Ontario College of Pharmacists
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Preparing for the College's Medication Safety Program

As part of its mandate to serve and protect the public, the College is introducing a mandatory, standardized Medication Safety Program for all community pharmacies in Ontario. The program includes a requirement to anonymously record medication incident data via the Pharmapod platform to identify trends and support improvements within pharmacies. Ultimately, learnings from the program will help prevent incidents from reoccurring and enhance patient safety across Ontario.

It is our expectation that community pharmacies are currently preparing for implementation of the Medication Safety Program.

June - December 2018:

- ✓ Designated Managers should familiarize themselves with the program requirements (see below and refer to the College website for more information) and educate staff about the program, including how it will help to improve patient safety and outcomes.
- ✓ Pharmacists and pharmacy technicians should understand their obligations under the program and participate in facilitating the integration of the program's four elements in the pharmacy.

September – December 2018:

- ✓ Designated Managers should respond promptly to communications from the College and Pharmapod regarding training associated with the program.

Throughout 2019 (beginning in December 2018):

- ✓ Once provided with access from Pharmapod, Designated Managers should facilitate timely staff log-on to the online Pharmapod incident recording platform and become familiar with the system.

Pharmacies must achieve all of the following four elements as part of the program:

Record. Anonymous recording of medication incidents by pharmacy professionals via the online Pharmapod platform in order to populate an aggregate incident database to identify issues and trends to support patient safety improvements.

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

Analyze. When a medication incident occurs, pharmacy professionals analyze the incident in a timely manner for contributing factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident. Pharmacies must complete a Pharmacy Safety Self-Assessment (PSSA), which will be available as part of the Pharmapod platform to facilitate use, within the first year of the implementation of the program, then at least once every two to three years. The PSSA can be a quality improvement tool, acting as a baseline of the pharmacy's efforts to enhance safety over time. Pharmacy leaders and management should also take the opportunity to analyze aggregate pharmacy data regularly to help inform the development of quality improvement initiatives.

Share Learnings. There should be prompt communication of appropriate details of a medication incident, including causal factors and actions taken as a result, to all staff. The development and monitoring of CQI plans and outcomes should be supported. Pharmacies should have regular CQI communication with pharmacy staff to educate all pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete a PSSA, and develop and monitor quality improvement plans.

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Frequently Asked Questions on the Medication Safety Program

Q: What is a medication incident? What is a near miss?

Medication incident: Any preventable event that may cause or lead to inappropriate medication use or patient harm. Medication incidents may be related to professional practice, drug products, procedures, or systems, and include prescribing, order communication, product labelling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Near miss: An event that could have led to inappropriate medication use or patient harm but did not reach the patient. Near misses provide valuable insight into areas of risk, and may indicate where systems can be improved to prevent harm

Q: How can I determine when to record a near miss?
If a potential error is caught outside of the established processes and procedures at the pharmacy but before the prescription reaches the patient, then it should be recorded as a near miss. Established processes and procedures could include the technical and therapeutic signoffs and/or any other regular process in place to catch errors such as input or DIN errors.

Regardless of when a near miss or medication incident is caught, if you notice that similar incidents are reoccurring on a frequent basis, this may indicate that the processes and procedures you have implemented into the workflow are not effective and should be reviewed.

The extent to which near misses are recorded will be a professional judgment decision of the Designated Manager in consideration of the nature of the near miss, its implication for patient safety and the extent to which it is recurring.

Q: What data will OCP have access to and what will it do with it? How anonymous is the data I record?
The College will not have the ability to view data at the level of a specific pharmacy, pharmacy professional or medication incident. OCP will only receive de-identified aggregate data for the purpose of reviewing medication incident trends to inform the development of resources to address gaps and issues identified, and to support shared learning across Ontario. The central offices for organizations with groups of pharmacies will also not have the ability to access data from the Pharmapod platform.

Q: How will OCP monitor pharmacy and pharmacy professional engagement with the mandatory requirements of the program?
Pharmacy implementation of the Medication Safety Program will be assessed by community practice advisors as part of the Community Pharmacy Assessment Program already in place at the College. The College will not access any individual records in the system, but pharmacy professional engagement with the program and evidence of meaningful use will be reviewed as part of the assessment process.

Read the rest of the Frequently Asked Questions on OCP's Website:
http://www.ocpinfo.com/about/key-initiatives/medicationsafetyfaq/