SUMMARY OF PROPOSED CHANGES TO THE SUPPLEMENTAL STANDARDS OF PRACTICE: October 2025

The table below summarizes the changes being proposed to the College's Supplemental Standard of Practice (new content in red text). Additional language changes have been made to improve clarity and reduce redundancy and repetition in alignment with the College's second strategic goal around clear communication and the organization's increasing commitment to clear, action-oriented messaging.

CURRENT SECTION REFERENCE	CHANGE TO SUPPLEMENTAL STANDARD	RATIONALE
Purpose (p. 1)	"To provide clarity regarding practice expectations for pharmacy professionals in Ontario to meet the National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting for Pharmacy Professionals."	Adapting the NAPRA Standards: ✓ Supports national alignment and consistency ✓ Offers an evidence-based framework and regulatory oversight ✓ May drive higher compliance and engagement with the AIMS Program
Supplemental Standard of Practice (page 2), paragraph 1	"An effective, standardized AIMS Program for pharmacies must address both medication incidents that reach the patient as well as near misses that are intercepted before the medication is dispensed. In addition to ensuring their conduct and practice align with NAPRA Standards for Continuous Quality Improvement and Medication Incident Reporting, pharmacy professionals must meet all of the following requirements of the mandatory AIMS Program."	
Supplemental Standard of Practice (page 2), table, row 1	**Report** "Anonymously record medication incidents and near misses soon after they occur into a medication incident reporting platform that:	Majority of provinces with medication safety programs provide pharmacies with the autonomy and flexibility to select their own reporting platform.

	a) Complies with OCP's criteria for reporting platforms b) Contributes to ISMP's National Incident Data Repository to support shared learning and to help identify systemic issues"	All provinces with medication safety programs currently contribute to ISMP's National Incident Data Repository (NIDR). Ontario's participation, given its size and number of pharmacies, would enhance regulatory alignment across jurisdictions, strengthen the quality of national data, and facilitate more meaningful shared learnings.
Supplemental Standard of Practice (page 2), table, row 3	**Analyze** "Analyze incidents and near misses for causal factors soon after they occur and implement appropriate steps to minimize the likelihood of recurrence. Develop CQI plans and measure the outcomes of changes implemented Complete a safety self-assessment (SSA) every two years. The Designated Manager may determine an SSA is required more frequently if a significant change occurs in the pharmacy."	The current "every two to three years" safety self-assessment requirement creates timing uncertainty and does not effectively support a culture of continuous quality improvement. Establishing a biennial (every two years) requirement will provide greater clarity, encourage consistent engagement, and better support ongoing quality improvement efforts.
Supplemental Standard of Practice (page 2), table, row 4	**Share** "Communicate relevant details of a medication incident or near miss promptly to all pharmacy staff, including causal factors and actions taken to reduce the likelihood of recurrence. Schedule CQI meetings with pharmacy staff at least once every quarter to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, and complete an SSA (when required). Share successful interventions, changes, or best practices that have helped reduce risk."	Using the term "regular" to describe the frequency of continuous quality improvement (CQI) meetings has resulted in inconsistent implementation, limiting the development of a strong safety culture. Establishing a minimum frequency of at least once every quarter (every three months) will support pharmacies in planning these meetings, enabling consistent discussion of medication events, identification of risks, shared learnings and more deliberate planning of quality improvement initiatives.

Responsibilities of Pharmacy Professionals in Meeting the sSOP (page 3, paragraph 3)	"All registered members (pharmacists and pharmacy technicians) are required to have a unique login for the medication incident reporting platform at their primary place of practice to meet these reporting standards."	Under the current model, most pharmacies maintain a single platform login assigned to the Designated Manager, which limits access for other pharmacy staff and reduces their engagement. Requiring unique logins for registered pharmacy professionals at their primary place of practice will improve access, strengthen the safety culture, and support increased reporting of medication events. *Note that this requirement does not apply to occasional or relief pharmacists*.