

Drug incident quarterly review report

Follow-up process: Standards for the Operation of Licensed Pharmacies

6.6 The licensee must, at least quarterly

- a. review the drug-error reports for the licensed pharmacy to evaluate whether practice changes or preventative measures are required to prevent future drug errors, and
- b. assess whether any changes implemented as a result of a drug error were successful in advancing patient safety.

6.7 Nothing in Standard 6.6 relieves a licensee from the duty to make changes or take preventative measures promptly in response to a drug error if the protection of the public requires it.

6.8 The licensee must communicate the results of the licensee's drug error review to all employees who work in the prescription department, along with any other information required to assist in ensuring that the risk of a drug error is reduced.

Retain this report for 10 years.

How to complete this report

For each quarter, please document

1. drug incidents and required actions reviewed - consider a review of ISMP Canada drug error reports for insight on similar errors;
2. any significant findings (e.g., repeated incidents of similar errors - are there any patterns?); and
3. further actions implemented and whether those actions resolved the issue.

Pharmacy information

Name PPC Drugstore Licensee name Sam Pharmed
 Address 456 Anyroad Ave Reporting year 2011
Anytown, AB T2T 2T2
 Phone 780-456-7890
 Email ph1@ppcdrugs.ca

First quarter review – January to March

Three drug incidents this quarter:

1. RX 123456 – incorrect insulin dispensed.
2. RX 135456 – incorrect strength dispensed
3. RX 158457 – incorrect drug dispensed.

Of note, in all 3 cases product labels were very similar in appearance, increasing the likelihood that the incorrect drug product/dose would be selected and dispensed to the respective patient. Reviewed findings with pharmacy staff. Some staff members were forgetting to scan all items to be included in final drug packaged and still multiple products with similar labeling stored next to each other on shelving. Assigned a staff member to arrange medications in a manner that minimizes risk of drug error and reviewed importance of verifying the DIN for all items during final check and of scanning all items during final check. Additionally, consulted with pharmacy software vendor to implement mandatory scanning such that drug product cannot be scanned out of pharmacy (i.e. picked up by patient) until proper scanning of product occurs. Will continue to monitor and follow-up in 2nd quarter to determine if these actions have resolved the issue.

Licensee name Sam Pharmer

Review date 01 / 04 / 2011

Licensee signature Sam Pharmer

Day / Month / Year

Second quarter review – April to June

Review date _____
Day / Month / Year

Licensee name _____

Licensee signature _____

Third quarter review – July to September

Review date _____
Day / Month / Year

Licensee name _____

Licensee signature _____

Fourth quarter review – October to December

Review date _____
Day / Month / Year

Licensee name _____

Licensee signature _____