This document is a draft update to the supplemental Standard of Practice. The proposed changes to the AIMS Program requirements are indicated in red text. Other changes have been made throughout the document to improve the clarity of the supplemental standard in alignment with the College's second strategic goal on effective communication and the organization's commitment to transparency and clear, action-oriented language.

Supplemental Standard of Practice: Mandatory Standardized AIMS Program in Ontario Pharmacies

Purpose

To provide clarity regarding practice expectations for pharmacy professionals in Ontario to meet the National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting for Pharmacy Professionals.

Introduction

The purpose of the Ontario College of Pharmacists' AIMS Program is to enhance patient safety and support continuous quality improvement (CQI) in pharmacy practice through the identification of medication incident trends and workflow issues leading to medication incidents.

Continuous quality improvement: Ongoing and systematic examination of an organization's work processes to identify and address the root causes of quality issues and implement corresponding changes.[1]

Effective CQI programs involve implementation of targeted changes to address identified areas of risk from both proactive review of work processes and retrospective review of specific medication incidents. The objective of CQI and medication incident reporting is to ensure that all pharmacy professionals learn from medication incidents and review and enhance their policies and procedures to reduce the chances of recurrence, thereby improving patient safety. To achieve safer care for patients, CQI must focus not only on system-wide change but also localized improvements – the tasks that individual practitioners perform.

The AIMS Program supports shared accountability: pharmacy owners and managers are held accountable for creating a work culture that supports staff in engaging in CQI and pharmacy professionals are held accountable for the quality of their choices. A critical element in safe medication practices is sharing lessons learned from medication incidents. To enable a culture that supports learning and accountability over blame and punishment, individuals must be comfortable to discuss medication incidents without fear of punitive outcomes.

DRAFT

[1] Boyle TA, Bishop AC, Duggan K, Reid C, Mahaffey T, MacKinnon NJ, et al. Keeping the "continuous" in continuous quality improvement: Exploring perceived outcomes of CQI program use in community pharmacy. Res Social Adm Pharm 2014 Jan-Feb; 10(1): 45-57.

Supplemental Standard of Practice (sSOP)

An effective, standardized AIMS Program for pharmacies must address both medication incidents that reach the patient as well as near misses that are intercepted before the medication is dispensed. In addition to ensuring their conduct and practice align with NAPRA Standards for Continuous Quality Improvement and Medication Incident Reporting, pharmacy teams must meet all of the following requirements of the mandatory AIMS Program :

Report	• Anonymously record medication incidents and near misses soon after they occur into a medication incident reporting platform that: a) Complies with OCP's criteria for reporting platforms b) Contributes data to ISMP's National Incident Data Repository to support shared learning and to help identify systemic issues.
Document	• Document required and relevant details of medication incidents and near misses in a timely manner. • Document CQI plans, outcomes of staff communications about medication events, and subsequent quality improvement initiatives or changes implemented.
Analyze	• Analyze incidents and near misses for causal factors soon after they occur and implement appropriate steps to minimize the likelihood of recurrence. • Analyze individual data (gathered at the pharmacy) and aggregate data (synthesized and shared by the NIDR) to inform the development of quality improvement initiatives. • Develop CQI plans and measure the outcomes of changes implemented. • Complete a safety self-assessment (SSA) every two years. The Designated Manager may determine an SSA is required more frequently if a significant change occurs in the pharmacy.
Share	• Communicate relevant details of a medication incident or near miss promptly to all pharmacy staff, including causal factors and actions taken to reduce the likelihood of recurrence. • Schedule CQI meetings with pharmacy staff at least once every quarter to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, and complete an SSA (when required). • Share successful interventions, changes, or best practices that have helped reduce risk.

Pharmacies must enable and support pharmacy professionals in meeting these requirements.

Responsibilities of Pharmacy Professionals in Meeting the sSOP

Pharmacy professionals must practice in accordance with all the requirements of the AIMS program, as outlined above.

According to the Standards of Practice, all pharmacists and pharmacy technicians have a responsibility and obligation to manage medication incidents and address unsafe practices. This includes documenting and communicating all medication incidents and near misses with the entire pharmacy staff and, as appropriate, to the patient and other healthcare providers (e.g., if the incident reaches the patient).

All registered members (pharmacists and pharmacy technicians) are required to have a unique login for the medication incident reporting platform at their primary place of practice to meet these reporting standards.

There is an expectation that pharmacy professionals will record medication incidents and near misses, engage in continuous quality improvement planning, and implement quality improvement initiatives to improve system vulnerabilities.

Responsibilities of Pharmacy Owners and Designated Managers (DMs) in Meeting the sSOP

Pharmacy owners and DMs must enable a safety culture.

Safety culture: An environment that supports learning and accountability over blame and punishment and that encourages individuals to discuss medication incidents without fear of punitive outcomes.

It is an expectation that all pharmacy operations are conducted in a manner that supports the purpose of the AIMS Program (as outlined in the introduction) and the requirements outlined in the sSOP, which were designed to enable pharmacy professionals to meet this goal.

It is the responsibility of pharmacy owners and DMs to ensure that the work environment is conducive to, and incorporates, the appropriate process and procedures to support pharmacy professionals in meeting the requirements of the AIMS program. This includes ensuring that pharmacy staff can anonymously record medication incidents and continually document, identify, and apply learnings from medication incidents to improve workflow within the pharmacy.