Taking AIMS

THE AIMS RESPONSE TEAM BULLETIN FOR THE PHARMACY PROFESSION IN ONTARIO

This bulletin is possible because of the important work of all pharmacy team members who have adopted the AIMS Pharmapod platform as part of the Assurance and Improvement in Medication Safety Program (AIMS). This bulletin aims to improve the safety of all patients who Ontario pharmacy team members have the honour of serving.

Key Insights

- 4,132 patient safety related events (incidents and near misses) have been recorded on the Pharmapod system as part of the AIMS program
- One in ten incidents involved the incorrect patient

Introduction

Pharmacists and pharmacy team members across Ontario report the details of any patient safety related events that occur in their pharmacies using the AIMS Pharmapod Platform. The system has been rolled out as part of the Ontario College of Pharmacists (OCP) AIMS Program. Each recorded incident or near miss is anonymized and aggregated into reports which are accessed and analyzed by members of the AIMS 'Response Team'.

This bulletin provides an overview of the AIMS Program roll-out to date and summarizes some key insights identified by the Response Team along with recommendations for pharmacy practice. Further updates will be issued on a regular basis, providing timely insights from the data and actions to drive improvements. Each bulletin will focus on a concise number of insights and actions for pharmacy teams to focus on. We commend all pharmacy teams who have demonstrated their dedication to improving patient safety through their engagement with Continuous Quality Improvement (CQI) by recording and learning from events through the AIMS Pharmapod Platform.

How to Use this Bulletin in your Pharmacy

CQI is about taking action and measuring the improvements made. This bulletin is intended to be used as a working document. An 'action summary page' is included at the end of the bulletin to allow you to action the Response Team's recommendations. We recommend that you print this page and complete the actions to drive improvements in your pharmacy. Share the bulletin and actions with the pharmacy team as part of your next patient safety meeting and file in a suitable location. In doing so, you will be able to track and demonstrate system improvements you have made over time. It is important that a pharmacy team member is selected as being accountable for each action and that they are completed against agreed upon time-lines.

About the Response Team

The Response Team consists of pharmacy professionals and patient safety domain experts and is chaired by Lisa Dolovich. The team analyzes the aggregate, anonymized provincial medication event data in Ontario to identify areas of risk and opportunities to improve patient safety. This report highlights their notable findings from the data collected thus far (incidents and near misses) from community pharmacies who have been reporting to the AIMS Program.

Data Insights - What the Data Says[1]

This bulletin provides some key insights identified by the Response Team from the data in the AIMS Pharmapod system to date. The Team looks at the data using a systems approach. A systems approach recognizes that errors will happen, even in the best organizations, and so recommendations or resources for practice are focused on those that can increase learning and improve system processes in pharmacy practice. As the system roll-out progresses and incident recording increases, so will the amount of data available for analysis.

Number of Recorded Events

As of May 31, 2019, 4,132 events (1,801 incidents and 2,331 near misses) had been recorded on the AIMS Pharmapod Platform. The level of reporting to date is really encouraging and provides a great start to building the AIMS incident data from which insights and learning can be taken and shared.

Recommendations and Resources for Practice Change

Designated Manager

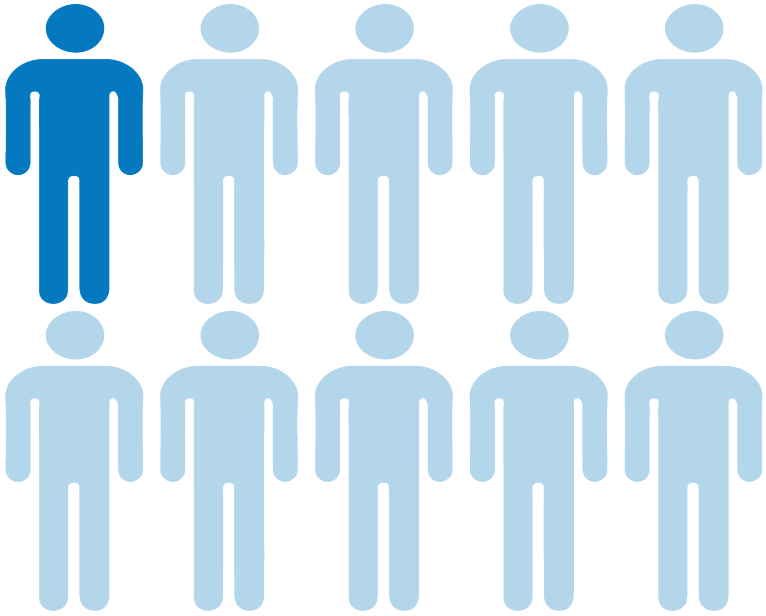
- ☐ Is your pharmacy team actively logging patient safety related events on AIMS Pharmapod Platform?
- ☐ Are team members commended when they record incidents and near misses?
- ☐ Have you discussed with your team about how they can keep up the great work and make incident reporting fit better into regular workflow?
- ☐ Have all your pharmacy team members completed the AIMS e-training available through the AIMS Pharmapod Platform? Is this incorporated into your orientation process for all new team members?
- ☐ Is your pharmacy meeting the requirements of the AIMS program as set out in the OCP's Supplemental Standard of Practice (sSOP)?[2]
- ☐ Have you reminded all team members about the importance of recording near misses?[3] These can also identify opportunities to create safer work processes.

Pharmacy Team Members

- ☐ Have you completed the AIMS e-training available through the AIMS Pharmapod Platform?
- ☐ Are you clear on what needs to be recorded on the AIMS Pharmapod Platform, including when near misses should be recorded?
- ☐ Have you any ideas about how recording on the system could fit better into your pharmacy's regular workflow? Have you shared these ideas with your manager?

1. Date range: 1 Feb 2018 - 31 May 2019
2. http://www.ocpinfo.com/library/other/download/supplemental-standard-of-practice-med-safety-program
3. A near miss is an event that could have led to inappropriate medication use or patient harm but that was intercepted before reaching the patient.

Incidents Involving the Wrong Patient



1 in 10 incidents involved the wrong patient

Recommendations and Resources for Practice Change

Designated Manager

- ☐ Observe how pharmacy team members collect and update patient information at each encounter (e.g. contact information). Are there opportunities to strengthen work processes? If so, discuss these opportunities with your team.
- ☐ Do two pharmacy team members check patient name and address information as part of the dispensing process to ensure the prescription is entered against the correct patient?
- ☐ Get together with your pharmacy team to address the following questions:
  - ☐ What independent check system is in place in your pharmacy to double check patient identifiers?
  - ☐ How well is your workflow system to double check patient identifiers working in your pharmacy?

Pharmacy Team Members

- ☐ Are two identifiers routinely used both when accepting prescription orders for entry and when releasing to the patient? (e.g. first and last name, date of birth and address)
- ☐ Are pharmacists asking patients questions to determine why they are receiving their medication? This will highlight if they are not expecting a medication for that purpose or indication.

Coming Soon: An Opportunity To Share Your Story

We want to hear from you. In future bulletins, we will include de-identified case studies sharing experiences from pharmacy teams across Ontario about how they have reflected on and reviewed their practice as a result of these bulletins and have made changes to improve patient safety. If you would like to share your story, contact aims.responseteam@pharmapodhq.com.

Print this page and complete actions to drive improvements in your pharmacy. Share with the pharmacy team as part of your next patient safety meeting and file in a suitable location.

Actions for Designated Manager:	Actioned By	Date
☐ Is your pharmacy team actively logging patient-safety related events on AIMS Pharmapod Platform?		
☐ Are team members commended when they record incidents and near misses?		
☐ Have you discussed with your team about how they can keep up the great work and make incident reporting fit better into regular workflow?		
☐ Have all your pharmacy team members completed the AIMS e-training available through the AIMS Pharmapod Platform? Is this incorporated into your orientation process for all new team members?		
☐ Is your pharmacy meeting the requirements of the AIMS program as set out in the OCP's Supplemental Standard of Practice (sSOP)?[1]		
☐ Have you reminded all team members about the importance of recording near misses? These can identify opportunities to create safer work processes.		
☐ Observe how pharmacy team members collect and update patient information at each encounter (e.g. contact information). Are there opportunities to strengthen work processes? If so, discuss these opportunities with your team.		
☐ Do two pharmacy team members check patient name and address information as part of the dispensing process to ensure the prescription is entered against the correct patient?		
☐ Get together with your pharmacy team to address the following questions:		
☐ What independent check system is in place in your pharmacy to double check patient identifiers?		
☐ How well is your workflow system to double check patient identifiers working in your pharmacy?		
Actions for Pharmacy Team Members:		
☐ Have you completed the AIMS e-training available through the AIMS Pharmapod Platform?		
☐ Are you clear on what needs to be recorded on the AIMS Pharmapod Platform, including when near misses should be recorded?		
☐ Have you any ideas about how reporting on the system could fit better into your pharmacy's regular workflow? Have you shared these ideas with your manager?		
☐ Are two identifiers routinely used both when accepting prescription orders for entry and when releasing to the patient? (e.g. first and last name, date of birth and address)		
☐ Are pharmacists asking patients questions to determine why they are receiving their medication? This will highlight if they are not expecting a medication for that purpose or indication.		

1. http://www.ocpinfo.com/library/other/download/supplemental-standard-of-practice-med-safety-program

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pharmapod

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