Extending Hospital-Based Medication Incident Reporting to Enhance Medication Safety and Continuous Quality Assurance in Pharmacy Practice

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Objectives

Medication system safety and risk management is a relatively foreign concept in community pharmacy practice when compared to other health care settings in Canada. This stems in part from the lack of a medication incident reporting and learning program designed for community pharmacies.

Based on experience acquired from hospital-based incident reporting, the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) program[1] was created specifically for community / ambulatory pharmacies. The program was designed to provide opportunities to optimize learning from past mistakes in community pharmacies.

Methodology

After multiple iterations of feedback, pilot-testing, and consultation with community pharmacy practitioners, CPhIR is now available to community / ambulatory pharmacies (**Figure 1**).

CPhIR contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS)[2].

Reported incidents are analyzed anonymously by analysts at ISMP Canada using a quantitative or qualitative aggregate analysis approach with key findings disseminated back to frontline users through safety bulletins[3].

Results

As of December 31, 2011:

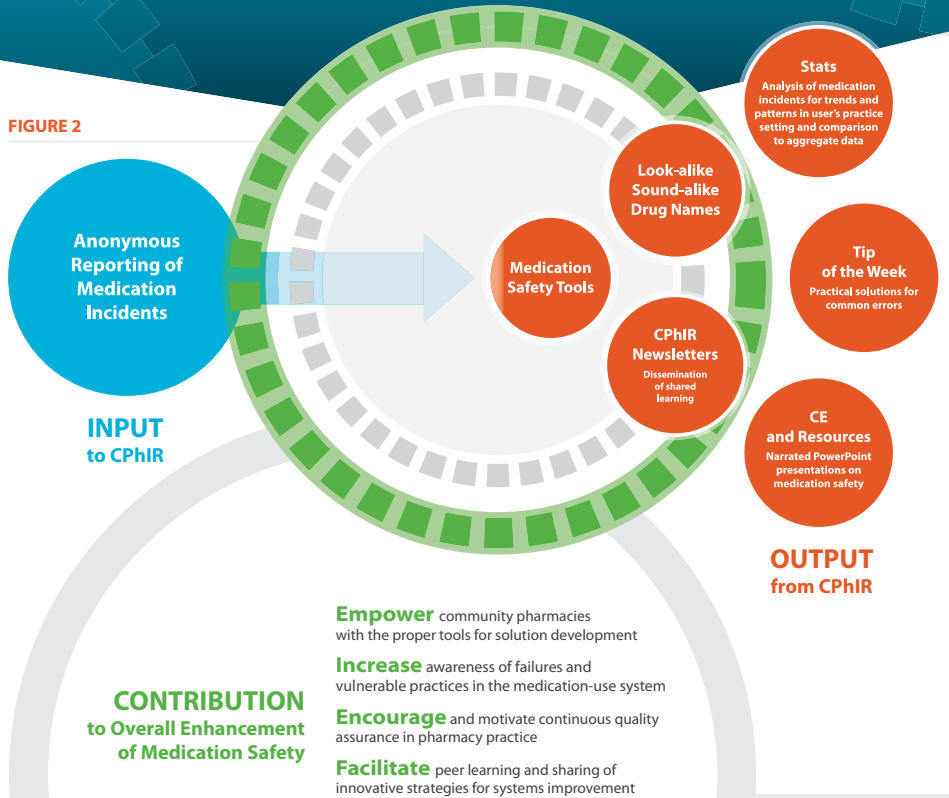
- There are over 300 registered CPhIR users.
- 23,598 medication incidents have been voluntarily reported by 273 community pharmacies in Canada.

CPhIR provides users with a secure online interface to document medication incidents, export data for analysis, and view comparisons of individual pharmacy and aggregate data.

FIGURE 1

CPhIR Data Elements	Indicator	Data Input Type/Format
Date incident occurred	Mandatory	Calendar
Time incident occurred	Optional	Pull-down menu
Type of incident	Mandatory	Radio buttons
Incident discovered by	Mandatory	Pull-down menu
Medication system stages involved in this incident	Mandatory	Check boxes
Medications	Mandatory	Text box
Patient's gender	Optional	Pull-down menu
Patient's age	Optional	Pull-down menu
Degree of harm to patient due to incident	Mandatory	Radio buttons
Incident description/how incident was discovered	Mandatory	Text box
Other incident info	Optional	Check boxes
Contributing factors of this incident	Optional	Check boxes
Actions at store level (Include action plan, person in charge, and target date for completion)	Optional	Text box
Shared learning for us to disseminate (What has been done to prevent a similar occurrence in the future)	Optional	Text box

FIGURE 2



Conclusion

The CPhIR program provides the necessary tools to empower community pharmacies to enhance safe medication practices (**Figure 2**).

Through the analysis of incidents and sharing of findings, practitioners can learn from reported incidents and implement safeguards.

Through anonymous reporting, community pharmacies can analyze medication incidents, identify root causes, and consequently implement system-based strategies for continuous quality assurance.

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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References

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2. Canadian Medication Incident Reporting and Prevention System (CMIRPS). www.ismp-canada.org/cmirps
3. ISMP Canada Safety Bulletins. www.ismp-canada.org/ISMPCSafetyBulletins.htm
4. SafetyNET-Rx – Canada. www.safetyNETRx.ca