



THE COLLEGE OF
PHYSICIANS &
SURGEONS
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Dialogue - March/April '06

Practice Partner - ISMP

Sharing of information among health-care professional is critical to patient safety

As discussed in this issue's [Doc Talk](#) column, the sharing of information among health-care professionals is critical to patient safety. Recently, several observant physicians were able to mitigate a risk for error by reporting concerns to an organization created for the purpose of sharing and analyzing information on medication adverse events or "near misses."

Three anaesthesiologists individually submitted reports to the Institute for Safe Medication Practices (ISMP) Canada, noting that the generic name (bupivacaine) had been omitted from the label of Sensorcaine® Polyamps. Bupivacaine is a potent, potentially lethal local anaesthetic that is used for local infiltration and for spinal and epidural anaesthesia. It is considerably more cardiotoxic than many other local anaesthetics.

ISMP Canada relayed concerns about the potential for confusion and error to the manufacturer and to Health Canada, and distributed a safety bulletin to alert health care providers to the problem. The company then quickly recalled the product.

The ISMP Canada was created on the premise that in sharing and analyzing information on adverse events or "near misses," it can identify contributing factors and prevent the same errors from occurring repeatedly in different settings.

Recent draft guidelines published by the World Health Organization note that:

"We know that health-care errors are provoked by weak systems and often have common root causes which can be generalized and corrected. Although each event is unique, there are likely to be similarities and patterns in sources of risk which may otherwise go unnoticed if incidents are not reported and analyzed."

Complications from drug therapy are recognized as the most common category of non-operative adverse event in hospital settings. Although some adverse drug events (for example adverse drug reactions) may be unavoidable outcomes of treatment, many adverse drug events are preventable.

ISMP Canada is working in collaboration with the Canadian Institute for Health information (CIHI) and Health Canada to establish the Canadian Medication Incident Reporting and Prevention System (CMIRPS). This national reporting system will strengthen Canada's ability to effectively manage and coordinate medication incident information, and will facilitate the development and implementation of preventive actions and processes.

Although CMIRPS is still in the development stage, individual practitioners can already submit reports through

ISMP Canada's existing voluntary practitioner reporting program, which offers confidential (or anonymous, when preferred) reporting of an incident and does not collect information about individual patients. ISMP Canada can work with practitioners or organizations to identify factors that contributed to the incident, and can facilitate the sharing of important information through safety bulletins distributed broadly to health professionals. This work is supported by Health Canada and the Ontario Ministry of Health and Long-Term Care.

Any practitioner may report a medication incident through the **ISMP Canada** website at www.ismp-canada.org, or by telephoning **1-866-54-ISMP**.

Additional information on **CMIRPS** is available at: <http://ismp-canada.org/cmirps.htm>

E-mail: cmirps@ismp-canada.org

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[Next Article](#)

[March/April '06 Table of Contents](#)

[Dialogue Online Table of Contents](#)

[Home](#) | [What's New](#) | [About the College](#) | [Publications](#) | [Doctor Search](#) | [Info for Public](#) | [Info for Physicians](#) | [Policies](#) | [Links](#) | [Search](#) | [Feedback](#) | [Site Map](#)