

# Closing the Loop

*Douglas Sellinger*

Autumn is my favorite season. Here on the prairies, I appreciate the cool evenings and terrific sunsets. Autumn is also the time when we get to see what our hard work and some luck have yielded, and it's the season when the Canadian Society of Hospital Pharmacists (CSHP) renews its Executive team. On behalf of CSHP members and officers, I thank Janice Munroe, who completed her 3-year Executive term with the passing of the new CSHP bylaws.

Just in time for fall, Dr Jake Thiessen submitted his report on the chemotherapy underdosing incident in Ontario and New Brunswick, which affected 1202 patients receiving cyclophosphamide and gemcitabine. Thiessen concluded that the error was neither malicious nor a deliberate drug-sparing dilution. He also concluded that, although the ultimate impact on patients remains unknown, the probability of an overall serious effect is small (see [www.health.gov.on.ca/en/public/programs/cancer/drugsupply/docs/report\\_thiessen\\_oncology\\_under-dosing.pdf](http://www.health.gov.on.ca/en/public/programs/cancer/drugsupply/docs/report_thiessen_oncology_under-dosing.pdf)).

With an incident this large, many stakeholders have been consulted. CSHP at the national level, as well as its Ontario and New Brunswick branches, worked with other stakeholders, including the Ontario Ministry of Health and Long-Term Care, the Ontario College of Pharmacists, and the Ontario Hospital Association, as well as Health Canada and an ad hoc working group with representatives from across Canada. The goal of these consultations is to prevent a similar incident anywhere in Canada.

One important aspect of the underdosing was the specialized compounding pharmacy that prepared the drugs. Many pharmacists are familiar with the relatively recent introduction of these commercial compounding pharmacies, which compound both sterile and nonsterile preparations primarily for resale to other pharmacies, including hospital pharmacies. Pharmacies are now purchasing compounded products from these companies, rather than preparing compounds on site, for a variety of reasons, such as optimizing the use of human and financial resources, convenience, and creating dosages unavailable due to drug shortages.

It was soon realized that the underdosing incident could be replicated in other provinces if proper safety measures were not put into place. A quick review of the regulatory framework for hospital pharmacists and hospital pharmacies across the country indicated that they differ from one

province to another. Furthermore, few provinces have regulations for commercial compounding manufacturing premises. CSHP supports the regulation and inspection of commercial compounding manufacturing premises and of hospital pharmacies to promote and ensure best practices in the preparation and use of medications. Therefore, at our summer meeting, CSHP Council passed a resolution supporting the introduction of regulations for these "drug preparation premises" by the Ontario College of Pharmacists.

Work remains to be done in terms of distinguishing commercial compounding manufacturing from the bulk compounding (sterile or nonsterile) performed in hospitals and health regions and also in terms of ensuring that pharmacies requiring the services of commercial compounding manufacturing premises have access to safe preparations with appropriate labelling at a fair price. Of course, all of these measures are intended to ensure that patients' medication experiences are as safe as possible. It is hard to believe how much was achieved so quickly in an effort to improve patient safety, and everyone involved can be commended for their selfless efforts throughout the spring and summer.



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