictions Strategy in collaboration with the Ministry of Children and Youth Services.
- Announced an investment of $222 million over the next three years for the First Nations Health Action Plan and, as part of Ontario's response to the Truth and Reconciliation Commission, announced investments to expand access to Indigenous Mental Health and Addictions Treatment and Healing Centres and mental health and wellness programs.
- Launched key initiatives to support public health and health promotion such as the Smoking Cessation Action Plan, expansion of Ontario's publicly funded vaccine program to include shingles coverage for eligible seniors and HPV (Human Papillomavirus) coverage for boys and the passage of the *Healthy Menu*

Choices Act, 2015.

- Provided support and stability to the health care workforce, including funding to improve primary care recruitment and retention of nurses and other interdisciplinary team members, as well as personal support worker (PSW) wage increases.
- Passed the *Health Information Protection Act* to improve the privacy, transparency and accountability of the health care system.

Your mandate is to provide leadership for the health care system. This leadership is focused on implementation of the Patients First Action Plan through delivery of integrated and comprehensive health services across primary and specialist care, home and community care, hospitals, and other health care settings. Your specific priorities include:

Access: Providing Timely Access to the Right Care

- Ensuring that patients who want a primary care provider have one.
- Implementing a publicly available performance report to track and report on primary care access, including attachment, same day/next day, after hours and weekend access.
- Improving availability of same-day, next-day, after-hours and weekend care by primary care providers to improve care and help reduce unnecessary emergency department visits.
- Bringing down wait times for specialists by improving the referrals process, better co-ordinating care, improving access to the right providers and making capital investments where appropriate.
- Implementing the expanded scope of practice of registered nurses to allow them to prescribe some medications directly to patients.
- Implementing the First Nations Health Action Plan to improve access to service and culturally appropriate care for Indigenous people in collaboration with the Ministry of Indigenous Relations and Reconciliation and Indigenous partners.
- Working with the Minister Responsible for Accessibility to establish a Standards Development Committee in fall 2016 to begin work on developing a health standard under the *Accessibility for Ontarians with Disabilities Act*.
- Ensuring, as you work to improve access to services, that a focus on equity of access is reflected in solutions.

Connect: Delivering Co-ordinated and Integrated Care in the Community and Closer to Home

- Developing a capacity planning framework to help support the provision of care in the most appropriate setting possible across the health care continuum — hospital, long-term care and community — by reducing the rate of Alternative Level of Care, lowering hospital readmission rates, implementing the Home and Community Care Roadmap, improving palliative care in all settings and making capital investments where appropriate.
- Connecting and integrating the mental health and addictions system for all patients, including co-ordination with the Ministry of Children and Youth Services, to ensure patients receive high quality care wherever

they access services, following advice received from the Mental Health and Addictions Leadership Advisory Council.
- Improving the safety and quality of life for those living in long-term care homes today and in the future, by considering necessary investments, including staffing, and by advancing the Enhanced Long-Term Care Home Renewal Strategy as quickly as possible and ultimately eliminating all four bed wards in Ontario's long-term care homes.
- Bringing forward a plan to make Ontario a leader in digital health care, in collaboration with the Minister Responsible for Digital Government, centred on the principle of improved patient access to information and health care services.
- Expanding culturally and ethnically appropriate continuum of care services for seniors, including in long-term care homes.

Inform: Providing Education, Information and Transparency to Support Informed Decision Making

- Developing a one-stop website that provides information to help people make choices about their health and effectively navigate the health care system.
- Making tangible improvements to the province's immunization system and aim to ensure caregivers can easily access the information they need on school-aged immunization.
- Providing education, information and targeted programs for Ontarians on responsible alcohol consumption to help people make better informed choices.
- Exploring opportunities to enhance the environmental health of Ontarians, including supporting research and engaging key stakeholders such health care providers, public health partners, and patients on potential areas of action.

Protect: Making Decisions Based on Value and Quality to Sustain the Health Care System for Generations to Come

- Undertaking additional initiatives that will reduce the misuse of prescription opioids across Ontario, and provide support to those with addictions.
- Increasing low-risk birthing options and availability to improve quality of care and value for the system.
- Working with the Minister Responsible for Women's Issues and the Violence Against Women Roundtable to take action to protect patients from sexual abuse, based on the recommendations of the Minister's Task Force on the Prevention of the Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991*.

In addition to the priority activities above, I ask that you also deliver results for Ontarians by driving progress in the following areas:

- Ensure the voices of patients, caregivers and stakeholders are heard and actively consulted through transformation of the health care system.
- Partner with health service providers on transformation. Make efforts to support health care workers to

ensure the demands we are placing on all levels of front-line workers are sustainable.

- Support the mandate of the newly established Patient Ombudsman as well as the planned provincial Patient and Family Advisory Council.
- Work with the Minister Responsible for Seniors Affairs on initiatives, such as the development of a dementia strategy that will especially impact seniors.
- Continue implementation of Immunization 2020 to improve vaccine coverage at all stages of life, from newborns to seniors.
- Continue to advance a national approach to public drug benefits that ensures equitable access to high quality prescription drugs for all Ontarians.
- Work with the Chief Health Innovation Strategist to drive collaboration across the health care system, and champion Ontario as a leading centre for new and innovative health technologies and processes.

As you know, taking action on the recommendations contained in the Truth and Reconciliation Commission report is a priority for our government. That is why we released *The Journey Together*, a document that serves as a blueprint for making our government's commitment to reconciliation with Indigenous peoples a reality. As we move forward with the implementation of the report, I ask you and your fellow Cabinet members to work together, in co-operation with our Indigenous partners, to help achieve real and measurable change for Indigenous communities.

Having made significant progress over the past year in implementing our community hubs strategy, I encourage you and your Cabinet colleagues to ensure that the Premier's Special Advisor on Community Hubs and the Community Hubs Secretariat, at the Ministry of Infrastructure, are given the support they need to continue their vital cross-government work aimed at making better use of public properties, encouraging multi-use spaces and helping communities create financially sustainable hub models.

Responsible fiscal management remains an overarching priority for our government — a priority echoed strongly in our 2016 Budget. Thanks to our disciplined approach to the province's finances over the past two years, we are on track to balance the budget next year, in 2017–18, which will also lower the province's debt-to-GDP (Gross Domestic Product) ratio. Yet this is not the moment to rest on our past accomplishments: it is essential that we work collaboratively across every sector of government to support evidence-based decision-making to ensure programs and services are effective, efficient and sustainable, in order to balance the budget by 2017–18, maintain balance in 2018–19, and position the province for longer-term fiscal sustainability.

Marathon runners will tell you that an event's halfway mark is an opportunity to reflect on progress made — but they will also tell you that it is the ideal moment to concentrate more intently and to move decisively forward. At this halfway mark of this government's mandate, I encourage you to build on the momentum that we have successfully achieved over the past two years, to work in tandem with your fellow ministers to advance our economic plan and to ensure that Ontario remains a great place to live, work and raise a family.

I look forward to working together with you to build opportunity and prosperity for all Ontarians.

Sincerely,

Kathleen Wynne

Premier

Updated: September 23, 2016

Published: September 23, 2016

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Open letter to Ed Clark

October 7, 2016

Further to our discussions, I am writing to seek your expert advice based on your experience in valuing public and private assets with respect to Ontario's digital health strategy.

As you know, over the last eight years, Ontario's health care system partners have worked steadily to establish a connected health information network with leadership from eHealth Ontario. eHealth was established in 2008 with a mandate to facilitate the establishment and maintenance of electronic health records for all of Ontario's residents. While the agency has encountered some setbacks and challenges, significant progress toward this goal has been achieved. Nearly all residents of Ontario who have interacted with the health system now have health records that are electronic. Most family physicians in our province have electronic medical records in their practices. In addition, nearly all hospital-based diagnostic imaging is now digital and key lab results are now available through a provincial information system

These systems have generated significant value for Ontario. In its 2015-16 annual report, Canada Health Infoway – the federal/provincial body charged with overseeing the use of innovative digital health solutions to improve Canadians' health – estimated that since 2007, digital health systems have produced an estimated $16 billion in benefits nationally . It is acknowledged that Ontario's share of the national benefits is substantial. In fact, a report prepared by CHI looking specifically at Ontario health technology accomplishments shows that the province is leading the country in several key areas.

Today, I am writing to you as the Premier's Business Advisor and Chair of the Advisory Council on Government Assets to assess and validate the value these systems have created for Ontario and to recommend ways to take them to the next level. Specifically, I am asking you to consider advising the government on two key issues with support from experts in digital health, as appropriate. First, I would ask you to provide the government with a value assessment of Ontario's digital health assets and all related intellectual property and infrastructure. Secondly, please provide us with recommendations related to how to maximize the value of these assets for Ontarians by improving how care is delivered, the patient experience in interacting with the health care system and, indirectly, through the economic value that is created for Ontario's economy. To inform the valuation, I would ask that you engage an international expert in digital health, such as Dr. John Halamka. In addition, please seek advice from the Information and Privacy Commissioner's Office of Ontario to ensure the protection of personal health information in all recommendations.

I believe there is growing opportunity in moving to a digital health care system. Consistent with the government's Digital Government plan, as announced in the 2016 Budget, our focus is shifting from providers to patients. We already have the infrastructure in place to connect and equip physicians, hospitals and other health care providers. Now, we need to focus on patient and consumer-focused tools and services that enable direct access to health information and improved care, such as accessing an individual's own health records, booking physician appointments online, keeping track of medicines, renewing prescriptions electronically, accessing services and advice remotely, and more. This is the direction that will serve emerging public and patient needs.

As the mandate of eHealth Ontario nears expiry at the end of December 2017, I feel now is the opportunity to renew our vision for digital health as part of our work to transform our health-care system into one that is truly patient-centred. Shortly, my ministry will be consulting with patients, health stakeholders and digital health experts about a new digital health strategy. But the full extent and value of our existing digital health assets must be fully understood if we are to move forward with a new vision.

I want to be absolutely clear that in the course of your work on digital health and your resulting

recommendation(s), the protection of personal health information is paramount. Enormous energy, resources and intellectual effort have been dedicated to ensuring the integrity and privacy of people's personal health information. The purpose of this work is to better understand the value of our digital assets to help guide, in combination with the advice of other experts, Ontario's future digital health strategy.

I hope you will accept my request to lead this work, and would welcome your advice before the end of December 2016 so that we can assess this information in advance of the final year of the agency's current mandate.

Signed,
Dr. Eric Hoskins
Minister of Health and Long-Term Care

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Ontario

HLTC2976IT-2016-238

Dear colleague:

Communities throughout North America and beyond are struggling to fight an increasing number of opioid-related overdoses. Unfortunately, Ontario is not immune to this epidemic. As health care providers, we've all seen the very real, human cost of opioid misuse and addiction. We ask that you stand with us now in taking action to end this public health crisis.

Between 2010 and 2014, the number of prescription opioids legally dispensed in Canada climbed almost 24 percent. In a country of 35 million people, more than 21.7 million prescriptions were dispensed. Opioid misuse is the third leading cause of accidental death in Ontario.

Building on the significant work already underway, today Ontario is announcing a comprehensive strategy to address opioid misuse and addictions. The plan, based on the expert advice we received from Ontario's Methadone Treatment and Services Advisory Committee, chaired by Dr. Meldon Kahan, among other expert and stakeholder groups, will ensure Ontario health care providers have the tools, resources and information needed to provide the highest-quality care to patients.

We are working with pain management experts and investing in Ontario's Chronic Pain Network to ensure that health care providers have the resources and tools they have told us are required for treating pain safely and effectively. As health care providers, it is important to ensure patients get the treatment they need – manage pain without risking addiction to opioids and help patients who are already suffering from addiction. In order to achieve this, patient access to interdisciplinary pain management teams and evidence-informed harm reduction services is being improved

Dr. Williams, Ontario's Chief Medical Officer of Health, will also be serving as Ontario's first Provincial Overdose Coordinator, and we are working closely to improve the surveillance of opiate overdoses and deaths and increase access to information concerning fatal and non-fatal opioid-related overdoses. Data from the Narcotics Monitoring System will be more readily available so you have up-to-date prescription records for your patients when making decisions concerning prescribing opioids.

Your voice and experience are key to the collective action required to turn the tide of this epidemic. We urge you to be an active participant in the upcoming consultations. We are engaging health care professionals and other service providers, patients, and individuals with lived experience to gain a deeper understanding of their needs and to ensure our actions are making a real difference.

Patients look to their health care providers for leadership and guidance. We hope that you will embrace this challenge and work with us as partners to stem this crisis for the good of all Ontarians. If we are going to reverse this trend, we must work together.

Yours sincerely,

Dr. Eric Hoskins
Minister

Dr. David Williams
Chief Medical Officer of Health

Ontario College of Pharmacists
Putting patients first since 1871

Memo

Date: **November 29, 2016**

To: **Executive Committee**

From: **Mark Scanlon, OCP Representative on NAPRA**

Re: **NAPRA Meeting Update – November 2016**

The NAPRA (National Association of Pharmacy Regulatory Authorities) Board of Directors meeting was held Wednesday, November 9 and Thursday, November 10, 2016 in Saskatoon, Saskatchewan.

Noted below are some of the key discussions held at that meeting.

Medical Marijuana

- NAPRA continues to support the existing evidence-based process for drug review, evaluation, and approval and does not support a separate process for this product; i.e. drugs available for sale in Canada should meet a high threshold for safety.
- CPRC (the Council of Pharmacy Registrars of Canada) would like to consider the broader issue of distribution in greater detail due to the complex nature of regulation development and enforcement. Anticipated timeline for this discussion is February 2017.

Participation on Pharmacy Specialization Working Group

- A needs assessment of specialization in pharmacy in Canada was funded by the Blueprint for Pharmacy with a grant from Walmart Canada, the Pharmacy Examining Board of Canada and the Canadian Council on Continuing Education in Pharmacy.
- Because there is provincial variation in approach to specialization, NAPRA considers its appropriate role to be observer, (not participant) pending terms of reference and more clarity.

Antimicrobial Resistance in Veterinary Drug Context

- NAPRA supports Health Canada proposal for regulatory changes requiring pharmacies importing Active Pharmaceutical Ingredients (API's) that contain medically important antimicrobials to have an Establishment License. This is in line with enhanced antimicrobial stewardship.

Review of Strategic Plan 2016-2017

- National Drug Schedules – not started due to emerging priorities
- Standards for non-sterile compounding – delayed due to prolonged consultation period
- Model Standards of Practice for Pharmacists – delayed, due to other key priorities in 2016
- Proactive Influence and Leadership – ongoing

The Board also approved the 2017 Budget, including the planned 2.5% increase to Member Fees.

Governance Review

- As NAPRA has evolved over its 20-year history, there has been recognition that a governance review was needed to examine challenges related to structure and function in order to strengthen the organization to better serve its members.
- An Ad-hoc Committee was created in April 2016 and with the support of the Institute on Governance, at this November meeting, the Committee put forth recommendations for the Board's consideration.
- A significant portion of this meeting was taken up with the discussion of the Ad-hoc Committee's recommendations, which the Board accepted *in principle*, and member organizations have been asked to provide feedback. A memorandum from NAPRA is attached for Council's review and consideration.

Respectfully submitted,

Mark F. Scanlon
OCP Representative on NAPRA

NAPRA ANORP
National Association of Pharmacy Regulatory Authorities ®
Association nationale des organismes de réglementation de la pharmacie

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Memorandum to: NAPRA Member Organizations

Date: November 24, 2016

Subject: Proposed Changes to NAPRA Governance

Context:

Good governance is a fundamental component of a healthy and productive organization. As NAPRA has evolved over its 20-year history, so has its governance needs. It has, therefore, been recognized by NAPRA's leaders that a governance review is now needed to examine challenges related to structure and function in order to strengthen the organization to better serve its members and for NAPRA's role within pharmacy in Canada.

With this in mind, in April 2016, NAPRA's Board of Directors created an Ad-hoc Committee on Governance ("the Committee" hereafter) to identify and/or validate concerns with the current governance approach, to explore options for improvement, and to make recommendations to the Board regarding governance changes. The Institute on Governance (IOG) was engaged to support the Committee in its work.

This memorandum serves to inform you – all NAPRA Member organizations – of the work of the Ad-hoc Committee on Governance and to share the recommendations it put forth. During the November 9th, 2016 meeting of the NAPRA Board of Directors, the Board reviewed the recommendations of the Committee. After valuable discussion, the Board accepted the recommendations *in principle* with the understanding that each Board member would share the recommendations with his/her Member Organization to inform each of the work undertaken to date, and to seek meaningful feedback from the their own Councils/Boards in order to move forward with a change in NAPRA's governance.

The remainder of this memorandum shares information under the topics of 1) deliberations of the Committee and the Board 2) the recommendations and 3) next steps.

Deliberations

As part of the governance review process, a data-gathering phase was undertaken in Spring 2016 that included a survey, focus group and interviews with Board members and registrars, as well as a review of key NAPRA documents.

That data-gathering phase identified and/or validated a number of key issues including:

1. The need to clarify NAPRA's purpose and value proposition into the future;
2. The need for the NAPRA Board to have a more strategic focus, with greater attention to organizational health, including financial and human resources, and effective monitoring and mitigating of risks, and for Board members to better understand their roles and responsibilities;
3. The need to address concerns regarding the duplication of effort between the Council of Pharmacy Registrars of Canada (CPRC) and the NAPRA Board; and
4. The need to improve governance and structure to allow NAPRA to become more nimble.

As *form follows function*, the mandate, mission and value proposition of NAPRA and its corresponding services were reviewed. The conclusion was that the mission and mandate remain sound and that programs and services generally align well with the value proposition. The data-gathering phase did identify somewhat differing views on the organization's value proposition (e.g. the role of NAPRA in running its own national programs), and although the differences were not significant to warrant addressing immediately, it was suggested that the Board review the organization's value proposition during its next visioning and strategy exercise, which is proposed to immediately follow completion of this governance review process.

With function assessed, form was considered. Numerous options for Board governance were analyzed, supported by a review of several case studies of other organizations to gain an understanding of the pros and cons of different models. It is recognized that no governance model is perfect and the goal is to seek a model that will best allow NAPRA to address the key issues identified above.

After contemplation of the pros and cons of a range of Board composition options, including representative, constituent and skills-based models, a number of specific composition options for NAPRA were reviewed, including 1) the current composition model with Member organization representatives[1] as the voting directors 2) the registrars as the voting members of the Board or 3) a mix of registrars and Member organization representatives[1] as the voting members.

Option 3 of having a Board composed of a mix of registrars and Member organization representatives[1] was rejected by the Committee because of concerns that this model would not address duplication of effort concerns. Thus, the Committee focused on the other two options – 1) the current composition model (note: in our current model, registrars do typically attend board meetings but they are not directors and do not have the right to vote) or 2) the option of having the registrars as the voting members of the Board.

As already indicated, no model will be perfect, and an analysis of the two options was undertaken, with the pros and cons of each outlined in the chart that follows.

[1] In practice, most Member organization representatives serving as NAPRA Board Directors are current or past Presidents of the Boards of the provincial/territorial regulatory authorities. Note also that some PRA's use the term 'President' and others use 'Chair of the Board' to describe the position of Board Chair.

Registrars as the Board		**Member Organization Representatives as the Board[1]**	
Pros	*Cons*	*Pros*	*Cons*
• More aware of the regulatory issues, in particular related to the day-to-day operations • Better able to understand and meet the needs of member organizations • Potentially more efficient use of staffing resources (no need to support both Board and CPRC) • Elimination of duplication of effort between Board and CPRC	• Lack of renewal / not possible to have term limits • Time commitment could be a challenge • Risk that not focused enough on "board work" and too much on former CPRC work • Conflict of interest in relation to fiduciary duty and legal obligations to their provincial/territorial boards of directors • Only one perspective (registrar) at the table – lack of 'front line' perspective • Potential for overconfidence & lack of consultation • Smaller selection pool to populate committees tasked to complete Board work	• Clarity of role / less risk of delving into operational issues • Somewhat broader range of perspectives at the board table, including 'front line' • Leadership development opportunity • Terms and term limits can be set	• Lack of detailed subject matter knowledge • Conflict of interest in relation to fiduciary obligations to both national and provincial/territorial organization if Board representative is a current President (or Past President still serving on PRA Board) • Continued duplication of effort (CPRC would continue to be required) • Potentially less efficient use of NAPRA staff resources (would still support Board and CPRC) • Full reliance on the Board to be fully informed to make adequate decisions if registrars not present at Board table

The issue of potential conflicts in fiduciary obligations was an important consideration, and it is acknowledged that this exists whether the Board is made up of Member organization representatives who are current Presidents (or Past Presidents who are still serving on PRA Boards) or made up of registrars. Overall it is felt that potential for actual conflicts to arise would be rare, and that the consensus-based model ensures the need for agreement (or stand aside) on all key decisions.

The need to reduce duplication of effort between the Board and CPRC and the need for pharmacy regulation expertise at the board table is believed to be the key consideration. Ideas on how some of the weakness of the registrars as the NAPRA Board could be addressed included potential modifications to the model with, for example, the addition of 'directors at-large' to the Board to bring a broader set of perspectives and ensure attention to the Board's governing role (and not just the work formerly done by CPRC).

The recognition of the risk that a Board populated by registrars could become too focused on issues that registrars addressed through CPRC at the expense of the Board's strategic, leadership and oversight roles, led to discussion of a potential meeting format to both complete the work formerly done by the CPRC and NAPRA's governance responsibilities. The Institute on Governance (IOG) introduced the concept of a Committee of the Whole. A Committee of the Whole is a structure in which a board of directors sits as a single committee with all board members being committee members. A Committee of the Whole deals with the detailed work assigned to it by the Board and makes recommendations to the Board. A practical example of this would be discussion of interjurisdictional issues that might lead to a recommendation to the Board (e.g. jurisdictional challenges and experiences on implementation of NAPRA's compounding standards). The benefit of the Committee of the Whole for NAPRA would be that it draws a clear line between the registrars (and other board members) meeting to share information, identify common issues, etc., and the same group meeting as a Board to fulfill its governance obligations.

Finally, a review was undertaken of how board meeting frequency, improving meeting structures, and ensuring active member engagement in the organization's priority setting could assist in addressing some of the potential shortcomings / risks in a new model, as well as facilitate NAPRA's ability to be more nimble than it has been able to be to date.

As noted earlier, the Board of Directors engaged in a half-day session to review and discuss the recommendations during their recent meeting on November 9th. The work of the Committee formed the basis of some very thoughtful and informed discussion. The dialogue, facilitated by the Institute on Governance, provided opportunity for response and discussion of questions and concerns raised by Board members and registrars, with particular focus on the new proposed composition of the Board. At the conclusion of the session, the Board supported the recommendations *in principle* with the understanding that engagement with their Member organizations about the NAPRA governance changes would be a next step.

Recommendations:

The following are the recommendations that were put forth by the Committee for consideration by the Board of Directors at the November 9th meeting. *(Note the wording used permits discussion of the concepts, and can be adapted for better structure for bylaws later)*:

1. Board Composition:
    - That the NAPRA Board consist of 14 individuals, comprised of the registrars from each of the provincial pharmacy regulatory authorities and representatives of the governmental agencies of the territories and Canadian Forces Pharmacy Services, plus up to three directors at-large
    - That the three directors at-large may include a registered pharmacist, a registered pharmacy technician and a public member (*Note: it is proposed that the Nominating Committee have final discretion to allow it to recommend those that best fit the Board's and NAPRA's needs).*
    - The Committee recommends that the 'public' director bring an independent view, and therefore not be a current or former pharmacist or pharmacy technician.
    - The Committee also recommends that the other two director at-large positions (for registered pharmacist and registered pharmacy technician) be drawn from outside the Boards of the PRAs to avoid conflicts of interest.

2. Terms:
   - That the registrars have one year, renewable terms without term limits.[2]
   - That the directors-at-large have a maximum of two consecutive three-year terms, and that terms be staggered
3. Decision-making
   - That the Board continue to operate with its existing consensus decision-making model, with stand aside option.
4. Meetings:
   - That the Board meet six times per year:
     - That four of the six meetings be in-person, for two days each
     - That the remaining two meetings be teleconference meetings, for two hours each.
5. Board Committees:
   - That there be no Executive Committee.
   - That the Board hold further discussions on the role and function of other standing and ad hoc committees, once the key decisions around Board structure and function have been made.
6. Board Advisory Committees:
   - That the CPRC be disbanded.
7. Board Leadership:
   - That the Chair of the Board continue to be elected by the Board.

In the preparation of these recommendations, some of the key risks of the proposed model were recognized and mitigation strategies identified for them:

Risk #1: Registrars as the Board may be too insular
Mitigation: Add directors at-large to bring other perspectives and skill sets

Risk #2: Terms and term limits not possible with registrars as the Board, leading to lack of renewal
Mitigation: Directors at-large, with terms and term limits, will allow for limited renewal

Risk #3: Registrars as the Board may be too focused on issues formerly addressed by CPRC
Mitigation: (1) Directors at-large may help ensure greater focus on governing role; (2) Meeting structures, including a 'Committee of the Whole' approach to former CPRC-work, will provide necessary structure to ensure both the 'detailed doing' work and the 'governing' work are completed; (3) An effective orientation process for new directors will ensure directors understand their roles and responsibilities.

Risk #4: Conflicts in fiduciary obligations and potentially employment obligations for registrars
Mitigation: (1) consensus-based decision making approach; (2) NAPRA members' (i.e. PRA Boards) input and buy-in regarding NAPRA priorities to be regularly sought.

[2] A registrar would remain as a Board Director as long as he/she is the registrar of the Member organization, but we are legally required to renew them each year through voting by members at our Annual General Meeting.

It was agreed that the following actions would occur following the November 9th, 2016 Board meeting – 1) that each Board member would take the recommendations back to each Member organization as already indicated and 2) that a communication tool would be provided to open the discussion for NAPRA's Board members within their own jurisdictions – this memorandum serves that latter purpose.

Next Steps

Any changes to NAPRA's governance *must be adopted by NAPRA's Member organizations* at a Special or Annual General Meeting (AGM). NAPRA's next Annual General Meeting will take place in 2017. NAPRA is your organization and it is your right and responsibility to set how it will be governed.

To keep the process moving forward productively, an Ad-hoc Committee on Governance Implementation was created at the November 9th, 2016 Board meeting to undertake a deeper examination into the expectations and the requirements for the implementation of a governance change, including: a timeline for implementation; the financial and staff resourcing impact; legal requirements; committee structure and population; ongoing communications; and other areas of relevance.

The work of the Ad-hoc Committee on Governance Implementation allows us to explore the intricacies of such a governance change, while at the same time moving forward with the critical engagement and discussion with all our Member organizations. This tandem effort of moving forward may enable NAPRA to be in a position to propose governance changes for Member approval at the April 2017 AGM.

What is most critical at this time is ensuring that each of you, NAPRA's Member organizations, are informed of the proposed changes and that you have the opportunity to understand the deliberations undertaken, and if you have any questions, to have them answered. Staff and members of our Committee are here to engage with you on this important proposal.

To allow us to keep moving forward to, hopefully, bring governance changes to our April 2017 AGM, we are seeking each Member organization's meaningful feedback on the recommendations **by February 20, 2017**, to allow us to adequately prepare for the AGM. In the meantime, members of the Committee, including myself, and Adele, our Executive Director, are available to assist however we can in your discussions, including arranging for someone to visit you in person or by teleconference to discuss the proposed recommendations with your Board/Council if you desire. Please do reach out to Adele or I and we will be happy to respond to your questions and coordinate any conversations to meet your needs as you consider the content of this memorandum.

We look forward to hearing from you and continuing with you in the evolution of our critical national association.

Anjli Acharya
President, NAPRA

Ontario College of Pharmacists
Putting patients first since 1871

Memo

Date: **December 2016**

To: **Council**

From: **Anne Resnick, Interim Acting Registrar**

RE: **Draft Model Standards for Pharmacy Compounding of Non-Sterile Preparations**

The College posted the *Model Standards for Pharmacy Compounding of Non-Sterile Preparations* for consultation between October 20 and November 17, 2016. All feedback received during the consultation is posted on the OCP website, in keeping with the College's consultation process and posting guidelines. Responses were received from a number of stakeholder groups including pharmacists, pharmacy technicians and pharmacy organizations:

Total Responses	
Pharmacist	20
Pharmacy Technician	4
Pharmacy Assistant	1
Applicant	1
Hospital	1
Compounding Pharmacy	4
Reply	3
Organizations • Ontario Pharmacists Association • Shoppers Drug Mart and Loblaw	2

The submissions are generally supportive of the publication and adoption of standards in this area. A significant amount of the feedback included detailed responses that are inserted into the consultation table provided by NAPRA for the submission.

THEMES

The College reviewed the submissions with the support of a Working Group comprised of pharmacy professionals in community pharmacy, or working within the area of non-sterile compounding, and identified the following themes:

Training

There is support for training, particularly with respect to safe handling techniques and the use of PPE and for an annual assessment and agreement for the position of a trained compounding supervisor, similar to what is indicated for Hazardous Sterile Products. There is support for annual skills assessment and the use of pharmacy assistants who are trained and experienced.

Levels of Compounding

It was determined there was a need for more guidance on the distinction between levels and requirements (some inconsistency in document)

- Some of the requirements may not be able to be implemented immediately, and may not be feasible for a community pharmacy, for example, the requirement for a dedicated non-sterile compounding area. Could be achieved with appropriate preparation and cleaning of an area that could then be utilized for other purposes.
- Need greater clarity regarding NIOSH and Data Safety Sheets (interpretation and use)

Active Pharmaceutical Ingredients (API)

There was discussion on whether commercially available products and API are interchangeable

- It was determined that it was best to rely on established formulations supported by evidence

Beyond Use Dates (BUD)

The Publication recommends assigning a conservative BUD. In the view of the working group, a BUD can be assigned with sufficient evidence.

- It is not always possible to have an established reference and the BUD may be different according to technique and materials used

Office Use

There is concern to ensure that office use preparations will continue to be available, as they are for other professions that permit their preparation in established circumstances, where there is a relationship between a patient and healthcare professional

Personal Protective Equipment (PPE)

The use of PPE should be flexible according to the product and requirements, including the experience of the compounding pharmacy, rather than strictly defined according to levels defined in this document

Labelling

NAPRA should work with vendors to achieve labelling requirements.

- Need to clarify that the primary contact on the label is the dispensing pharmacy
- Support the use of ‘inpatient labelling’ as an exception, although outpatient pharmacy must meet the community pharmacy standards
- Veterinarian labelling – need to review the requirement for withdrawal times on the label as they are not a ‘direction for use’

Pediatric Non-Sterile Compounding

Document does not include any reference to pediatric compounding and should include a reference in section 5.3 “assessing risk for compounding non-sterile products” and link to internationally approved reference

Ontario College of Pharmacists
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Strategic Priorities 2015 - 2018

Progress Update – December 2016

Mission

The Ontario College of Pharmacists regulates pharmacy to ensure that the public receives quality services and care.

Vision

Lead the advancement of pharmacy to optimize health and wellness through patient-centred care.

Values

Transparency – Accountability - Excellence

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #1: CORE PROGRAMS – FULFILLMENT OF MANDATE - Processes meet or exceed societal expectations. *(Members, Premises)*						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments**	**Noteworthy Accomplishments this Quarter**
		PF	**EC**	**CQI**		
Fair and objective assessment framework.	Refine assessment tools and activities. Premises: Current authority and others i.e. long-term care, family health teams. Members: Pharmacists - at entry, in practice, (site based and standardized). Pharm techs – as above.	High	Med	High	• 30% of practice assessments now being scheduled (target of 95%) to increase preparedness of members and pharmacies resulting in improved effectiveness of assessment process. Benefits of scheduling include DM presence, staff awareness and increased resources available to provide overlap, enabling uninterrupted time with both the DM and staff pharmacists. • Model for peer/practice QA assessment pilot approved by QA Committee. • Initial group of QA coaches/assessors recruited and training underway. • PACE milestones reached: ▪ OPPCAT assessment tool, standards and item-weighting finalized ▪ Technology solutions developed and ready for testing ▪ Assessor training enhanced with standardized online and in-person components to better develop Assessor expertise • "How to file a complaint" video to inform the public of OCP's fair and objective process developed and posted to website. • Launched new public register designed to provide the public with easier access to information in clear, concise, simple language to assist them in making informed decisions. • Hospital Practice Assessment Criteria document posted on the public website for increased transparency. • DPRA Regulations proclaimed effective August 1 enabling College oversight of hospital pharmacies. • Hospital Assessment tool revised to support re-assessment of high risk operations (chemotherapy and sterile compounding).	• 36% of practice assessments now scheduled (target of 95% by end of 2017) as previously reported. • Behavioral based interview tool to promote consistency in QA practice assessments drafted and being calibrated. • QA coaches completed initial training and supervised coaching sessions. • PACE milestones reached: • Implementation and evaluation plans for 2017 pilot complete • Policies and resources for pilot launch posted on website • Technology for records delivered and tested • On target to achieve 90% of required Assessors in place by December 31 • Assessment criteria (domains and elements) to support the Pharmacy Technician Standardized Assessment Tool (entry-to-practice) on track – draft shared with national stakeholders for input. • Breakfast meeting piloted to assist in preparation for upcoming assessments. Data to be collected to determine effectiveness of this strategy over next quarter. • 85% of 2016 hospital assessments completed using revised assessment document. • Community and Hospital Practice Advisors and QA Remediation staff completed Vital Smarts Influencer training to enhance coaching skills for practice assessments.

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Strategic Priority #1: CORE PROGRAMS – FULFILLMENT OF MANDATE - Processes meet or exceed societal expectations. *(Members, Premises)*						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments**	**Noteworthy Accomplishments this Quarter**
		PF	**EC**	**CQI**		

A decision-making framework that is consistently applied across the organization.	Utilize risk tools for use at adjudicative committees.
	Develop informed and objective decision-makers – training/legal support.
	Define and mine data to support decisions.
	Develop or acquire analytic and technical expertise.
		Low	Low	High	• Implemented an internal Dashboard to track progress against Key Performance Indicators for each area of I&R.
					• Completed survey of other regulators' processes to determine best practices related to investigations of sexual abuse/sexual harassment and the use of expert opinions.
					• Discipline Committee *Decision Writing Working Group* struck to develop best practices, identify resources for decision writing and establish timelines for issuing decisions.
					• Implemented an on-line survey for complainants who have received an ICRC decision to determine satisfaction with the process, e.g. credible, timely, responsive.
					• Action taken to resolve critical vulnerabilities identified in the STRA and high level plan to address remaining issues in place.
					• IT system expectations for various initiatives defined:
					  • PACE workshops
					  • Profile reports for companies and members
					  • NAPRA interface
					  • Site based member assessments
						• Benchmarks developed for I&R Dashboard for consistent reporting, tracking and data analysis.
						• Established a checklist for investigations into allegations of sexual abuse.
						• Developed a scoring system for screening Intakes for member specific matters coming to the attention of I&R.
						• Streamlined the internal process for data submission to CIHI for improved data quality.
						• Delivered an Advanced Management Program to build management capacity and skills for leadership team decision making.
						• Developed staff skills inventory bank for technical and transferable skills within the College.
						• Established internal mechanism to manage ongoing development of the Public Register, and initiated development of criteria to determine when information may be deleted/removed from the Register.

A defined Professional Development Framework that incorporates coaching, remediation and monitoring.	Raise awareness of Standards of Practice and Code of Ethics. Develop and refine tools and resources that apply to all members. Develop specific tools and resources that apply to identified applicants/ members/premises. Develop model for coaching and remediation/monitoring.	Med	High	Med	• High-level plan developed for new professional development and remediation approach which fosters consistency and includes a remediation resource library.	• Professional development and remediation approach moving forward with a communication plan and the identification of a lead and program area coordinators.

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #2: OPTIMIZE PRACTICE WITHIN SCOPE – Patients receive quality health care services from pharmacy professionals.						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments**	**Noteworthy Accomplishments this Quarter**
		PF	**EC**	**CQI**		
Pharmacists consistently practicing to established expectations including Standards of Practice and Code of Ethics.	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	Med	High	Med	• Baseline data collected for 50% of 2016 target for pharmacist assessments. • Completed first module of explaining elements of the Code of Ethics and how they should be applied in practice. • Practice guidance in place upon DPRA Regulation proclamation. • Secured agreement with UofW for funding Pharmacy 5in5 program to gain deeper understanding of deficiencies in practice knowledge. • Compounding Working Group proposed implementation timelines for NAPRA model standards of practice for non-hazardous and hazardous sterile compounding. • Guidance for pharmacy professionals who are dispensing or selling naloxone provided in response to change of schedule status to permit access without a prescription. • Completed Pharmacy Act regulation amendments to permit pharmacists to administer expanded list of vaccines. • Jointly developed (with CPSO) Fact Sheet providing supplementary guidance for physicians and pharmacists when prescribing and dispensing fentanyl patches in accordance with new legislation.	• Baseline data collected for 76% of 2016 target for pharmacist assessments by 31/10/2016. • Consulted on and responded to draft NAPRA model standards of practice for non-hazardous compounding and initiated member communication on implementation of hazardous sterile compounding standards. • Completed 2nd and 3rd Code of Ethics learning modules and 2nd and 3rd interactive learning videos. • Launched 5in5 project with UWaterloo to create Advisory Group, review annual deliverables and reporting analytics.
Pharmacy Technicians consistently practising to established expectations including Standards of Practice and Code of Ethics.	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	Med	High	Med	• QA Regulation framework developed to enable mandated program to define continuing competency requirements for pharmacy technicians.	• Presentation to CCAPP program coordinators on NAPRA model standards for sterile compounding. • Four presentations to pharmacy buyers to educate about hospital assessments including compounding standards and future practice based assessments.

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #2: OPTIMIZE PRACTICE WITHIN SCOPE – Patients receive quality health care services from pharmacy professionals.						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments**	**Noteworthy Accomplishments this Quarter**
		PF	**EC**	**CQI**		
Pharmacies meeting Standards of Operation and consistently providing an environment to support pharmacy professionals practising to established expectations including the Standards of Practice and Code of Ethics.	Educate and reinforce to the "controllers of the pharmacies" their obligations. Develop and communicate Standards of Operation.	Med	Med	Med	• Demonstrated movement in adherence to standards of operation: 21% of pharmacies assessed in first quarter of 2016 required Action Plans vs 16% in 3rd quarter 2016. • Achieved 53% of 2016 Target of 2500 community pharmacy assessments in 2016 to assess 2500 community pharmacies as of 7/31. • Hospital assessment guidance document circulated for site visits.	• Achieved 79% of 2016 target to assess 2500 community pharmacies, on track for 100% by year end.
The pharmacy profession integrates technology and innovative approaches to improve the quality and safety of patient care.	Raise awareness of PPMS (pharmacy practice management systems) with members, stakeholders, government. Participate and influence e-Health initiatives. OCP assessments and adjudications encourage and support innovation in practice.	Low	High	Med	• None.	• Established cataloguing system to align professional development and remediation activities with competencies to identify and eliminate gaps in training.

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #3: INTER & INTRA PROFESSIONAL COLLABORATION - High performing health professional teams in place to achieve coordinated patient-centered care.						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments**	**Noteworthy Accomplishments this Quarter**
		PF	**EC**	**CQI**		
Pharmacy Team: Pharmacy services are organized to empower pharmacists and pharmacy technicians to practice to their full scope. Pharmacists and pharmacy technicians maximize their respective roles.	Gather data to determine the degree to which pharmacies are meeting expectations and understand the barriers. Educate members through videos, sharing best practices. OCP to encourage and support experimental models that integrate technicians in practice.	Med	High	High	• None.	• Initiated identification of reporting analytics and new content needed for Pharmacy 5in5 to enhance and assess scope of practice of pharmacy teams.
Health Care Team: Pharmacists and pharmacy technicians exercise their responsibility within the patient's professional team.	Develop and provide guidance to members on how they can educate and collaborate with other health care professions. Develop guidance on expectations at transitions of care. Gather information from patients on their understanding of the pharmacy services role in health care team.	High	High	Med	• Participation with Centre for Effective Practice to develop resources to support clinicians involved in provision of MAiD.	• None.

Ontario College of Pharmacists
Putting patients first since 1871

Memo

Date: **November 1, 2016**

To: **Executive Committee**

From: **Anne Resnick, Interim Acting Registrar**

RE: **Appointment of Inspectors**

In accordance with Article 10.5 of the College's By-law No. 4, please be advised that the following individuals are currently appointed as Inspectors* for the College pursuant to section 148(1) of the *Drug and Pharmacies Regulation Act*:

Heather Arnott
Nicole Balan
Linda Chilibeck
Lisa Craig
Judy Chong
Lap Kei Chan
Peter Gdyczynski
Maryan Gemus
Andrew Hui
Gurjit Husson
Lilly Ing
Susan James
David Malian
Shelina Manji
Jane McKaig
Debra Moy
Michelle Nagy
Ijeoma Onyegbula
Tina Perlman
Marina Pinder
Greg Purchase
Jessie Reid
Kristin Reid
Anne Resnick
Ruth Schunk
Lisa Simpson
Nadia Sutcliffe
Melody Wardell
Melanie Zabawa

* "Inspectors" as referenced under the DPRA, are also referred to as Practice Advisors in the field and by the College.

Ministry of Health and Long-Term Care

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Ontario

Anne Resnick
Acting Registrar, Ontario College of Pharmacists
483 Huron St
Toronto, ON M5R 2R4

Dear Ms. Resnick,

I am pleased to hear of preliminary communication between the Ontario College of Pharmacists (OCP) and the Institute for Safe Medication Practices (ISMP) in support of the development of enhanced efforts to support pharmacy error reporting and continuous quality improvement.

Medication safety in Ontario is a priority for my ministry, and given recent tragic events that have been reported in the Ontario media, the proposed work of the ISMP and OCP is timely. I am very supportive of initiatives like this to improve transparency and safety in pharmacies.

As you know, there is no mandatory reporting for mediation errors under the Regulated Health Professions Act, 1991, Pharmacy Act, 1991 and Drug and Pharmacy Regulations Act that govern the profession and practice of pharmacy in Ontario. It will be important that as the work of the OCP and ISMP proceeds to develop a structure for error reporting that transparency, accountability and usability of such a system is considered.

I look forward to hearing of the progress on this important work. Thank you for your continued commitment to serve and protect the public interest by ensuring pharmacists provide the public with quality pharmaceutical service and care, including the provision of safe and appropriate medications, in accordance with established standards of pharmacy practice.

Yours sincerely,

Dr. Eric Hoskins
Minister

From: Ushma Rajdev
To: Ushma Rajdev
Subject: MAID legislation introduction
Date: Thursday, December 08, 2016 3:56:12 PM

Colleagues,

I am pleased to advise that earlier today the government introduced the *Medical Assistance in Dying Statute Law Amendment Act, 2016*. This Bill complements the federal government's recently-enacted medical assistance in dying (MAID) legislation (Bill C-14), and seeks to address issues that fall within provincial jurisdiction. This Bill consists of narrow amendments to Ontario statutes that would provide clarity and legal protections for clinicians and patients navigating MAID. The legislation, if passed, would also establish a new role for the Coroner in overseeing MAID deaths.

In particular, the amendments seek to:

- Ensure that having a medically-assisted death would not affect a right or benefit that would otherwise exist under a contract or statute (i.e., life insurance);
- Provide immunity to physicians, nurse practitioners and persons assisting them in the lawful provision of MAID, from civil actions or proceedings for damages;
- Bolster privacy protections for clinicians and health care facilities;
- Require that the Coroner be notified of all MAID deaths, but allow the Coroner to determine whether to investigate the death; and
- Clarify application of the Vital Statistics Act and related regulations, consistent with the Coroners Act amendments.

The *Medical Assistance in Dying Statute Law Amendment Act, 2016, would, if passed,* amend six pieces of legislation including:

- The ***Excellent Care For All Act****:* to ensure that having a medically-assisted death would not affect a right or benefit that would otherwise exist under a contract or statute (i.e., life insurance) and to provide immunity to physicians, nurse practitioners and persons assisting them in the lawful provision of MAID, from actions or proceedings for damages;
- The ***Workplace Safety and Insurance Act***: to clarify that a person who received MAID is deemed to have died as a result of their underlying injury or illness;

- The ***Freedom of Information and Protection of Privacy Act*** and ***Municipal Freedom of Information and Protection Privacy Act***: to prevent sensitive information about MAID, including information about clinicians willing to provide MAID, from disclosure under the access to information provisions;

- The ***Coroners Act***: to require that the Coroner be notified of all MAID deaths, but allow the Coroner to determine whether to investigate the death; and,

- The ***Vital Statistics Act*** and Ontario Regulation 1094 made under the *Vital Statistics Act*: to clarify application of the Act and its Regulation, consistent with the *Coroner's Act* amendments.

Attached is a copy of the proposed legislation and below are links to the news release and backgrounder: https://news.ontario.ca/mohltc/en/2016/12/ontario-introduces-legislation-on-medical-assistance-in-dying.html
https://news.ontario.ca/mohltc/en/2016/12/the-medical-assistance-in-dying-statute-law-amendment-act.html

In addition, you will receive an invitation shortly for a webinar that will be held on Friday, December 9th at 11am. The purpose of the webinar is to provide a technical briefing on the proposed legislation to all impacted stakeholders.

The legislation is subject to the consent of the Legislative Assembly; however, should the Bill pass, we look forward to working with all of our stakeholders to ensure its smooth and successful implementation.

In addition to the proposed legislative amendments, Ontario has been exploring ways to support access to MAID for eligible patients. Ontario will be establishing a Care Coordination Service (CCS) that can be accessed by clinicians and patients (public facing) while not altering current health regulatory college policies which require clinicians to make an effective referral. The ministry will share further information regarding the CCS in early 2017.

Sincerely,

Patrick Dicerni
ADM, Strategic Policy and Planning
Ministry of Health and Long-Term Care

Medical Assistance in Dying Statute Law Amendment Act, 2016

EXPLANATORY NOTE

Various Acts are amended in response to the Federal *Criminal Code* legislation dealing with medical assistance in dying.

The *Coroners Act* is amended to provide that, in the case of a medically assisted death, the doctor or nurse practitioner who provided the medical assistance in dying shall notify the coroner and provide the coroner with any information necessary to determine whether to investigate the death, and other people with knowledge of the death shall provide the coroner with information on request.

The *Excellent Care for All Act, 2010* is amended to provide protection against litigation for doctors, nurse practitioners and people assisting them for performing medical assistance in dying. (This does not apply where negligence is alleged.)

Also, the fact that a person received medical assistance in dying may not be invoked as a reason to deny a right or refuse a benefit or any other sum which would otherwise be provided under a contract or statute.

The *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* are amended to provide that they do not apply to identifying information relating to medical assistance in dying.

The *Vital Statistics Act* is amended to provide that the requirements respecting the coroner's documentation do not apply in cases of medical assistance in dying if the coroner has determined that the death not be investigated.

The *Workplace Safety and Insurance Act, 1997* is amended to provide that a worker who receives medical assistance in dying is deemed to have died as a result of the injury or disease for which the worker was determined to be eligible to receive medical assistance in dying.

Bill **2016**

An Act to amend various Acts with respect to medical assistance in dying

Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

CORONERS ACT

1. The *Coroners Act* is amended by adding the following section:

Medical assistance in dying

10.1 (1) Where a person dies as a result of medical assistance in dying, the physician or nurse practitioner who provided the medical assistance in dying shall give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, the coroner shall investigate the circumstances of the death and if, as a result of the investigation, the coroner is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

Requirements re giving of notice

(2) The physician or nurse practitioner who provided the medical assistance in dying shall provide the coroner with any information about the facts and circumstances relating to the death that the coroner considers necessary to form an opinion about whether the death ought to be investigated, and any other person who has knowledge of the death shall provide such information on the request of the coroner.

Non-application of clause 10 (1) (f)

(3) Clause 10 (1) (f) does not apply in respect of a deceased person who died as a result of medical assistance in dying.

Review

(4) The Minister shall, within two years after the *Medical Assistance in Dying Statute Law Amendment Act, 2016* receives Royal Assent, establish a process to review the provisions of this section.

Definitions

(5) In this section,

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

"nurse practitioner" means a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*;("infirmière praticienne ou infirmier praticien")

"physician" means a member of the College of Physicians and Surgeons of Ontario. ("médecin")

EXCELLENT CARE FOR ALL ACT, 2010

2. (1) Section 1 of the *Excellent Care for All Act, 2010* is amended by adding the following definitions:

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

"nurse practitioner" means a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière praticienne ou infirmier praticien")

"physician" means a member of the College of Physicians and Surgeons of Ontario; ("médecin")

(2) The Act is amended by adding the following sections:

MEDICAL ASSISTANCE IN DYING

Immunity, MAID

13.8 (1) No action or other proceeding for damages shall be instituted against a physician or nurse practitioner or any other person assisting him or her for any act done or omitted in good faith in the performance or intended performance of medical assistance in dying.

Exception

(2) Subsection (1) does not apply to an action or proceeding that is based upon the alleged negligence of a physician, nurse practitioner or other person.

MAID has no effect on rights and benefits

13.9 (1) Subject to subsection (2), the fact that a person received medical assistance in dying may not be invoked as a reason to deny a right or refuse a benefit or any other sum which would otherwise be provided under a contract or statute.

Contrary intention

(2) Subsection (1) applies unless an express contrary intention appears in the statute.

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

3. Section 65 of the *Freedom of Information and Protection of Privacy Act* is amended by adding the following subsections:

Non-application of Act

(11) This Act does not apply to identifying information relating to medical assistance in dying.

Interpretation

(12) In subsection (11),

"identifying information" means information that identifies a person or facility or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify a person or facility; ("renseignements identificatoires")

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada). ("aide médicale à mourir")

MUNICIPAL FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

4. Section 52 of the *Municipal Freedom of Information and Protection of Privacy Act* is amended by adding the following subsections:

Non-application of Act

(5) This Act does not apply to identifying information relating to medical assistance in dying.

Interpretation

(6) In subsection (5),

"identifying information" means information that identifies a person or facility or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify a person or facility; ("renseignements identificatoires")

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada). ("aide médicale à mourir")

VITAL STATISTICS ACT

5. Section 21 of the *Vital Statistics Act* is amended by adding the following subsection:

Exception

(7) Subsections (5) and (6) do not apply if the person has died after receiving medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada), and a coroner has been given notice of or information about the death under section 10.1 of the *Coroners Act* and determined that the death ought not to be investigated.

WORKPLACE SAFETY AND INSURANCE ACT, 1997

6. (1) Subsection 2 (1) of the *Workplace Safety and Insurance Act, 1997* is amended by adding the following definition:

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

(2) Part I of the Act is amended by adding the following section:

Medical assistance in dying

2.2 For the purposes of this Act, a worker who receives medical assistance in dying is deemed to have died as a result of the injury or disease for which the worker was determined to be eligible to receive medical assistance in dying in accordance with paragraph 241.2 (3) (a) of the *Criminal Code* (Canada).

COMMENCEMENT AND SHORT TITLE

Commencement

7. This Act comes into force on the day it receives Royal Assent.

Short title

8. The short title of this Act is the *Medical Assistance in Dying Statute Law Amendment Act, 2016*.

Ontario

NEWS

Ministry of Health and Long-Term Care

Ontario Introduces Legislation To Prevent Sexual Abuse of Patients

Protecting Patients Act Would Ensure Health and Safety of Patients and Families

December 8, 2016 1:30 P.M.

Ontario has introduced legislation that would, if passed, further protect patients in Ontario and keep them healthy, including strengthening and reinforcing Ontario's zero tolerance policy on sexual abuse of patients by any regulated health professional.

The Protecting Patients Act, 2016 includes legislative amendments that would, if passed:

- Expand the list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional's license
- Remove the ability of a regulated health professional to continue to practice on patients of a specific gender after an allegation or finding of sexual abuse
- Increase access to patient therapy and counselling as soon as a complaint of sexual abuse by a regulated health professional is filed
- Ensure that all relevant information about regulated health professionals' current and past conduct is available to the public in an easy-to-access and transparent way.

Additional amendments contained in the Act would:

- Help parents make informed decisions about immunizing their children and make it easier for parents to keep track of the vaccinations their kids are required to get in order to attend school
- Improve and modernize Elderly Persons Centres across the province, to help seniors stay healthy, active and engaged
- Make it easier and more convenient for people to be reimbursed for certain prescriptions that are written by nurse practitioners
- Continue to ensure that community laboratory services are safe and effective by updating inspection provisions and streamlining licensing requirements.

Ensuring the health and safety of all patients is part of the government's plan to build a better Ontario through its Patients First: Action Plan for Health Care, which is providing patients with faster access to the right care, better home and community care, the information they need to stay healthy and a health care system that is sustainable for generations to come.

QUOTES

" The initiatives outlined in the Protecting Patients Act are part of our government’s Patients First strategy to protect Ontario’s health care system for generations to come. For example, our strategy will ensure patients have the information they need to protect themselves from

preventable disease, and ensure our health care system is protecting patients from sexual abuse by health professionals."

- Dr. Eric Hoskins
Minister of Health and Long-Term Care

" We are pleased to see government taking a positive first step to protect patients from sexual abuse and support survivors of sexual abuse by health professionals. We look forward to continuing to work with government to make progress on all the recommendations from To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act."

- Farrah Khan and Sly Castaldi, co-chairs of Ontario's Roundtable on Violence Against Women and Sheila Macdonald, member of Ontario's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act

QUICK FACTS

- With this legislation, the government is able to introduce amendments to several statutes at one time, to ensure that patients in Ontario are healthy and safe.
- The re-introduction of the Immunization of School Pupils Act and the Seniors Active Living Centres Act are part of Ontario's commitment to re-introduce all government bills that were before the legislature in spring 2016, so that debate on important issues may continue.

LEARN MORE

- The Protecting Patients Act, 2016
- Patients First: Action Plan for Health Care
- Patients First: Action Plan for Health Care Year One Results
- Elderly Persons Centres
- To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act

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Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: DECEMBER 2016

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Executive Committee

TOPIC: Continuous Quality Improvement (CQI) for Medication Safety

ISSUE: Following an incident linked to a compounded medication error, the College reviewed how medication incident reporting is addressed in practice and what resources are available to improve and strengthen existing measures.

BACKGROUND:

Recent critical medication incidents have contributed to a review of the College's current policies and standards (Appendix 1) for pharmacies and members related to management of medication errors to improve patient safety. The College continuously reminds practitioners of their responsibility to appropriately manage medication incidents in their practice through broad communications (e.g., articles or practice tools) and as part of discussions during regular pharmacy practice assessments in hospitals and community pharmacies. The College also maintains and frequently refers members to a medication incident resource page to support practice.

The objective of this approach, which includes analysis of how the error came to be and reporting the error to an external body, is to ensure that all practitioners learn from these incidents and review and enhance their policies and procedures to reduce the chances of recurrence thereby improving patient safety.

Hospitals have also had a long standing commitment to patient safety and have been required to report medication incidents to the Canadian Institute for Health Information (CIHI) National System for Incident Reporting for many years. In addition, regulations under the Public Hospitals Act require that all hospitals have a Quality Committee which, among other things, reviews aggregate data on critical incidents in order to consider lessons learned and to develop system-wide improvements to avoid similar incidents in future.

Media and public attention regarding the recent medication incident in Ontario has been focused on the issue of mandatory reporting of medication errors, and in response, the Minister of Health and Long Term Care has indicated his intent to "look into the process in Nova Scotia, the only province that requires the reporting and public notification of pharmacy errors". Although the College does not currently mandate the reporting of medication errors to an external body [such as the Institute for Safe Medication Practices (ISMP)], it has always been a recommended best practice.

Included in the examination of this issue the College completed a jurisdictional review (Appendix 2) of the protocols and reporting requirements of other provincial regulatory authorities. The review confirmed that Nova Scotia is the only province with a requirement for mandatory reporting to an external third party, as defined in their standards of practice (Appendix 3) , and that Saskatchewan is currently piloting the same approach. The review confirmed that Ontario's

approach, which is to rely on standards of practice (for practitioners) and standards of operations (for pharmacies) that require quality assurance processes for management of medication errors, is consistent with other provinces.

The College has since consulted with the Nova Scotia College of Pharmacists to gather information about SafetyNET-Rx, which is a standardized CQI program that enables community pharmacies to report medication incidents to a third party. Reporting is submitted anonymously online to the ISMP Canada national database, and can be aggregated and reported back for comparison of pharmacy data against a national level.

ANALYSIS:

Management of medication errors is only one component of the broader issue of patient safety. Implementation of continuous quality improvement programs that allow for a systematic review of processes and root cause analysis of incidents, have become a standard approach among regulators to promote learning that may result in the prevention of recurring errors and thereby enhance patient safety. The additional requirement of reporting of errors, although less common, is gaining interest in the light of recent incidents. Evaluation of these models will help to determine if they provide added value to the existing CQI measures.

DECISION FOR COUNCIL:

To expand on the existing expectation for continuous quality improvement for medication safety, by requiring reporting of errors to a third party, with the expectation that aggregate reports will be received by the College for targeted practice improvement initiatives.

Appendix 1

Standards of Practice Relating to Safety and Quality
Pharmacists and Pharmacy Technicians

Pharmacists

Pharmacists regardless of the role they are fulfilling:

- Manage errors, incidents and unsafe practices
- Promptly disclose alleged or actual errors, incidents and unsafe practices to those affected and in accordance with legal and professional requirements
- Record and report alleged and actual errors, incidents and unsafe practices in accordance with legal and professional requirements
- Adhere to applicable laws, regulations and policies applicable to pharmacy practice

Pharmacists, when providing patient care:

- Report the occurrence of adverse events and close-calls

Pharmacists, when managing a pharmacy:

- Review errors and incidents to determine patterns and causal factors that contribute to patient risk
- Develop and implement policies and procedures that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events and close-calls

Pharmacy Technicians

Pharmacy technicians are responsible and accountable for ensuring the safety and quality of prescription-product preparation and release

Pharmacy technicians, when contributing to management within a Pharmacy:

- Maintain inventory to maximize safe and efficient drug distribution, including:
  - Identifying / locating, reporting and removing expired, defective, unsafe or recalled drugs and medical devices
- Complete required audits and reconciliations for controlled substances according to current laws, regulations and policies, identifying and reporting any discrepancies or potential issues to the pharmacist
- Support safe and effective drug distribution through workflow management, organizing their roles and responsibilities to allow the priority to be on patient care and to minimize diversion and dispensing errors

Pharmacy technicians, regardless of the role they are fulfilling:

- Recognize and report any unsafe, illegal, unethical or unprofessional actions or situations to the appropriate person or authority and assist in their resolution
- Recognize and report problems within the distribution system
- Report the occurrence of adverse events and close-calls to the pharmacist and disclose the event as appropriate
- Determine the immediate safety and care needs of patients affected by adverse events and close calls, and provide appropriate interventions
- Participate in and promote patient safety initiatives

- Collaborate in the documentation and review of adverse events and close calls and the development of policies and procedures to minimize adverse events and to promote safety initiatives

Standards of Practice Relating to Safety and Quality
Pharmacies

The Pharmacy has a continuous quality improvement process in place to manage and review prescription incidents.

- The Pharmacy must have policies and procedures in place that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events.
- The Pharmacy must have policies and procedures in place that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report close-calls.
- Pharmacy Staff should review the Article - CQI Benefits Patients in Community Pharmacies (Pharmacy Connection Winter 2015).
- A Dispensing Error Incident form is available on the OCP website.
- Discuss the CQI changes implemented to address the prescription discrepancies identified.

Appendix 2
Amended

Medication Safety and Error Reporting Requirements: Community Pharmacy

Jurisdiction	Level of Reporting	Requirements
British Columbia	No mandatory medication error report to the College or to Government Participation in the quality management program is required. Errors are to be reported to those who are affected by them and utilized to implement practice changes and/or preventative measures.	A quality management program is mandated for reporting, documenting and following up on known, alleged and suspected errors and discrepancies
Alberta	No mandatory medication error report to the College or to Government Participation in the quality assurance process is mandated. A voluntary program for drug error management resource is provided: the *Systems Approach to Quality Assurance* (in collaboration with ISMP)	Standards of practice for pharmacists and pharmacy technicians require participation in the quality assurance process Standards of Operation require the implementation of a quality assurance program

Jurisdiction	Level of Reporting	Requirements
Saskatchewan	COMPASS is expected to be mandatory in November 2017. The Community Pharmacists Advancing Safety in Saskatchewan (COMPASS) program utilizes a standardized continuous quality improvement (CQI) framework (similar to the SafetyNET-Rx CQI program in Nova Scotia), including reporting and self-assessment tools (in collaboration with ISMP Canada)	Voluntary participation in the Community Pharmacists Advancing Safety in Saskatchewan (COMPASS) pilot program was supported by the Saskatchewan College of Pharmacy Professionals for 120 pharmacies (i.e. 1/3 of community pharmacies in Saskatchewan) in 2016. Three phases of COMPASS pilot program have been completed since 2013.
Manitoba	No mandatory medication error report to the College or to Government The Pharmacy is required to maintain a policy and procedure manual, including procedures with respect to medication incidents and discrepancies, for the purpose of review and prevention.	A member is required to take action to support patient safety in the event of any drug-related error Standards of Practice require documentation of medication incidents
Ontario	No mandatory medication error report to the College or to Government The College does not mandate a specific report system or tool for reporting medication incidents. There is an expectation of joint responsibility between members and pharmacies in preventing and addressing medication incidents and near misses, with an emphasis on continuing quality improvement (CQI) Ongoing operational assessments are conducted in both community and hospital pharmacies and drug preparation premises. During the assessment, the practice adviser and appropriate staff member review and discuss the policies and procedures in place that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events and close calls	Standards of practice for pharmacists and pharmacy technicians require participation in the quality assurance process Standards of Operation require the pharmacy to have policies and procedures in place that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events.
Quebec	No mandatory medication error report to the College or to Government. There is a requirement to report to the Professional Liability Insurance Fund if an incident has had consequences for the patient. In cases where the incident has national application or where it could be repeated in other pharmacies, best practice is to report it to the ISMP. However this is not a requirement.	Standards of practice for pharmacists require management of incidents including a disclosure policy for patients, staff, and the liability insurer.

Jurisdiction	Level of Reporting	Requirements
New Brunswick	No mandatory medication error report to the College or to Government The Pharmacy Manager is responsible for implementation and adherence to the ongoing quality management program. • There must be a process for documenting and reporting medication errors, protecting the confidentiality of information relating to clients • Voluntary reporting is undertaken utilizing the Community Pharmacy Incident Reporting Program (CPhIR) (in collaboration with ISMP Canada)	The pharmacy is required to maintain a quality management process. 67 pharmacies (i.e. 1/3 of community pharmacies in New Brunswick) have opted in and are currently using the ISMP Canada CQI tools (i.e. CPhIR and MSSA), similar to the SafetyNET-Rx CQI program in Nova Scotia, in order to fulfil their quality management program requirement.
Nova Scotia	Mandatory participation in the SafetyNET-Rx CQI program (in collaboration with ISMP Canada) Standards of Practice require anonymous reporting to an independent, objective third party organization for population of a national aggregate database from which learnings arising from trends and patterns can be communicated across the profession	The pharmacy is required to maintain a quality assurance program for documenting, reporting and analyzing medication errors The mandated CQI program fulfills the requirement to engage in enhancement of safety and quality. ALL pharmacies in Nova Scotia are currently using the ISMP Canada CQI tools (i.e. CPhIR and MSSA) as part of their SafetyNET-Rx CQI program.
Prince Edward Island	No mandatory medication error report to the College or to Government • CPhIR and the MSSA tools are available (in collaboration with ISMP)	Voluntary participation in ISMP Pilot Project
Newfoundland and Labrador	No mandatory medication error report to the College or to Government	A provincial quality assurance program is established which promotes continuing competence and quality improvement

Appendix 3

Nova Scotia College of Pharmacists
Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies http://www.nspharmacists.ca/?page=continuous-quality-assurance-cqa&showKey=Safety%20Net#StandardsOfPracticeContinuousQualityAssurance

January 19, 2010

Introduction

Given community pharmacy's key role in the medication management segment of the health care process, an effective continuous quality improvement (CQI) process for community pharmacies that is both proactive and responsive, and that enables enhancement of the safety culture of the pharmacy as well as its practices, can be expected to have a substantial impact on patient safety.

Recognizing the importance of continuous quality improvement (CQI) in enabling pharmacies to provide optimal patient care, the Practice Regulations to the Pharmacy

Act includes a requirement for pharmacies in Nova Scotia to establish and maintain a continuing, documented quality assurance program.

In consideration of the existing evidence on best practice in the area of CQI, including the results from the SafetyNET-Rx project, the NSCP has identified the required components of an effective quality assurance program, and community pharmacies in Nova Scotia will be assessed for compliance with the Practice Regulations against this standard. While it is recommended that each pharmacy identifies a staff member who will act as a quality assurance (QA) coordinator and oversee the undertaking of the activities described in these standards, it is the responsibility of the pharmacy manager to ensure that the pharmacy develops, maintains and enforces policies and procedures to comply with these standards of practice.

Purpose

To provide a standard for an effective CQI process for community pharmacies that ensures pharmacies engage in active enhancement of the safety and quality of their professional services and practices both on a regular, ongoing basis as well as in response to quality related events (QREs). QREs include known, alleged or suspected medication errors that reach the patient as well as those that are intercepted prior to dispensing.

Standard

A CQI process that fulfills a pharmacy's legislated requirements as set out in the Practice Regulations achieves the following:

1. Monitors staff performance, equipment, facilities and adherence to standards of practice.

2. Manages known, alleged and suspected medication errors that reach the patient consistent with the best practices for this activity undertaken by others in the profession, including:

    . Taking appropriate and necessary action to optimize patient care, including prompt consultation with the patient's other health care provider(s) for determination of appropriate action to minimize negative impact on the patient.

    i. Ensuring the management of error process is appropriately communicated to the patient.

    ii. Ensuring the management of error minimizes undue stress and frustration for the patient.

    iii. Ensuring the management of error should include an apology (as enabled by the Apology Act) in which the pharmacist acknowledges the negative impact to the patient, and commits to taking the steps appropriate to minimize the likelihood of recurrence of the incident.

    iv. Promptly analyzing the error for causal factors.

    v. Communicating to the patient the causal factors of the error when appropriate, and actions taken to reduce the likelihood of recurrence.

    vi. Documenting the details of the known, alleged or suspected error or discrepancy promptly and thoroughly, including statements from all

pharmacy staff involved and the steps taken to resolve the problem.

vii. Communicating to all pharmacy staff the appropriate details of the error, including the causal factors of the error and actions taken to reduce the likelihood of recurrence.

3. Enables and requires anonymous reporting of quality related events (QREs) to an independent, objective third party organization for population of a national aggregate database from which learnings arising from trends and patterns can be communicated across the profession.

Please note: *QREs include errors that reach the patient as well as those that are intercepted prior to dispensing. The extent to which intercepted errors are reported will be a professional judgment decision of the pharmacy manager in consideration of the nature of the intercepted error, its implication for patient safety and the extent to which it is recurring.*

1. Encourages open dialogue on QREs between pharmacy staff and management through quarterly review of the pharmacy's aggregate QRE data (e.g. total number of incidents, type of incidents, etc.).
2. Documents quality improvements made as a result of the quarterly CQI meetings of staff.
3. Requires completion of a medication safety self assessment annually, and monitoring the progress of the resulting enhancement plan at quarterly CQI meetings.
4. Includes provisions to protect the confidentiality of information relating to specific patients.
5. Achieves the purposes of an effective CQI program as described at the beginning of this document through ongoing education of pharmacy staff on the current best practices in QRE management and adoption of these practices, with the goal of discouraging punitive identification or other approaches that are detrimental to reporting and learning.

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Resources

The information about the following Institute for Safe Medication Practices Canada (ISMP) tools is being provided as a reference for pharmacists and pharmacies desiring assistance in

identifying resources to assist them in achieving compliance with the NSCP Standards of Practice for Continuous Quality Assurance Programs in Community Pharmacies, specifically Standards 3 and 6.

Standard 3: Community Pharmacy Incident Reporting (CPhIR) Program

Medication incidents are often under reported. CPhIR will provide community pharmacies with the ability to document, anonymously report and analyze contributing factors (e.g. miscommunication, staffing, and education) that can cause errors in the medication use system. From the data reported and through understanding of the contributing factors, the pharmacy team can develop and implement system based strategies for quality improvement and prevent potential errors from occurring again in the future.

Community Pharmacy Incident Reporting Program (CPhIR website)

(Pharmacies can test using CPhIR by accessing the CPhIR Training Site at http://www.cphir.ca/training. Login with the **username** = testuser and **password** = testuser. There is also a Training Centre (see top menu bar after login) with a self directed video clip on how to use CPhIR)

Standard 6: Medication Safety Self Assessment® for Community/Ambulatory Pharmacy (MSSA-CAP)

The Institute for Safe Medication Practices Canada (ISMP Canada) MSSA-CAP is designed to:

- Heighten awareness of the distinguishing characteristics of a safe medication system in community pharmacy practice;
- Act as a quality improvement tool; and
- Create a baseline of a pharmacy's efforts to enhance the safety of medication use and evaluate these efforts over time.

The self assessment tool is divided into 10 key elements that most significantly influence safe medication use. Each key element is defined by one or more core distinguishing characteristics of a safe medication system. Representative self assessment items are provided to help pharmacies evaluate the degree to which their practice meets each of the core distinguishing characteristics. For example, under the Key Element of Patient Information, there is one core distinguishing characteristic followed by 6 self assessment item that represent practices that enhance medication system safety in that area. The pharmacy team completing this tool rates the level of implementation in the pharmacy for each self assessment item.

Medication Safety Self-assessment for Community Pharmacy (ISMP website)