Medication Safety in Community Pharmacies

ISMP's Community Pharmacy Incident Reporting (CPhIR) Program

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A recent study found that medication incidents are under reported in community pharmacy practice relative to other health care settings (Kelly, 2004). Although many pharmacists have recommended steps to rectify medication incidents once they occur, very few may have looked at preventing these incidents from recurring. A possible solution is to create a centralized, national portal to track medication incidents from the community setting and allow health care practitioners to analyze and review medication incidents. Through anonymous reporting, pharmacists can analyze medication incidents and learn about the possible causes of the incidents. By understanding the contributing factors and supporting an open, blame-free discussion of the incidents among team members, health care practitioners may change their practice by implementing new system-based safeguards and consequently prevent similar incidents from happening in the future.

ISMP Canada has developed the Community Pharmacy Incident Reporting (CPhIR) Program (www.cphir.ca), with support from the Ontario Ministry of Health and Long-Term Care, to allow community pharmacies to document and analyze contributing factors that may lead to errors in the medication-use system (ISMP Canada, 2010). The authors would like to acknowledge contributions to the development of CPhIR by various pharmacists, pharmacy technicians, pharmacy students, members from provincial regulatory bodies, members from professional associations, and researchers from academic institutions in Ontario and Nova Scotia (the latter through the SafetyNET-Rx research project, available at www.safetynetrx.ca/). The CPhIR Program also contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (www.ismpcanada.org/cmirps.htm). A goal of CMIRPS is to analyze medication incident reports and develop recommendations for enhancing medication safety in all healthcare settings (ISMP Canada, 2010).

CPhIR offers community pharmacies a systematic incident reporting tool, an analytical interface which allows users to compare their incident statistics with the national aggregate incident data, and a continuing professional development section dedicated to medication safety. If you would like more information about CPhIR, please contact ISMP Canada at cphir@ismp-canada.org.

Quality improvement in current practices is motivated by lessons learned from past mistakes. The goal of CPhIR is to create a national platform for community pharmacy practitioners to document and analyze medication incidents and stimulate a learning culture through anonymous incident reporting. By identifying the contributing factors and recognizing potential flaws in the medication-use system, safeguards can be employed to prevent future occurrences of medication incidents.

Reference:

ISMP Canada (2010). Hospitals Report on Medication Safety in Canada. *ISMP Canada Safety Bulletin*, 10(2), 1-4.

Kelly, W. *N. (2004). Medica*tion errors: lessons learned and actions needed. Professional Safety, 49(7), 35-41.