A Multi-Incident Analysis on Medication Incidents Associated with Patient Harm

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Objectives
- Medication incidents associated with harm are rare, but potentially devastating events with significant implications for patient well-being.
- The objective of this multi-incident analysis was to gain a deeper understanding of the possible contributing factors to incidents associated with patient harm, and to develop recommendations to prevent incident recurrence.

Methodology
- A total of 971 medication incidents associated with patient harm were extracted from the Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPIR) Program from 2006 to 2017.
- Following exclusion criteria, we conducted a qualitative, thematic analysis on 909 incidents, and provided recommendations to address safety gaps corresponding to harm-related incidents.

Results
Figure 1: Designing Effective Recommendations Using the Hierarchy of Effectiveness

Conclusion
- Independent double checks are an effective strategy for preventing incidents associated with high-risk medications.
- Clear communication within the circle of care is necessary for safe and effective medication use.
- Clinical decision support systems and collaboration with professional judgment can help avoid preventable adverse drug reactions.
- Findings from this multi-incident analysis can provide a platform for reflection and shared learning.

References:
- World Health Organization (WHO), Safe Use of Medicines (2016).

Table 1: Theme 1 – High-Risk Processes in the Pharmacy

Table 2: Theme 2 – Communication Gaps

Table 3: Theme 3 – Preventable Adverse Drug Reactions