cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

ismp CANADA
Institute for Safe Medication Practices Canada
L'Institut pour l'utilisation sécuritaire des médicaments du Canada

CIHI ICIS
Canadian Institute for Health Information
Institut canadien d'information sur la santé

MEDICATION INCIDENT REPORTING IN CANADA

A WHITE PAPER

Key Messages

Overview

- A key action item from the Medication Safety Summit, co-hosted by the Canadian Patient Safety Institute (CPSI) and the Institute for Safe Medication Practices Canada (ISMP Canada) was the development of a white paper on the current landscape of medication incident reporting in Canada. This was identified as a first step towards a pan-Canadian, cohesive sharing and learning strategy.
- ISMP Canada (with funding from CPSI) and the Canadian Institute for Health Information (CIHI) collaborated on the White Paper. The White Paper describes findings and makes recommendations from each of three phases of the project: a literature scan, a survey, and a series of stakeholder interviews.

Reporting systems in Canada are collectively broad in scope but are rarely interconnected

- National, provincial/territorial, regional and facility level systems offer avenues for reporting to a broad range of health system participants, including acute and long-term care institutions, individual healthcare practitioners, community pharmacies, and patients/consumers.
- Fewer than 30% of survey respondents share some or all of their incident reports outside of their own facility or health region, thereby impeding pan-Canadian sharing and learning.
- Barriers to broader sharing included lack of linkages across systems, concern for privacy, lack of resources, lack of mandate/incentive to share and inconsistent nomenclature across systems.

Although reporting systems are broadly available, there are gaps in what is reported

- Many groups report infrequently, including patients/consumers, physicians from all care settings, and pharmacists, nurses and other healthcare providers working in the community.
- Mandated reporting is more frequent for more serious and/or harmful outcomes.
- Barriers to reporting included a lack of awareness of available reporting systems, confusion of what to report to which system, cumbersome reporting processes, unclear relevance to patient safety, reporting culture, and lack of clear definitions (e.g., medication incidents vs. adverse drug reactions).

Recommendations are proposed to improve the quantity and quality of incident reporting, and to improve linkages across reporting systems

- Expand awareness of reporting systems and portals available to all types of reporters, especially outside of acute care.
- Promote development of a cohesive network of medication incident repositories to maximize sharing and learning capabilities.
- Promote the use of a single data standard and taxonomy across reporting systems to facilitate ease of use during reporting and data aggregation for sharing and learning.

Next Steps

- ISMP Canada will lead the development of an advisory group to review these findings and recommendations with the aim to develop strategies to improve the sharing and learning capacities of reporting systems across Canada.