ISMP Canada is an independent Canadian nonprofit agency established for the collection and analysis of medication error reports and the development of recommendations for the enhancement of patient safety.

The Healthcare Insurance Reciprocal of Canada (HIROC) is a member-owned expert provider of professional and general liability coverage and risk management support.

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NCCMERP Statement on Medication Error Rates Provides A Clear Direction for Hospitals

The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) has recently developed a guiding statement on error benchmarking for hospitals:

"Use of Medication Error Rates to Compare Health Care Organizations is of No Value. "
http://www.nccmerp.org/rec_020611.htm

Because of differences in culture, differences in the definition of a medication error, differences in patient populations and differences in the type(s) of reporting and detection systems being employed, the use of medication error rates to compare health care organizations is not recommended.

NCCMERP is a national consortium of healthcare professional organizations and regulatory bodies in the US established for the purpose of mounting a nationwide campaign for medication error reporting and prevention. They develop strategies and recommendations that are broadly promoted to colleges, schools, and state associations of medicine, pharmacy, and nursing; national professional associations; managed care organizations; and third-party payers. ISMP is a member organization of NCCMERP. The recently released statement is shared here in our bulletin because of the guidance provided to Canadian hospitals and because we endorse in principle the importance of taking steps to **discourage using medication error rates for "benchmarking" purposes or as quality indicators.**

Many healthcare facilities still believe that their "error rate" is a measure of patient safety. The true incidence of medication errors will vary, depending very much on the vigor with which errors are identified and reported. Although many hospitals have a relatively standardized method to define a medication incident (a medication error that reaches a patient), the manner in which they are detected and the efforts to report them differ widely. Simply comparing "numbers" of medication errors lacks validity, and more importantly can dangerously undermine efforts for full reporting. A high error rate could suggest unsafe medication practices, or it could reflect an organizational culture which promotes error reporting. Likewise, low error rates may suggest a successful error prevention program or may be the result of an inherent punitive approach which inhibits individuals from reporting errors and analyzing causes of errors. Hospitals that focus their attention on maintaining a "low error rate" may inadvertently promote an unproductive cycle of under-reporting of errors, and allow unrecognized weaknesses in the medication use system to continue. Low error rates can result in a false sense of security and an implicit acceptance of preventable errors.[1]

The question then arises "How do Risk Managers measure the safety of medication use and the effectiveness of error prevention strategies within their organization"? According to Michael Cohen of ISMP, analyzing the causes of actual incidents and potential incidents and implementing changes to address these causes, and measuring outcomes of the change is an effective and more meaningful way to gauge error prevention efforts.[2]

A Canadian version of the Medication Safety Self-Assessment, originally developed by ISMP (US), has been adopted by ISMP Canada. This assessment tool can be used to measure whether or not, basic recommendations for safe medication practices have been incorporated into a hospital's medication use systems.

References:

1. ISMP Medication Safety Alert! vol.3, issue 18, September 9, 1998.
2. Michael Cohen, ISMP, Personal Communication.

SOUND-ALIKE / LOOK-ALIKE Drug WARNING

ISMP Canada has received correspondence from several health care professionals expressing concern about the name of a recently approved product **Pegetron®**. There is potential for confusion with a previously marketed product **PEG-Intron®.** Pegetron is a combination product of Peginterferon alfa-2b powder for solution and Ribavirin 200mg capsules. PEG-Intron is the trade name for the Peginterferon alfa-2b product as a single entity. Both products are used to treat chronic hepatitis C.

Practitioners should take extra precautions in distinguishing between the two products since Pegetron will be on the market soon.

It is interesting to note that the Pegetron product is not marketed in the U.S. and there are no plans to market the product in the U.S. ISMP Canada has contacted Schering Canada for possible remedial efforts to prevent the mix-up of these two products.

ISMP Canada has also notified Health Canada about the concerns of these two sound-alike / look-alike names.

ISMP Canada is a national voluntary medication incident and 'near miss' reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.
To report a medication error to ISMP Canada: (i) visit our website www.ismp-canada.org or (ii) email us at info@ismp-canada.org or (iii) phone us at 416-949-4839. ISMP Canada guarantees confidentiality and security of information received. ISMP Canada respects the wishes of the reporter as to the level of detail to be included in our publications.