Ontario College of Pharmacists
Putting patients first since 1871

AIMS Assurance and Improvement in Medication Safety
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

Backgrounder

- In the fall of 2016, the College established a Medication Safety Task Force to review options to proceed with a medication incident reporting program in the province.

- The Task Force's recommendation to develop and implement a mandatory standardized medication safety, quality assurance and anonymous incident reporting program for all pharmacies was presented at the March 2017 Council meeting and unanimously approved following public consultation in June 2017.

- With the ultimate goal of reducing the risk of patient harm caused by medication incidents in, or involving, pharmacies, the program focused on four core elements:

    - Report: *Medication incidents and near misses will be recorded by pharmacy professionals via a third-party platform in order to populate an aggregate incident database to identify issues and trends to support patient safety improvements at the pharmacy and broader system levels;*

    - Document: *Pharmacy professionals will document appropriate details of medication incidents and near misses in a timely manner to support accuracy. Continuous quality improvement (CQI) plans and outcomes of staff communications and quality improvements implemented are also documented;*

    - Analyze: *Pharmacy professionals will analyze the incident in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident;*

    - Share Learnings: *Pharmacy professionals will ensure prompt communication of appropriate details of a medication incident or near miss, including causal factors and actions taken as a result, to all pharmacy staff.*

- The College developed the components of the program and in the fall of 2017 established a partnership with Pharmapod Ltd to develop and implement the technical solution to support the anonymous incident recording and related quality improvement components of the program.

- The program was developed over the subsequent months and in February 2018 the College implemented the preliminary phase of the roll out involving 100 volunteer community pharmacies to test and provide feedback on the program's various components prior to a late 2018 province-wide implementation.

- Starting the week of November 19, 2018, the first of six waves involving all remaining community pharmacies throughout the province will begin to be onboarded to the program, known formally as the Assurance and Improvement in Medication Safety (AIMS) Program, including the incident recording platform. By mid-2019, all 4,300+ community pharmacies in Ontario are expected to be onboarded and formally integrating the program into their operations.

- Moving forward with Ontario's new medication safety program will lead to more standardized, accurate and complete tracking of medication incident information across the province and help provide a better understanding of medication incidents in pharmacies and how they can be prevented.

- The focus on the reduction of medication incidents is a priority for the entire health system, not just in Ontario, but across the country and throughout the world.

- Last year, the World Health Organization launched a global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% over the next five years. The Global Patient Safety Challenge on Medication Safety aims to address the weaknesses in health systems that lead to medication errors and the severe harm that results. It lays out ways to improve the way medicines are prescribed, distributed and consumed, and increase awareness among patients about the risks associated with the improper use of medication.

- Across Canada, other provinces have begun to implement similar medication safety programs for pharmacies including Saskatchewan and Nova Scotia.

- There has always been an expectation that pharmacies are engaging in continuous quality improvement, illustrated in the NAPRA Model Standards of Practice, the College's pharmacy assessment process and policies for pharmacy professionals and designated managers (DMs).

- These expectations have been further reinforced with a new supplemental Standard of Practice which provides further clarity on how the NAPRA standards should be implemented in Ontario, and the Standards of Operation which outline the DM responsibility to ensure their pharmacy professionals are adhering to these standards.

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