What do we need in medication incident reporting for effective shared learning?

By Jim Kong and Certina Ho

In order to learn from breakdowns in the healthcare system that lead to potential harm in patients, incident reporting needs to be implemented with a blame-free, non-judgemental, and non-biased manner. Incident reporting is a retrospective process that captures data for analysis and shared learning, allowing healthcare practitioners to investigate the root causes of incidents for future prevention and patient safety advancement. In recent years, mandatory incident reporting programs for community pharmacies have gradually been implemented across different provinces in Canada. With pharmacy regulatory authorities aligning processes and objectives to enhance patient medication safety, a standardized core data set for incident reporting is the foundation for a cohesive, robust national incident data repository where all healthcare practitioners can contribute, share, and facilitate continuous quality improvement in their practice settings.

MANDATORY MEDICATION INCIDENT REPORTING PROGRAMS IN COMMUNITY PHARMACIES ACROSS CANADA PRESENT A GREAT OPPORTUNITY FOR SHARED LEARNING ON HOW TO ADDRESS SYSTEM-BASED ERRORS AND IMPROVING PATIENT SAFETY NATIONALLY

Medication incident is defined as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer; medication incidents may be related to professional practice, drug products, procedures, and systems, and include prescribing, order communication, product labelling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use". Although the mechanism of reporting medication incidents and the associated application programming interfaces for the purpose of reporting may differ among reporters and reporting organizations, ISMP Canada has led the development and maintenance of the core data set for community pharmacies through the use of its community pharmacy incident reporting program originally adapted from the Canadian Medication Incident Reporting and Prevention System (CMIRPS) Core Data Set for Individual Practitioner Reporting which is aligned with the WHO conceptual framework for the International Classification for Patient Safety (ICPS) for incident type "Medication/IV Fluid". This core data set represents a universal set of incident reporting data categories that can be effectively utilized by any reporter or analyst to review, reflect, and learn from medication incidents that occurred in community pharmacies. Such harmonization of reporting characteristics not only facilitates the collection of incident data towards the national incident data repository, but also allows more comprehensive quantitative and qualitative incident analyses from which healthcare practitioners can learn from their mistakes. The seven mandatory categories of the core data set are designed to capture a cohesive narrative for reported medication incidents. The optional categories, if incorporated, are designed to further capture complexities that may be relevant to the incident narrative. Finally, by excluding any identifying information of the parties involved in the incident, as well as information regarding the healthcare professional, or relationship between the individual reporting the incident and the patient involved in the incident, the core data set eliminates the "blame and shame" potential of incident reporting that may deter potential reporters.

MANDATORY DATA FIELDS IN THE CORE DATA SET FOR COMMUNITY PHARMACY INCIDENT REPORTING

Mandatory medication incident reporting programs in community pharmacies across Canada present a great opportunity for shared learning on how to address system-based errors and improving patient safety nationally. Adopting the core data set for community pharmacies is the first step for contributing to the national incident data repository that offers a collaborative information-sharing platform where multi-disciplinary healthcare practitioners can gain a better understanding of medication incidents, as well as develop effective and feasible strategies to prevent patient harm. H

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