

Hospital Pharmacy Assessment Criteria

The following chart outlines the hospital pharmacy operations criteria that are used by Hospital Operations Advisors (HOAs) when conducting a hospital pharmacy assessment. The document is divided into categories and for each category specific standards are identified with a link to the appropriate reference (legislation, standards, policies, guidelines, etc.). The guidance section illustrates specific activities required to ensure adherence to the standard and is provided to assist pharmacy professionals in understanding expectations and preparing for an assessment. Educational resources may also be listed in the Guidance column to provide additional information.

Any location where drugs are stored, compounded, dispensed, supplied from or supplied for hospital patients (by a hospital, in premises located in a hospital, whether inpatient or outpatient) is deemed to be a pharmacy¹. For the purposes of an assessment, the standards will be evaluated both in the primary pharmacy location itself (where applicable) and in other locations throughout the hospital (e.g., wards, patient care units, pharmacy satellites, etc.) referred to as “patient care areas” hereafter.

Hospital pharmacy administrators and Chief Executive Officers (CEO)/owners are responsible for implementing and maintaining the standards of [accreditation](#) and [operation](#) of the pharmacy². Failure to maintain the standards could result in referral to the Accreditation Committee and may constitute proprietary misconduct and/or professional misconduct.

CATEGORIES

Hospital Pharmacy, Patient Care Areas

Standards of Operation

- [Medication Storage and Security in Patient Care Areas](#)
- [Safe Medication Management Systems in Patient Care Areas](#)
- [Controlled Substances in Patient Care Areas](#)
- [Record Retention, Auditability and Traceability](#)

Hospital Pharmacy, Primary Location(s)

Standards of Operation

- [Medication Storage and Security in Pharmacy](#)
- [Systems to Provide Safe and Effective Pharmacy Services](#)
- [Technology in Pharmacy](#)
- [Packaging and Repackaging](#)
- [Controlled Substances in Pharmacy](#)

[Automated Dispensing Cabinets](#)

[Delegation](#)

[Telepharmacy](#)

¹ [Drug and Pharmacies Regulation Act](#), s119

² [Drug and Pharmacies Regulation Act](#), s166

Hospital Pharmacy, Patient Care Areas

Category: Standards Of Operation

MEDICATION STORAGE & SECURITY IN PATIENT CARE AREAS

STANDARD	GUIDANCE
The hospital has the facilities and equipment needed to ensure medications are stored securely and safeguarded from unauthorized access. Reference: OCP Standards of Operation for Pharmacies; Accreditation Canada, Medication Management	Medications stored in patient care areas must be secure and safeguarded from unauthorized access (e.g. workstations with medications must be locked when not in use; protected by locked doors, swipe access, key, or similar secure barriers).
The hospital has policies and operational processes to ensure medications are stored securely and safeguarded from unauthorized access. Reference: OCP Standards of Operation for Pharmacies; Accreditation Canada, Medication Management	Personnel authorized to obtain medications stored in patient care areas must be documented.
	The hospital must have policies and operational processes to ensure medications are stored securely and safeguarded from unauthorized access. Contingency procedures should be tested, documented and reviewed for system improvements.
	Access to medication storage areas must be removed when staff leave the hospital, including for an extended leave.
	The hospital should have a policy and procedure in place for medication-related equipment in the event of downtime due to equipment failures or other situations.
Medication storage areas are designed, located, constructed and maintained to be fit for their purpose to preserve the integrity of the medication supply. Reference: OCP Standards of Operation for Pharmacies; Protecting the Cold Chain Guideline; Accreditation Canada, Medication Management; Accreditation Canada, Required Organizational Practices; ISMP Targeted Medication Safety Best Practices for Hospital; High-Alert Medications Need Multiple Safeguards (ISMP); ISMP MSSA; O. Reg. 67/93: HEALTH CARE AND RESIDENTIAL FACILITIES (under the Occupational Health and Safety Act)	Medication storage areas must have the appropriate conditions of temperature, light and humidity necessary to ensure a safe medication management system.
	Refrigerator temperatures must be monitored regularly. For manual recording, the minimum and maximum temperatures should be recorded twice per day.
	All personnel involved in handling cold chain products must be trained on cold chain maintenance policies and procedures.
	Risk identification and mitigation strategies must be in place for high-alert medications (e.g., segregation, labelling, etc.) in storage and preparation areas. High-alert medications that are available as ward stock require additional safeguards to ensure a safe medication management system.

	All large-volume bags and bottles of irrigation solutions, organ storage solution, and sterile water (e.g., for inhalation, irrigation) must be stored and labeled in a way that clearly differentiates them from solutions that may be administered parenterally.
	Medication storage areas must have the sanitary conditions necessary to ensure a safe medication distribution system. The medication storage areas must not be used to store food and drinks and only be used to store only medication and medication-related supplies.
Specialized equipment is appropriate to safeguard the health, safety and wellbeing of patients. Reference: OCP Standards of Operation for Pharmacies	Oral syringes which cannot be connected to parenteral tubing should be available in the patient care areas for medication administration.
	Medications should be dispensed/available in single-unit (unit dose) packages, in a ready-to-administer form wherever possible to minimize the potential for an incident to occur.
The hospital has policies and operational processes for the handling of hazardous medications to mitigate risk while providing healthcare to patients. Reference: NIOSH list of antineoplastic and other hazardous drugs in healthcare settings	Hazardous medications must be clearly identified and have safe-handling processes in place. It is recommended that the hospital review occupational health and safety resources (e.g., NIOSH, CCO, ISMP, etc.)
	Solid dosage forms of hazardous drugs should not be manipulated (e.g., crushing tablets, opening capsules) in patient care areas to avoid cross-contamination and unintentional exposure.
The hospital has policies and procedures to regularly audit medication storage areas and ensure inventory is managed in a manner that maintains the quality and timeliness of the medication supply. Reference: Accreditation Canada, Medication Management; OCP Guideline – Protecting the Cold Chain	There must be a procedure to evaluate and determine which medications can be stocked in specific patient care areas. The review should be done in collaboration with a pharmacist.
	There must be a process to remove and dispose of expired, outdated, unusable or recalled medications from patient care areas in a timely manner.
	The process of auditing medication storage in patient care areas should be documented and shared within the organization.

SAFE MEDICATION MANAGEMENT SYSTEMS IN PATIENT CARE AREAS

STANDARD	GUIDANCE
The hospital has processes to ensure medication administration records (MARs) serve as a complete documentation record of the medications administered to a patient. Reference: Accreditation Canada, Medication Management	Medication administration records (MARs) must be current and kept up to date.
	Policies and procedures for medication administration records (MARs) should be consistent hospital- wide and not unique to specific patient care areas.
	All orders transcribed onto the medication administration record (MAR) must be verified against the original order before the first dose is administered.
The hospital has a collaborative process for performing medication reconciliation at each transition of care. Reference: Accreditation Canada, Required Organizational Practices; ISMP Ontario Primary Care Medication Reconciliation Guide; Strengthening Medication Reconciliation (MedRec) at Discharge (ISMP)	There must be a process to ensure relevant information is obtained during the Best Possible Medication History (BPMH) and the Medication Reconciliation is documented in the patient health care record.
	There must be a process to ensure the health care professional's responsibility in the Best Possible Medication History (BPMH) and/or Medication Reconciliation is clearly documented and reflects accountability.
The hospital has policies and procedures to address the identification, storage, security and use of patient's own medication(s) when brought into the hospital by/for patients.	There must be a policy outlining requirements to be in place for a patient to use their own medications.
	There must be strategies in place to prevent the diversion of the patient's own medication supply during storage (especially narcotics, controlled drugs, benzodiazepines, and targeted substances).
	Patients' own medications must not be stored in the pharmacy to safeguard the medication supply.
The hospital has policies and procedures for medications dispensed to patients leaving the hospital. Reference: Drug and Pharmacies Regulation Act, s156	Criteria for the provision of Leave of Absence (LOAs) medications must meet legislative and regulatory body requirements and be consistent across the organization.
	Criteria for dispensing of "to go" doses must meet legislative and regulatory body requirements and should only occur if it has been determined that the patient does not have reasonable or timely access to a community pharmacy.
	Criteria for medications dispensed to ambulatory patients for home use must meet legislative and regulatory body requirements.
	There must be a process to track medications dispensed to patients going home.

The hospital has a policy on self-administration of medication by patients. Reference: Accreditation Canada, Medication Management	Criteria for determining which patients can self-administer medications, and which medications can be self-administered, must be established.
	A prescriber's order is required for self-administration such as "May self-administer", specifying the drug, dose, frequency, route, etc.
	A prescriber's order is required for medications to be kept at bedside and should include "May be kept at the bedside". Medications should be kept secure (i.e. locked).
The hospital has policies and procedures to monitor, report, and review adverse drug reactions (ADRs). Reference: R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT; Accreditation Canada: Medication Management; Food and Drug Regulations; Protecting Canadians from Unsafe Drugs Act (Vanessa's Law); ISMP: Mandatory Reporting of Serious Adverse Drug Reactions and Medical Device Incidents	There must be an interdisciplinary review process for each reported adverse drug reaction, to identify trends and plan for system improvements to mitigate risk. The review should be done in collaboration with a pharmacist.
	Adverse drug reactions should be reported to Health Canada and the manufacturer. https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html
	Serious adverse drug reactions (defined in C.01.001(1.1) of the Food and Drug Regulations) must be reported to Health Canada as outlined in the Guidance document - Mandatory reporting of serious adverse drug reactions and medical device incidents by hospitals
The hospital has continuous quality improvement program to detect, record, analyze and manage medication incidents. Reference: OCP Standards of Operation for Pharmacies; OCP AIMS (Assurance And Improvement in Medication Safety) Program Standards & Expectations; Accreditation Canada: Required Organizational Practices; Accreditation Canada: Medication Management; CSHP Medication Incidents: Guidelines on Reporting and Prevention (2012); ISMP Canada Medication Safety Self-Assessment® (MSSA)	There must be a process to identify when patients are not receiving medications as ordered by the prescriber or "missed" receiving a dose of medication.
	There must be procedures for recording medication incidents and near-misses in the safety incident management system.
	There must be a collaborative interdisciplinary process to review and analyze individual medication related incidents and near misses in a timely manner for contributing and/or causal factors, including follow-up with individuals involved, and to identify possible trends.
	There must be a process to plan for system improvements and/or implementation of risk mitigation strategies to reduce the likelihood of incident reoccurrence.
	Changes must be monitored after implementation for evidence of effectiveness and improvement toward safer systems/processes and patient outcomes.
	There must be a process to complete a medication safety self-assessment (MSSA) at least every 2-3 years.

The hospital has a process to communicate safe medication practices and share lessons learned within the organization. Reference: QCP Supplemental Standard of Practice; Accreditation Canada, Required Organizational Practices; CSHP Medication Incidents: Guidelines on Reporting and Prevention (2012)	There must be a process to educate staff on patterns or trends of medication incidents, contributing factors, and how to avoid a recurrence.
	There must be a process to communicate unsafe medication practices to the hospital's risk management department.
	There must be a process to communicate continuous quality improvement plans and outcomes with staff.
In consultation with Infection Prevention and Control (IPAC), the hospital has policies and procedures to ensure medications do not contribute to cross contamination. Reference: O. Reg 264/16; Infection Prevention and Control (IPAC) Program Standard	Procedures must ensure the medication supply is kept free of potential contamination.
	Contaminated medications should not be returned to the pharmacy from patient care areas.
	There must be procedures to ensure medication storage areas are not sources for potential contamination (e.g. returns bin in Automated Dispensing Cabinets, patient bins/drawers, medication cassettes, medication carts, medication rooms, Workstation On Wheels, barcode scanners, etc.).
Sterile preparations compounded in the patient care areas are only for immediate use. Reference: NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations and Hazardous Sterile Preparations; USP <797>; Accreditation Canada, Medication Management	Hazardous sterile preparations do not qualify as immediate-use preparations.
	Compounded sterile preparations prepared for immediate use in patient care areas must comply with the following conditions: • Compounding is performed only when the situation is critical, with a requirement for immediate administration to the patient. • The preparation does not exceed 3 "sterile units" and for each sterile unit used, there are no more than two entries into any one container/device • Aseptic technique is rigorously applied and does not require more than 1 hour of continuous preparation.
	The Beyond-Use Date (BUD) at controlled room temperature or stored in the refrigerator is one hour. Preparations cannot be stored for later use (i.e. in freezer). Administration of the preparation must begin within 1 hour after the start of compounding; otherwise, the preparation must be discarded.
	Compounding in worse than ISO Class 5 conditions increases the likelihood of microbial contamination, and administration durations exceeding a few hours increase the potential for clinically significant microbial colonization and patient harm, especially in critically ill or immunocompromised patients.

CONTROLLED SUBSTANCES IN PATIENT CARE AREAS

STANDARD	GUIDANCE
A random audit performed in the patient care area during the OCP assessment did not reveal a discrepancy. The audit demonstrates accurate documentation of the controlled substance inventory and the medication administration to the patient. Reference: Controlled Substances Regulations (SOR/2025-242), s. 172	A random audit performed in the patient care area during the OCP assessment must not reveal a discrepancy and must demonstrate accurate documentation of controlled substance administration.
	Hospital staff should review the Controlled Substances Regulations (SOR/2025-242) to ensure compliance with regulatory requirements
Documentation, retention, and provision of information and records related to controlled substances are managed in accordance with hospital policies and procedures and applicable regulatory requirements Reference: Controlled Substances Regulations (SOR/2025-242), ss. 184, 187	All records related to controlled substances must be maintained through a hospital process that allows an audit to be conducted at any time
	Random audits for controlled substances, including tracers, must be regularly performed through a defined process to reconcile the prescriber's order, transcription, withdrawal record, MAR, count/waste sheets, and related documentation to ensure accurate completion and reconciliation.
	Documentation pertaining to controlled substances must be legible, indelible, complete, and readily retrievable
	There must be a process to reconcile and record the use of controlled substances from emergency kits (e.g. code blue trays and hospital transport kits)
Fentanyl patches are managed through documented processes for collection and administration that safeguard them from misuse, abuse, and diversion. Reference: O. Reg. 305/16	Fentanyl patches must be managed under documented policies and procedures governing their administration and removal, with safeguards in place to prevent misuse, abuse, and diversion.

Controlled substances are stored securely and safeguarded from unauthorized access in accordance with hospital policies and operational processes that meet applicable regulatory requirements. Reference: Controlled Substances Regulations (SOR/2025-242); OCP Medication Procurement and Inventory Management Policy; Ontario College of Pharmacists – Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas	All reasonable measures must be taken by the hospital to ensure that controlled substances are securely stored, protected, and accessible only to authorized individuals.
	Access to controlled substance storage areas must be removed when individual personnel leave the hospital or no longer require access, including for an extended leave.
	Conducting inventory counts for controlled substances across the hospital should occur at minimum every six months (encompassing automated dispensing cabinets, pharmacy areas, and patient care units, etc.). Additional counts should be conducted after sudden staffing changes and following loss or theft incidents
	Resolving discrepancies in controlled substance counts must be addressed through hospital policies and procedures designed to identify and correct variances.
	Patients' own controlled substances must be managed through established hospital policies and procedures, including regular counting and reconciliation during the hospital stay and at discharge or following the patient's passing
Loss or theft of controlled substances is reported in accordance with applicable regulatory requirements and reporting timelines. Reference: Controlled Substances Regulations (SOR/2025-242), s. 173; Ontario College of Pharmacists – Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas	Staff must report any suspected loss or theft of a controlled substance through established hospital procedures.
	Loss or theft of controlled substances must be reported to the Office of Controlled Substances within 10 days of discovery as per the Health Canada Guidance on reporting loss or theft of controlled substances and precursors (CS-GD-005).
The destruction of controlled substances is carried out by the hospital in compliance with the Controlled Substances Regulations (SOR/2025-242) Reference: Controlled Substances Regulations (SOR/2025-242), ss. 174, 183	The destruction of controlled substances must be carried out by an authorized individual and witnessed by an eligible person, in accordance with the Controlled Substances Regulations (SOR/2025 242).
	The person who destroys controlled substances and the witness must sign and date a joint declaration attesting that the controlled substance was destroyed immediately following the destruction. Each signatory must add their name in printed letters.
	The record of destruction must be completed in accordance with the Controlled Substances Regulations (SOR/2025 242).
	The method of destruction must comply with applicable federal, provincial, and municipal environmental protection legislation.

Distribution and transportation of controlled substances to other hospitals is supported by hospital policies and procedures that meet applicable regulatory requirements Reference: Controlled Substances Regulations (SOR/2025-242), ss. 170–172, 182	The hospital must take all reasonable measures to ensure the security of any controlled substance while it is being delivered, sent or transported.
	The hospital must use a method of delivery, sending or transportation that ensures the tracking of the controlled substance until the consignee receives it.
	The record of the delivery, sending, or transportation of controlled substances to another hospital must include all required information, in accordance with the Controlled Substances Regulations (SOR/2025-242).
Opioid agonist therapy is managed through policies and procedures that guide its prescribing, procurement, dispensing, and administration. Reference: OCP Opioid Policy; CAMH Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorder; Ontario Health Transitions Between Hospital and Home Quality Standard	Opioid agonist therapies must be prescribed, procured, dispensed, and administered in accordance with hospital policies and procedures.
	Methadone doses must be prepared using a commercially available product as per the Health Canada Policy on Manufacturing and Compounding Drug Products in Canada (POL-0051).
	Prior to dispensing OAT to any patient admitted to hospital, the patient's pharmacy (or clinic/facility where the patient is receiving OAT) must be contacted to notify them of the patient's admission and to determine details of the last dose.
	Prior to the discharge of any patient on OAT, the patient's pharmacy (or clinic/facility where the patient is receiving OAT) must be contacted to notify them of the discharge date, time and amount of last dose to ensure uninterrupted treatment and a safe transition of care.

RECORD RETENTION, AUDITABILITY AND TRACEABILITY

STANDARD	GUIDANCE
Provision of medications delivered to patients includes a process that ensures medications are auditable and traceable to the patient level Reference: NAPRA Pharmacy Practice Management Systems Supplemental Requirements; NAPRA Compounding Standards	As an organization continue to strive for auditability and traceability of all medications doses to the patient level.
	There should be auditability and traceability for patient specific oral solids.
	There should be auditability and traceability for patient specific oral liquids.
	There should be auditability and traceability for patient specific non-sterile compounding.
	There should be auditability and traceability for patient specific methadone (MMT).

	There should be auditability and traceability for patient specific non-hazardous sterile compounding.
	There should be auditability and traceability for patient specific TPN.
	There should be auditability and traceability for patient specific hazardous sterile compounding/chemotherapy.
Records are retained in accordance with legislation. Reference: R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT; OCP Guideline - Record Retention, Disclosure and Disposal	Medication records relating to the care of a patient, regardless of form, must be maintained for a time period of at least 10 years from the last visit/date of discharge, or until 10 years after the day on which the patient reached or would have reached the age of 18 years, whichever is longer.
	Medication-related quality assurance/quality improvement documentation must be retained for 10 years.
In consultation with the privacy officer, patient confidentiality and personal health information is protected. Reference: Personal Health Information Protection Act	There must be policies and procedures to maintain confidential medication records and maintain privacy for all patients.
	The hospital must ensure that when disposing of personal health information that it be performed in a manner that ensures confidentiality.

Hospital Pharmacy, Primary Location

Category: Standards of Operation

MEDICATION SECURITY AND STORAGE IN THE PHARMACY

STANDARD	GUIDANCE
The pharmacy has the facilities and equipment needed to ensure medications are stored securely and safeguarded from unauthorized access Reference: OCP Standards of Operation for Pharmacies; Accreditation Canada, Medication Management	Medications stored in the pharmacy must be secure and safeguarded using from unauthorized access physical security measures (e.g. protected by locked doors, swipe access, key, or similar secure barriers).
	If medications being received are not delivered immediately and directly to the pharmacy, they must be stored in a secure environment (i.e. locked area) until received by authorized pharmacy staff.
The pharmacy has policies and operational processes to ensure medications are stored securely and safeguarded from unauthorized access Reference: OCP Standards of Operation for Pharmacies; Accreditation Canada, Medication Management	There must be appropriate measures in place to restrict access to the pharmacy to authorized pharmacy personnel only. Authorized personnel must be documented and access removed when staff leave the hospital, including for an extended leave.
	There must be swipe card/access code/key assignment records and a process to audit entry/attempted entry/detect unauthorized entry to the pharmacy areas to ensure personnel compliance with policies and procedures.
Medication storage areas and equipment are designed, constructed and maintained to be fit for their purpose to preserve the integrity of the medication supply. Reference: OCP Standards of Operation for Pharmacies; OCP Protecting the Cold Chain Guideline; Accreditation Canada, Medication Management; Accreditation Canada, Required Organizational Practices; ISMP Targeted Medication Safety Best Practices for Hospital; O. Reg. 67/93: HEALTH CARE AND RESIDENTIAL FACILITIES	The pharmacy must have adequate storage and work space, supplies, the appropriate layout, facilities, and equipment to store medications in a safe, secure and appropriate manner and location. Medications and supplies must be kept off the floor.
	Medication storage areas must have risk identification and mitigation strategies in place for high-alert medications (e.g., segregation, labelling, etc.) to ensure a safe medication distribution system.
	Products for irrigation must be clearly differentiated, labelled and stored separately from parenteral solutions for injection (e.g. manufacturer or pharmacy-prepared-irrigation solutions, organ storage solution, and sterile water).
	Medication storage areas must have evidence of the appropriate conditions of temperature, light and humidity necessary to ensure a safe medication management system.
	The pharmacy must ensure medication integrity and security is maintained throughout the preparation, delivery and transport process. This includes the medication drop off and returns bins/boxes.

	Storage of poisons and flammable products must follow the relevant occupational health and safety legislation, guidelines and standards.
The pharmacy has policies and procedures to regularly audit medication storage areas and ensure inventory is managed in a manner that maintains the quality and timeliness of the medication supply. Reference: Accreditation Canada, Medication Management; OCP Guideline – Protecting the Cold Chain; O. Reg. 67/93: Healthcare and Residential Facilities	There must be a process to remove and dispose of expired, outdated, unusable or recalled medications and active pharmaceutical ingredients (used for compounding) from the dispensing process (including automated packaging machines) in a timely manner.
The pharmacy has operational processes to ensure the cold chain is maintained. Reference: Accreditation Canada, Medication Management; OCP Standards of Operation for Pharmacies; OCP Guideline – Protecting the Cold Chain	All cold storage equipment for medication must be fit for its purpose and maintained at the required storage temperature range, calibrated and certified as required and supported by documentation.
	Refrigerator temperatures must be monitored regularly. For manual recording, the minimum and maximum temperature should be recorded twice per day.
	Standard operating policies and procedures must be in place within the pharmacy to ensure that the cold chain is maintained throughout the time a product is received, stored, dispensed and delivered and/or administered to the patient.
	There should be emergency preparedness processes in place to address any temperature excursions or breaks in cold chain (e.g. due to equipment failure, power outages, etc.).
	The pharmacy administrator is responsible for ensuring all medications found in the refrigerator/freezer during a temperature variance are appropriate to dispense. The integrity of medications must be assessed and verified such that patients do not receive a potentially sub-potent product.
	All pharmacy and support staff involved in handling cold chain products must be trained on cold chain maintenance policies and procedures.
	Pharmacy staff must be familiar with the Protecting the Cold Chain Guideline and the associated references on the OCP website.
	Pharmacy staff should review the standards specified in the Ontario Ministry of Health Vaccine Storage and Handling Guideline.

The pharmacy has policies and operational processes for the handling of hazardous medications to mitigate risk to staff and patients. Reference: NIOSH list of antineoplastic and other hazardous drugs in healthcare settings; Accreditation Canada, Medication Management; NAPRA Model Standards for Pharmacy Compounding of Non- Hazardous Sterile Preparations and Hazardous Sterile Preparations; NAPRA Model Standards for Pharmacy Compounding of Non-sterile Preparations	There must be separate storage areas for hazardous medications (e.g., segregation by location, by shelf, by drawers or another means) which are clearly labelled to alert all personnel. Storage areas should prevent spillage or breakage if the container falls.
	Hazardous medications must be clearly identified and pharmacy personnel are educated on safe handling and storage requirements. It is recommended that the pharmacy administrator review occupational health and safety resources (e.g., NIOSH, CCO, ISMP, etc.)
	There must be an inventory list of hazardous medications in the pharmacy that is accessible to all staff.
	Hazardous waste must be sealed and packaged in the appropriated container, kept segregated and clearly labelled.
	There must be processes that guides the proper packaging and delivery of liquid dosage forms, including parenteral formats, of hazardous drugs (including antineoplastics) to prevent leakage/spillage.
Medication storage areas must have the sanitary conditions necessary to ensure a safe medication management system. Reference: OCP Standards of Operation for Pharmacies; R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT; O. Reg. 67/93: HEALTH CARE AND RESIDENTIAL FACILITIES; Public Health Ontario: Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition; Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition	There must be a policy to assess compliance with infection prevention and control (IPAC) procedures in the pharmacy.
	The medication and prescription storage areas must not be used to store food and drinks and used to store only medications and medication-related supplies
	The pharmacy must have policies and procedures for the routine cleaning of the department.
	Patient's own medications must not be stored in pharmacy to safeguard the medication supply.
	Patient's own medications must not be sent to pharmacy for destruction, with the exception of narcotics, controlled drugs, benzodiazepines and targeted substances
	The pharmacy staff should be aware of Infection Prevention and Control (IPAC) resources on the Public Health website.
	The pharmacy staff should understand how and when to contact an Infection Prevention and Control (IPAC) Professional or Public Health.

SYSTEMS TO PROVIDE SAFE AND EFFECTIVE PHARMACY SERVICES

STANDARD	GUIDANCE
There are systems in place to safely dispense medications when the pharmacy is closed. Reference: Accreditation Canada, Medication Management	Medications obtained after-hours or in emergency situations must be verified and reconciled with the order by the pharmacist or pharmacy technician to ensure accurate medication selection when the pharmacy re-opens.
	There must be a process for a pharmacist to review prescriptions obtained after-hours to ensure therapeutic appropriateness.
	The pharmacy must have policies and procedures to regulate, limit, dispense and ensure safe after hour access to medications with necessary safeguards in place (e.g. access to an on-call pharmacist, authorized personnel only, controlled access, a limited selection of urgently required medication, etc.).
	Additional safeguards must be in place for high-alert medication. (e.g. requires a call to a pharmacist to review order prior to release of medication).
The pharmacy provides oversight for distribution and control of all medications used by the Hospital. Reference: Regulated Health Professions Act; O. Reg. 202/94; DPRA; Canadian Pharmacists Association – Drug Shortages: A Guide for Assessment and Patient Management ISMP: Drug Shortages and Medication Safety Concerns.	A pharmacist must approve all policies and procedures related to product specifications, drug distribution and control of medications throughout the hospital's medication management system
	There must be policies and procedures for medication supply issues such as shortages, back orders, and distribution allocations.
	There must be a process in place to address medication recalls.
	There should be a process in place to communicate and educate staff about drug shortages.
	There should be a process in place to alert stakeholders to impending shortages and potential alternatives.
	Emergency kits/trays/boxes prepared by the pharmacy must have a seal which visually indicates when they have been opened.
	There must be a process to audit medication management systems, and to track and trend reports for ongoing system and service improvement (e.g. unit dose cart fill, ADC processes, IV admixture preparation, controlled substance record audits, etc.).
	The pharmacy must ensure medication integrity and security is maintained throughout the delivery and transport process. This includes the medication drop off and returns bins/boxes.
	The pharmacy has a policy and procedure to notify pharmacists of all returned doses that cannot be explained by orders changes (e.g. changes to a drug, dose or frequency).

All medication orders received by pharmacy must be reviewed by a pharmacist for appropriateness. Reference: Accreditation Canada, Medication Management; Ministry of Health and Long-Term Care Professional Pharmacy Services Guidebook 3.0	The must be a policy and process to ensure that during pharmacy hours of operation all medication orders are reviewed by a pharmacist prior to release to the patient care area.
	There must be a policy and process to ensure that a pharmacist reviews new medication orders as well as ongoing medication orders against the patient's medication profile to ensure the medication is therapeutically appropriate for the specific patient.
	For patients with lengths of stay 90 days or greater, there must be a policy and process to ensure a pharmacist conducts a medication review at least every 3 months (quarterly).
The pharmacy has a process to document patient care and professional activities. Reference: CSHP – Documentation of Pharmacists' Activities in the Health Record: Guidelines (2013); OCP Documentation Guidelines; OCP Record Retention, Disclosure and Disposal Guideline	There must be a process to ensure that pharmacy professionals document their decisions/actions, supporting patient and related medication-related information in the patient health care record, as per hospital policy and as required by current legislation, standards, policies and guidelines applicable to pharmacy practice. Records must be clear, accurate and legible.
	There must be a process to enable pharmacy professionals to document pertinent information in the patient record in a way that is timely, readily retrievable, saved in a standardized fashion and done consistently to ensure continuity of care and that patient outcomes are optimized.
The pharmacy has policies and procedures to ensure accurate dispensing of medications. Reference: Accreditation Canada: Medication Management	The pharmacy must ensure dispensing policies and procedures are effective and safe. Policies and procedures must be sufficiently detailed for the labelling and verification of dispensed products.
	There must be a process to ensure pharmacy professionals document their activities and the information necessary to support the rationale and quality of these activities, in a timely manner, when preparing, dispensing and distributing medication.
	Authorization of the individuals responsible for each step in the dispensing process must be clearly documented and reflect accountability.
	Policies and procedures for accurate stock replenishment of medications in patient care areas must be sufficiently detailed.
	Policies and procedures for high risk medication therapies and high risk patient populations (e.g. pediatrics, neonates, etc.), must have additional safeguards to ensure patient safety prior to dispensing.

The pharmacy has organized workflow to enable pharmacists and pharmacy technicians to meet their standards of practice and to optimize patient care. Reference: OCP Standards of Operation for Pharmacies	There must be processes to permit optimal work flow management which do not impede pharmacy professionals from practicing to their full scope
	There must be processes to support patient care and permit pharmacy professionals to provide healthcare and services that meet the standards of practice of the profession.
	There must be a process to gather relevant information to enable pharmacy technicians to verify the technical accuracy of the medication against the order prior to dispensing the first dose, during pharmacy hours of operation.
	There must be a process for pharmacy technicians to refer drug utilization alerts and patients which require assessment, clinical analysis or application of therapeutic knowledge to a pharmacist for review prior to releasing the medication order.
	There must be a process for pharmacy technicians to identify and refer to the pharmacist discrepancies between a patient's current drug therapy and the intended therapy.
	There should be a process to prioritize patient monitoring based by identifying high risk populations and/or patients on high-alert medications.
	There must be a process to ensure pharmacists are responsible for monitoring medication therapy to detect, resolve and prevent drug therapy problems, at a frequency appropriate for the medical condition being treated, in accordance with NAPRA Standards.
	There must be a process for pharmacy professionals to prepare and provide handoff communication to appropriate personnel.
	Pharmacy personnel must receive appropriate orientation and training to premises-specific procedures and equipment, relevant to the services provided.
	Pharmacy personnel must be able to access references and resources as necessary to support the delivery of patient care.
	The pharmacy administrator must have a system to assess and update policies and procedures as required to ensure consistency with legislation, OCP by-laws, standards, policies and guidelines.
	The pharmacy administrator must be responsible for ensuring all pharmacists and pharmacy technicians maintain current licensure with the Ontario College of Pharmacists.
	The pharmacy administrator should review the NAPRA Model Standards of Practice for Pharmacists.
	The pharmacy administrator should review the NAPRA Model Standards of Practice for Pharmacy Technicians.

The pharmacy has a collaborative process for performing medication reconciliation at each transition of care. Reference: Accreditation Canada, Required Organizational Practices; ISMP Ontario Primary Care Medication Reconciliation Guide	There must be a process for pharmacy professionals conducting a Best Possible Medication History (BPMH) to document the BPMH in the patient health care record.
	There must be a process for pharmacists conducting medication reconciliation to document in the patient health care record.
	There should be a process for pharmacists to work collaboratively with other healthcare professionals to design, implement and deliver medication reconciliation at transitions of care.
The pharmacy has a continuous quality improvement program to detect, record, analyze and manage medication incidents. Reference: OCP Standards of Operation for Pharmacies; OCP Supplemental Standard of Practice; Accreditation Canada, Medication Management; CSHP Medication Incidents: Guidelines on Reporting and Prevention (2012); NAPRA Model Standards for Continuous Quality Improvement and Medication Incident Reporting	There must be a process to review and analyze individual medication incidents and near misses in a timely manner for contributing and/or causal factors, including follow-up with individuals involved, and to identify possible trends.
	The pharmacy must have a process to plan for system improvements and/or implementation of risk mitigation strategies to reduce the likelihood of recurrence.
	Changes must be monitored after implementation for evidence of effectiveness and improvement towards safer systems/processes and patient outcomes.
	There must be procedures for recording medication incidents and near-misses in the hospital's safety incident management system.
	Medication incident reporting processes should cultivate and foster a safety culture for promoting open and honest discussions and support shared accountability.
	Pharmacy professionals should be supported to meet their Standards of Practice. The Supplemental Standard of Practice outlines requirements for pharmacy professionals in the College's Assurance and Improvement in Medication Safety (AIMS) program.
The pharmacy has a process to communicate safe medication practices and share lessons learned with pharmacy staff. Reference: OCP Supplemental Standard of Practice; CSHP Medication Incidents: Guidelines on Reporting and Prevention (2012)	The pharmacy must have a process to communicate continuous quality improvement plans and outcomes with staff.
	There must be a process to educate staff on patterns or trends of medication incidents/near misses, contributing factors, and how to avoid a recurrence.
	There must be a process to communicate unsafe medication practices to the hospital's risk management department.

TECHNOLOGY IN PHARMACY	
STANDARD	GUIDANCE
The pharmacy has policies and procedures to ensure the safe operation of all pharmacy equipment and appropriate use of technology. Reference: OCP Standards of Operation for Pharmacies; NAPRA PPMS	There must be documentation that tracks the dispensing process from entry of an order into the system to final verification and includes the authorization (signature or some other unique identifier) of the individuals responsible for each step. Policies and procedures need to outline the checks embedded into the process in order to minimize the risk of error and detect unauthorized access.
	The pharmacy must ensure technology used is safe to use and fit for its purpose within the medication management system, including, as applicable, for the preparation, dispensing, distribution, storage and compounding of drugs and other medications.
	The pharmacy must have a log for initial certification, preventative maintenance, repairs, cleaning, and maintenance routines for all medication-related equipment.
	There must be policies and procedures related to medication-related equipment down time or failure to avoid delays or interruptions in a patient's therapy. Contingency procedures should be tested, documented and reviewed for system improvements.
	There must be a process to identify malfunction within the technology used (scanning, barcoding, dispensing automation, etc.) to determine the root cause. These deficiencies must be reviewed by the pharmacy administrator to track and trend improvements.
The pharmacy has a policy and procedure to ensure appropriate barcoding of the medication throughout the medication management system. Reference: Accreditation Canada, Medication Management; ISMP/CPSI Medication Bar Code System Implementation Planning; NAPRA PPMS - Supplemental Requirements on Traceability and Bulk Preparation Labelling	There must be systems in place to ensure barcodes are applied accurately before product release.
	Documentation (in a log or in an electronic database) must track the barcoding process from barcode generation to final verification and includes the signatures of the individuals involved in each step of the process.
	The policies and procedures must outline the checks embedded into the process to minimize the risk of error.
	There must be a process to identify deficiencies with scanning technology and determine and address the root cause.
	Records of barcode scanning failures should be retained and reviewed to track and trend for system improvements.

PACKAGING AND REPACKAGING	
STANDARD	GUIDANCE
The pharmacy has policies and procedures for repackaging according to standards. Reference: O.Reg. 264/16: GENERAL; Accreditation Canada, Medication Management; CSHP - Repackaging: Guidelines for Healthcare Facilities; USP General Chapter <1178>, <1146>	The pharmacy must have a policy and procedure for repackaging including the use personal protective equipment (PPE).
	There must be a process for pharmacy staff to be trained on repackaging including the use personal protective equipment (PPE) prior to engaging in this task.
	Repackaging records must be complete, auditable and traceable, and available for reference (methods, equipment, labelling, beyond use date (BUD), storage conditions, personnel responsible for packaging and checking (verification), etc.)
	There must be a policy and procedure to ensure unused medication is only returned to inventory if it is in a sealed dosage unit or container as originally dispensed, the labelling is intact includes a legible drug lot number and expiry date or beyond use date (BUD), and the integrity of the drug can be verified prior to re- distribution.
	Pharmacy policies and procedures must outline which drugs can be prepared/packaged using specific packaging and equipment/machines.
	Pharmacy staff must use the appropriate packaging to maintain the physical integrity, sterility and stability of the medication during handling, transportation and storage and until it is administered to the patient.
	Pharmacy staff should review USP for packaging and repackaging standards.
	Pharmacy staff should review CSHP - Repackaging: Guidelines for Healthcare Facilities
The pharmacy has a policy and procedure for the assignment of beyond use dates (BUDs) for repackaged medications.	Repackaging and storage of repackaged drugs should occur in an environment that is consistent with the conditions described in the original drug product's labeling. If temperature and humidity are not specified in the original labeling, the product should be maintained at "controlled room temperature" and in a "dry place"
	The pharmacy must have a policy and procedure for assignment of beyond use dates (BUDs) for repackaged medications including documentation of approval, date of review, and reference used. A pharmacist must be responsible for determining the BUDs for all medications in the pharmacy.

Reference: CSHP - Repackaging: Guidelines for Healthcare Facilities; USP General Chapter <1178>, <1146>	The pharmacy must use the appropriate packaging containers and materials to maintain the physical integrity, sterility and stability of the medication during handling, storage and transportation.
	The pharmacy must have policies and procedures on criteria that guide the appropriate selection of packaging materials for each type of drug/package/product/machine (e.g. ATC, PacMed, dry and wet Cadets).
The pharmacy has policies and procedures for repackaging of hazardous drugs according to established standards. Reference: NIOSH list of antineoplastic and other hazardous drugs in healthcare settings; USP <800> Hazardous Drugs—Handling in Healthcare Settings; Model Standards for Pharmacy Compounding of Non-Sterile Preparations; O. Reg. 67/93: HEALTH CARE AND RESIDENTIAL FACILITIES	Dedicated equipment must be segregated and properly labelled for hazardous drug use. (I.e. chemotherapy counting tray in addition to a non-antineoplastic drug counting tray). Equipment must be deactivated, decontaminated and cleaned after each use, or if disposable equipment is used, disposed of appropriately.
	The pharmacy must determine and identify medications requiring dedicated equipment and personal protective equipment (PPE).
	There must be a process to ensure personnel comply with the personal protective equipment (PPE) policies and procedures for hazardous product repackaging. Training must be completed and documented prior to engaging in this activity.
	Solid dosage forms of hazardous drugs should not be placed in automated packaging machines or counting machines which subject them to stress and may introduce powdered contaminants into the machine and/or environment.
	Hazardous drugs supplied by the manufacturer in unit dose packaging which do not require further manipulation must be dispensed in the original package, unless otherwise specified by the manufacturer or there are indicators of exposure hazards present (e.g. visible dust, leakage, etc.)
	Non-antineoplastic hazardous drugs that only require transfer from the manufacturer's package to the prescription container must be dispensed without any further requirements for containment unless required by the manufacturer.
	Non-sterile hazardous drug manipulation (such as crushing/splitting tablets or opening capsules) must be performed in accordance with occupational health and safety guidelines and recognized standards (i.e. in a BSC/CACI using appropriate PPE as outlined in NIOSH, OSHA, etc.).
	For occasional non-sterile hazardous drug manipulation, a C-PEC used for hazardous sterile compounding (e.g., Class II BSC or CACI) may be used but must be decontaminated, cleaned, and disinfected before resuming sterile compounding in that C-PEC.

CONTROLLED SUBSTANCES WITHIN THE PHARMACY	
STANDARD	GUIDANCE
A random controlled substances count performed during the OCP assessment within the hospital pharmacy department did not reveal a discrepancy and demonstrated matching documentation between the expected and actual count.	A random audit performed during the OCP assessment in the hospital pharmacy department must not reveal a discrepancy. Documentation must be accurate and reflect drug distribution activities
	Pharmacy staff should review applicable legislation and standards related to controlled substances to ensure compliance (e.g., Controlled Substances Regulations (SOR/2025-242))
Safeguarded from unauthorized access, controlled substances are securely stored and managed in accordance with hospital pharmacy policies and operational processes that meet applicable regulatory requirements.	The hospital pharmacy must take all reasonable measures to ensure the security of any controlled substance in its possession. Safeguards must be in place, to prevent unauthorized access.
	Random audits and verifications of controlled substances within the pharmacy department must be performed regularly, including review of purchase orders and receipts, dispensing records, and perpetual inventory records.
	The pharmacy must ensure delivery and movement of controlled substances within the hospital are secure, auditable and traceable.
AUTOMATED DISPENSING CABINETS	
STANDARD	GUIDANCE
There are policies and procedures for the use of Automated Dispensing Cabinets (ADCs) within the medication management system Reference: Accreditation Canada, Medication Management; ISMP Guidelines for the Safe Use of Automated Dispensing Cabinets; ISMP Canada Automated Dispensing Cabinets in the Canadian Environment; NAPRA Pharmacy Practice Management Systems Requirements	There must be policies and procedures to determine the location, access, which medications are stored in which patient care areas and in what quantity, type of medication information available, and verification for restocking.
	There must be a process to ensure medications are loaded accurately, and the ADC is stored safely and appropriately (e.g. temperature, humidity, low traffic areas, etc.) to maintain the integrity of the medications.
	There should be a process for a pharmacist to determine the appropriateness of medications in each ADC.
	There must be a process to identify and address security breaches within the ADCs.
	All ADCs should have an interface with the pharmacy practice management system (PPMS) for order entry and verification.
	Medications should be withdrawn from an active patient profile during pharmacy business

	hours. Limit overrides for ADC medications to after pharmacy hours.
	There must be a process for pharmacist review of all orders prior to administration when the pharmacy is open.
	An independent double check should be required for selected items removed through the override function (e.g., high-alert drugs, controlled substances, etc.)
	Access via override must be reconciled against the order by a pharmacist or pharmacy technician for each dose obtained; overrides for new orders must be reviewed by a pharmacist to ensure clinical appropriateness.
	The hospital should establish indicators and targets for use of the override function, and audit these indicators and targets regularly (e.g., monthly).
DELEGATION	
STANDARD	GUIDANCE
There is a delegation process for authorizing an individual to perform a controlled act. Reference: <i>Regulated Health Professions Act (RHPA)</i>; O. Reg. 202/94; OCP Policy - Medical Directives and the Delegation of Controlled Acts; HPRO - An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario	There must be a delegation policy and process for all controlled acts undertaken by regulated and unregulated staff in the pharmacy who do not have the independent authority to perform those acts.
	There must be documented procedures outlining the controlled act(s) being delegated and the assessment of the knowledge, skill and judgement to competently perform the acts.
	The pharmacy administrator must ensure there are documented procedures for the training of volunteers and confirmation that all volunteers have received training prior to performing assigned duties, even if not performing controlled acts, in the pharmacy.
	The pharmacy administrator should review Navigating Delegation of Controlled Acts on the OCP website.
	The pharmacy administrator should review the OCP Medical Directives and the Delegation of Controlled Acts Policy.

TELEPHARMACY

STANDARD	GUIDANCE
There are operational policies to ensure telepharmacy services meet all professional standards. Reference: CSHP Telepharmacy: Guidelines 2018; OCP Virtual Care Policy	The pharmacy administrator must have policies and procedures in place to ensure the safe, effective and consistent provision of pharmacy services and delivery of patient care via telepharmacy services.
	Pharmacy professionals providing telepharmacy services must have access to the same patient care and medication related information as the hospital pharmacy.
	The pharmacy administrator must ensure there are processes in place for auditing and evaluating the telepharmacy service provider on a regular basis.
	Telepharmacy professionals must only access electronic pharmacy records using a secure method of transmission that does not store unencrypted personal health information on the user's remote computer.
There are processes in place to facilitate documentation by the pharmacy professionals at the telepharmacy service. Reference: CSHP Telepharmacy: Guidelines 2018; OCP Virtual Care Policy; OCP Documentation Guidelines	The hospital must have a process to ensure that pharmacy professionals document their decisions/actions, supporting patient and related medication-related information in the patient record, as per hospital policy and as required by current legislation, standards, policies and guidelines applicable to pharmacy practice.
	The hospital must have a process to enable pharmacy professionals to document their decisions/actions, supporting patient and related medication-related information in the patient record in a way that is timely, readily retrievable, saved in a standardized fashion and done consistently to ensure continuity of care and that patient outcomes are optimized.