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Standardized Safety Programme in Community Pharmacy

John Zhang*

Department of Pharmacy, University of Yale, New Haven, United States

***Corresponding author:** John Zhang, Department of Pharmacy, University of Yale, New Haven, United States; E-mail: johnzhan@417gmail.org*

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DESCRIPTION

Pharmaceutical errors are avoidable events that can result in incorrect medication use or patient harm. Approximately one-quarter of all pharmaceutical errors resulting in patient harm occur in community pharmacies in North America. Common medication errors involve delivering the erroneous drug, concentration, or quantity as a result of a variety of environmental and drug-related issues such as prescription errors, personnel shortages, and drugs with similar names or packaging. Medication errors are expected to cost $2.6 billion per year in Canada, with additional expenditures incurred owing to lost productivity and time away from work.

There are also a greater culture of transparency surrounding pharmaceutical errors and the tactics followed by healthcare facilities to aid in the reduction of recurring incidences in order to promote patient safety globally. There are also global projects aimed at decreasing unnecessary drug errors, such as the World Health Organization's medication without harm safety challenge. Between 2017 and 2022, this programme intends to cut preventable patient harms associated with pharmaceuticals by half across all health systems. Furthermore, the Institute for Safe Medication Practices collects medication error studies from healthcare facilities across Canada in order to identify prevalent errors before they occur and adopt effective preventative interventions.

The OCP launched the Assurance and Improvement in Prescription Safety (AIMS) Program in order to reduce the risk of patient harm caused by medication errors in community pharmacies. Across Ontario, about 4700 community pharmacies provide retail pharmaceutical services and care to the public. Following a successful pilot programme in 100 community pharmacies, the AIMS Program was expanded provincially beginning in November 2018.All Ontario community pharmacy personnel are required to capture, analyst, and share learning's from medication-related occurrences. The use of the web-based AIMS Pharmapod platform allows all community pharmacies to achieve this criterion while standardizing the reporting procedure. It is necessary to report pharmaceutical mishaps and near misses anonymously.

There is currently insufficient information on the rate at which medication errors occur in community pharmacies across Canada and the United States, with considerable disparities in the volume of reports recorded by various reporting systems. Evidence suggests that the implementation of a confidential, compulsory medication error in system may result in higher reporting and the ability to detect rarer incidents and emergent problems across healthcare settings. As a result, we aimed to assess the uptake in reporting of medication-related occurrences since the AIMS Program's inception in 2018, analyze reporting trends, and identify early learning's that can be used to help develop measures to reduce future medication errors in community pharmacies.

Pharmacy professionals have access to the platform and must complete several mandatory eLearning modules focused on the AIMS Program objectives, importance, and how to complete the electronic report forms. Appendix A lists the mandatory and optional fields for completion on each standardized form. Except for the month and year of birth and gender, no personal health information about the involved patient is collected. Event severity is only collected for incidents and is categorized based on an assessment made by the pharmacy professional at the time of study. The high degree of reporting unevenness observed by pharmacies in this study is also significant, implying that reported events are clustered among a small proportion of community pharmacies. The number of reports per pharmacy varied greatly, implying that the results may be representative of the types of events occurring in higher reporting pharmacies rather than events occurring across all pharmacies in the province. The wide range of reporting by pharmacy is consistent with the distribution of reporting in Nova Scotia, which ranged from 1 to 2806 events per community pharmacy.

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