Medication Incident Reporting in PEI

Guidance for Pharmacy Professionals

The aim of this newsletter is to support implementation of the Model Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting by Pharmacy Professionals. The standards of practice and this guidance document aim to promote continuous quality improvement processes that contribute to patient safety and enhance patient trust in the safety of pharmacy practice in PEI. The standards represent the minimum expected standards of practice for continuous quality improvement and medication incident reporting. Other practices may be acceptable, but only if the pharmacy manager and/or pharmacy professional is able to demonstrate their equivalency or superiority to the practices outlined in the standards and guidance document.

The Council of the PEI College of Pharmacy has adopted the NAPRA Model Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting by Pharmacy Professionals. The College has approved an implementation timeline requiring all community pharmacies to report medication incidents/near misses and participate in a continuous quality improvement program by January 31, 2023.

Important Definitions

Medication Incident

Any preventable event that may cause or lead to inappropriate medication use or patient harm that has reached the patient. 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. (*ISMP Canada*)

Near Miss

An event that could have resulted in unwanted consequences but did not because, either by change or through timely intervention, the event did not reach the patient. (*ISMP Canada)*

National Database

A repository of medication incident and near miss reporting data submitted from across Canada. The data contained in a national database is de-identified and anonymized. ***PEICP has designated the National Incident Data Repository for Community Pharmacies (NIDR) as the national database.***

Everyone has a Role to Play in Patient Safety

The role of the Managing Pharmacist

Pharmacy manager standards are outlined in Section 1 of the NAPRA model standards. The managing pharmacist is responsible for the implementation and oversight of continuous quality improvement processes and medication incident reporting within the pharmacy.

The role of Pharmacy Professionals

Standards for pharmacy professionals are outlined in Section 2 of the NAPRA model standards. Pharmacy professionals incorporate continuous quality improvement in their practice and report medication incidents in accordance with the procedures in their workplace.

The role of PEICP

The data gathered from MIR does not reside with and is not owned by PEICP. The data gathered in the NIDR will not be used to trigger disciplinary or punitive action against pharmacy professionals. Pharmacy personnel must have the option to remain anonymous when reporting into the platform. The College will receive aggregate data (deidentified and anonymous) to monitor trends and participation in the mandatory medication incident reporting program (at the pharmacy level.) College practice advisors will discuss the pharmacy's use of an MIR platform and continuous quality improvement during site visits.

Why is medication incident reporting (MIR) important?

The goal of medication incident reporting is to promote continuous quality improvement processes that contribute to patient safety and enhance patient trust in the safety of pharmacy practice. The data gathered from medication incident reporting is used to promote continuous learning and quality improvement that enhances patient safety and reduces the number of harmful medication incidents.

MIR across Canada

The development of national standards of practice for reporting, analyzing, preventing, and learning from medication-related incidents was identified in NAPRA's 2019-2023 Strategic Plan.

In 2010, Nova Scotia was the first jurisdiction to implement a requirement for community pharmacies to anonymously report medication incidents for quality improvement, and for submission of data to a national database through the SafetyNET-Rx project. Since then, several provinces have implemented mandatory quality and safety improvement programs with a reporting component, including New Brunswick, Manitoba, Saskatchewan and Ontario.

Globally, the cost associated with medication errors has been estimated at $42 billion USD annually.
(World Health Organization, 2017)

The National Incident Data Repository (NIDR)

The National Incident Data Repository for Community Pharmacies (NIDR) is a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS). It is a collection of reported medication incidents submitted anonymously for the purpose of improving medication safety in the community and elsewhere. The database was established in 2008.

ISMP hosts an FAQ for further detail on the NIDR:

https://www.ismp-canada.org/CommunityPharmacy/NIDR/NIDR-faq.pdf

Costs Associated with Medication Incident Reporting

The subscription costs of the reporting platform vary based on the platform chosen.

There is an annual data processing fee of $70+tax per pharmacy payable to the NIDR, which is paid by either the pharmacy or the reporting platform provider.

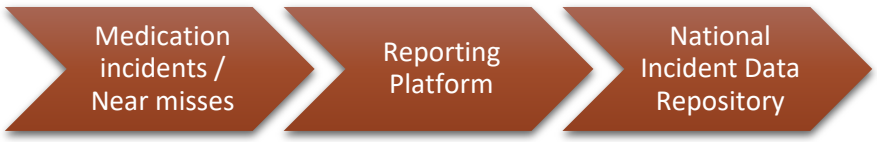
Steps to MIR Implementation

1. **Review the NAPRA Model Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting by Pharmacy Professionals and forward any questions or concerns to PEICP.**

2. **Choose a reporting platform provider.**
   a. **If your pharmacy is part of a corporation which already subscribes to a reporting platform, make sure the platform meets the requirements outlined in Appendix A.**
   b. **Otherwise, you may choose any reporting platform which meets the requirements outlined in Appendix A. There are several reporting platform options available.**

3. **Sign a data sharing agreement with ISMP Canada between the data owner (pharmacy or corporation) and the NIDR (housed by ISMP Canada).**
   a. **The data sharing agreement will name your selected reporting platform.**
   b. **Contact the NIDR team at: NIDR@ismpcanada.ca to start the process.**

4. **Inform the College when a reporting platform is chosen, and a data sharing agreement is signed with the NIDR.**
   a. **Please note that the College will not be approving reporting platform providers. It is the responsibility of the managing pharmacist and permit holder to ensure that the chosen platform meets the criteria outlined in Appendix A.**



When Should Near Misses be Reported?

The pharmacy manager must develop, document and implement a pharmacy-specific policy outlining when a near miss should be reported through the reporting platform to the NIDR.

Sample criteria for reporting of near misses are found in Appendix A of the NAPRA Model Standards of Practice for CQI and MIR. They include:

- Were it to reach the patient, the near miss may cause harm.
- The near miss has been a recurrent issue in the pharmacy.
- The near miss provides a learning opportunity for the particular pharmacy or for pharmacy practice in general.

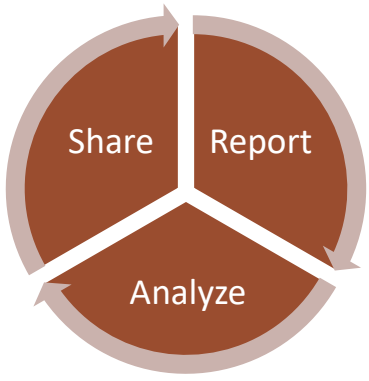
Near miss reporting is important as it gives the opportunity for analysis and change prior to a medication incident occurring. Near miss reporting prevents future medication incidents, thereby avoiding patient harm.

Continuous Quality Improvement

The continuous quality improvement process involves analysis of medication incidents, holding routine pharmacy team meetings and completing safety self-assessments.

Continuous quality improvement processes will be addressed in a future newsletter. Continuous quality improvement includes:

- Root cause analyses to identify root causes and contributing factors
- Routine pharmacy team meetings to discuss summary reports and analyses
- Safety self-assessments to proactively identify and address potential safety concerns in the pharmacy.



Appendix A – Reporting Platform Criteria

- Reporting platform must submit medication incidents/near misses to the NIDR
- Reporters must have the option to be anonymous when reporting into the platform
- Reporting platform must allow more than one user to add medication incident/near miss details as often more than one person has information regarding a medication incident/near miss.

- The following fields are mandatory:
    - Date Incident Occurred
    - Type of Incident
    - Incident Discovered By (anonymous, i.e. pharmacist, patient, other)
    - Medication System Stages Involved in this Incident
    - Medication(s) Involved
    - Degree of Harm to Patient due to Incident
    - Incident Description/How the Incident was Discovered.

- The following fields are optional:
    - Time Incident Occurred
    - Patient's Gender
    - Patient's Age
    - Other Incident Information
    - Contributing Factors to this Incident
    - Actions at Store Level (Include action plan, person in charge, and target date for completion)
    - Shared Learning for ISMP Canada to Disseminate (What has been done to prevent a similar occurrence in the future)

Questions or Concerns?
Please contact the PEICP office
info@pepharmacists.ca
902-628-3561