Aggregate Analysis of Medication Incidents in Community Pharmacy


Objective

To enhance medication safety and reduce the risk of medication incidents in community pharmacy practice.

Data Source

The Institute for Safe Medication Practices Canada (ISMP Canada) reviewed 229 medication incidents that were reported to the Ontario College of Pharmacists (OCP) Complaints Committee from 2001 to 2007.

Method / Activities

- De-identified medication incident data (n = 229) were reported to the online ISMP Canada Medication Incident and Near Miss Reporting Program.
- A quantitative analysis of the medication incidents was performed.

Results

Severity of Outcome

- The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index for Categorizing Medication Errors was used to categorize medication incidents according to their severity (Figure 1).
- 26% (59 of 229) of the incidents were associated with harm or death
- 97% (57 of 59) were classified as producing only temporary harm (Figure 2)
- 74% (170 of 229) of the incidents were associated with no harm
- 15% (26 of 170) required interventions or monitoring in order to prevent harm or confirm the lack of harm to patients (Figure 2)

Possible cause(s) of medication incidents (Figure 6)

Conclusion

- Analytical results of this small sample size could not be generalized to represent community pharmacy practice.
- Continued compilation and analysis of medication incidents from community pharmacy practice would provide a more valuable data source.
- Through analysis of incidents and sharing of findings, practitioners can learn from reported incidents and implement safeguards.
- Creating a culture of patient safety with the support of a non-punitive reporting system needs to be encouraged within all areas of pharmacy practice.

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