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

AIMS DATA SNAPSHOT:

September 2019

The following de-identified, aggregate data was recorded as part of the Assurance and Improvement in Medication Safety (AIMS) Program through the reporting platform administered by Pharmapod Canada Ltd from February 1, 2018 to May 31, 2019 during which time community pharmacies in Ontario have been gradually onboarded to the platform. An independent team of experts, the Response Team, has analyzed the information to promote shared learning and encourage quality improvement to reduce the risk of medication incidents and has published their first bulletin now available on the College website.

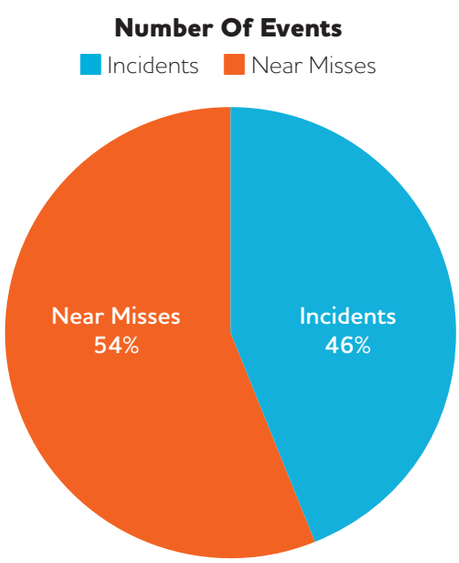
This AIMS Data Snapshot provides additional information on trends and although it does not include analysis or recommendations, the College is making this information available as a supplement to the Response Team bulletin in order to encourage continuous quality improvement and reduce the risk of medication incidents throughout the entire health system through a transparent release of this information. Please note that as the total number of events reported in this data snapshot was extracted from the database on August 21, 2019, it is different from the total number of events in the Response Team bulletin due in part to a rolling implementation of the program among community pharmacies which continue to record incidents and near misses in the program.

Phased Onboarding of Pharmacies:
In November 2018, the College moved forward with the commencement of a full province-wide roll out to all remaining community pharmacies across Ontario. As of August 21, 2019, approximately 3,600 community pharmacies had access to the reporting platform and by fall 2019, it is expected that all 4,500+ community pharmacies in Ontario will be onboarded and formally integrating the program into their operations.

REPORTED MEDICATION SAFETY EVENTS

Medication incidents are any preventable event or error that reaches a patient and that may cause or lead to inappropriate medication use or patient harm. Near misses are any event that could have led to inappropriate medication use or patient harm but was intercepted before reaching the patient. A total of 4,426 medication safety events were recorded during the reporting period. Of those events, 2,406 were near misses and 2,020 were incidents.

Event Category	Number	Percentage
Incidents	2,020	46%
Near Misses	2,406	54%
TOTAL	4,426	100%

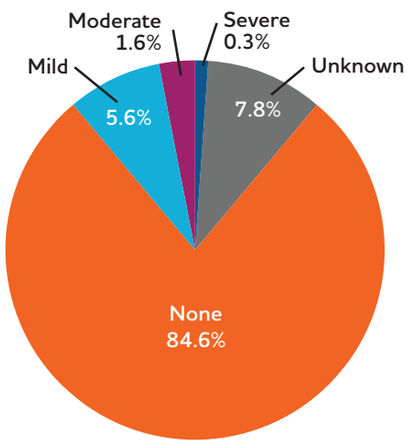


REPORTED PATIENT HARM LEVEL

The Institute for Safe Medication Practices defines harm as a temporary or permanent impairment in body functions or structures. This includes mental, physical, sensory functions and pain. The majority of reported incidents did not result in patient harm. Of those that did, most were mild with few resulting in moderate or severe harm. No deaths were reported.

Incident Harm Level Category	Number	Percentage
Mild	114	5.6%
Moderate	33	1.6%
Severe	7	0.3%
Death	0	0%
Unknown	158	7.8%
None	1,708	84.6%

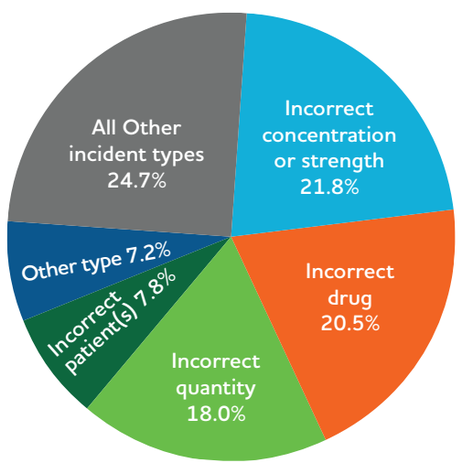
Number Of Events By Harm Level



REPORTED CATEGORIES OF WHAT HAPPENED

Pharmacy professionals can use the AIMS Program platform administered by Pharmapod to record what happened involving a medication incident or near miss. The top five recorded incident categories are, in order from most commonly reported: incorrect concentration or strength; incorrect drug; incorrect quantity; incorrect patient; 'other type'; and incorrect frequency.

What Happened

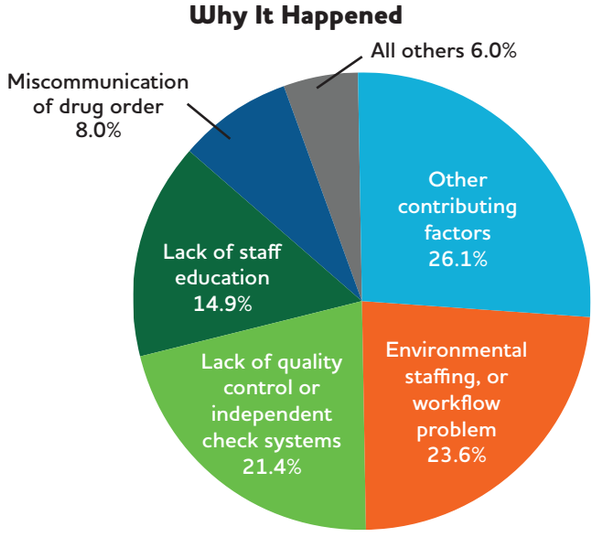


Incident Category	Number	Percentage
Incorrect concentration or strength	966	21.8%
Incorrect drug	908	20.5%
Incorrect quantity	797	18.0%
Incorrect patient(s)	347	7.8%
Other type	320	7.2%
Incorrect frequency	307	6.9%
Incorrect label	174	3.9%
Incorrect dosage form/formulation	163	3.7%
Omitted medication/dose	125	2.8%
Incorrect duration	73	1.6%
Incorrect prescriber	64	1.4%
Duplication of therapy	54	1.2%
Prescribing error	42	0.9%
Expired drug/incorrect beyond use date	26	0.6%
Medication inappropriately discontinued	22	0.5%
Incorrect route of administration	15	0.3%
Incorrect storage	12	0.3%
Drug Monitoring Problem	8	0.2%
Professionals services event	3	0.1%

REPORTED CATEGORIES OF WHAT LED TO THE INCIDENT

Pharmacy professionals can also use the AIMS Program platform administered by Pharmapod to record what led to a medication incident or near miss. While further analysis is intended to reveal more insights and uncover other patterns in order to develop prevention and safety recommendations, the five most commonly reported categories are: contributing factors defined as 'other'; environmental, staffing or workflow problems; lack of quality control or independent check systems; lack of staff education; and miscommunication of drug orders.

Why It Happened



Contributing Factor	Number	Percentage
Other contributing factors	1,351	26.1%
Environmental, staffing or workflow problems	1,223	23.6%
Lack of quality control or independent check systems	1,108	21.4%
Lack of staff education	774	14.9%
Miscommunication of drug order	416	8.0%
Drug related issues	215	4.1%
Critical patient information missing	50	1.0%
Lack of patient comprehension	46	0.9%

Note: Pharmacy professionals can select "other contributing factors" in the incident-recording platform administered by Pharmapod if the contributing factor in the event they are recording is not reflected in the other fields that are available/provided in the platform. As more community pharmacies onboard to the AIMS Program, the College will continue to monitor and work with Pharmapod to identify ways that the platform could be adapted/improved to help pharmacy professionals find what they need to record information about a medication event quickly and accurately. This will not only encourage reporting but improve the quality of the data.