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.

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Rhonda Donovan
Senior Labour Relations Consultant
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Queensway-Carleton Hospital

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

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 across Canada 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.