NEWS RELEASE

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ISMP Canada Calls for a National Standard for Labelling Cancer Chemotherapy Solutions with Overfill Volumes

Toronto, Canada

An incident involving the management and labelling of cancer chemotherapy medications highlights the need for a national labelling standard. Since March 2012, several hospitals purchased premixed cancer medications from a supplier and it was recently realized that more than 1100 patients in Canada may have received lower than intended doses of these drugs.[1,2]

In general, the intravenous (IV) medication preparation process involves diluting the drug with an IV solution in an IV bag. If this is done by adding a drug to a commercially available IV bag prefilled with diluent solution then the concentration (amount per millilitre) will be less than if the drug and solution are added to an empty IV bag. In both methods the total amount of drug is the same. The difference in concentration is related to the common manufacturing practice of including an overfill volume in commercially available IV bags with solution.

Awareness about the overfill volume, through labelling of prepared solutions, can be important to guide processes for medication preparation and administration (including use of equipment such as infusion pumps). Management of any overfill volume is perceived to be more critical for oncology medications because the dosing of these drugs is specific to each individual patient and the type of cancer being treated.

ISMP Canada recently worked with international partners to develop the International Medication Safety Self Assessment (MSSA) for Oncology—a type of checklist—to assist hospitals providing oncology services to identify process vulnerabilities related to managing oncology medications[3]. The use of overfill is identified as a point where safeguards may be required. Specifically, the MSSA states the need for "a standard process to identify the overfill volume on the pharmacy label for compounded IV chemotherapy/biotherapy solutions". An opportunity exists to create and implement a national standard for labelling overfill. The opportunity to improve labelling in this context likely applies to other compounding situations as well.

Learning from medication incidents helps to identify improvement opportunities. Provincial and national medication incident reporting systems and programs share the aim to learn from incidents and prevent future harms. ISMP Canada is working in consultation and collaboration with its partners to share learning from these incidents and to continue to heighten awareness of medication safety in oncology.

The **Institute for Safe Medication Practices Canada (ISMP Canada)** is an independent national not-for-profit agency committed to the advancement of medication safety in all health care settings. ISMP Canada works collaboratively with the health care community, regulatory

agencies and policy makers, provincial, national, and international patient safety organizations, the pharmaceutical industry, and the public to promote safe medication practices. ISMP Canada's mandate includes receiving and analyzing medication incident and near-miss reports, identifying contributing factors and causes and making recommendations for the prevention of harmful medication incidents.

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[1] Cancer Care Ontario News Release: Patients Being Informed of Chemotherapy Drug Underdosing in Four Hospitals, April 2, 2013 Available from: https://www.cancercare.on.ca/about/newsroom/newsreleases/

[2] Horizon Health Network News Release: The Saint John Regional Hospital informs patients of chemotherapy drug underdosing. April 3, 2013 Available from: http://horizonnb.ca/home/information-news/news-releases/the-saint-john-regional-hospital-informs-patients-of-chemotherapy-drug-underdosing.aspx

[3] ISMP International Medication Safety Self Assessment for Oncology; available from: https://mssa.ismp-canada.org/oncology/printmssa.