The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit 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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Engaging Consumers in Medication Incident Reporting and Prevention

In response to a growing consensus on the importance of including consumers* in efforts to improve the safety of the healthcare system, ISMP Canada is developing a consumer-focused medication safety website (www.SafeMedicationUse.ca). The objective of this website will be to strengthen consumers' learning and to coordinate reporting by consumers within the Canadian Medication Incident Reporting and Prevention System (CMIRPS).[2] This effort supports the original vision for CMIRPS, which recognizes consumers' interest in contributing to the national system to enhance medication safety learning. Including reports of medication incidents† from consumers will complement the information that is already being collected from healthcare providers. The purpose of this bulletin is to provide both background information on this aspect of CMIRPS and an update on the status and planning for the consumer-oriented website.

Background

In a 2008 survey of adults with health problems, nearly 1 in 10 Canadians reported receiving the wrong medication or the wrong dose when prescriptions were filled at a pharmacy or during hospital stays within the 2 years preceding the survey.[4] Although not all medication incidents lead to harm, they are clearly an important health safety issue in Canada. Consumers who have experienced such medication incidents often have a strong desire to convey information that may prevent harm to others. In particular, they can help in identifying underlying conditions that might have contributed to particular incidents. Reports submitted by consumers to the Individual Practitioner Reporting component of CMIRPS have already formed the basis of 2 ISMP Canada Safety Bulletins.[5,6]

The Agency for Healthcare Research and Quality in the United States has noted that "patients and their family members are in a unique position to view the continuum of care, which enables them to identify gaps in care that may have contributed to adverse events."[7] The World Health Organization notes that "safety will be improved if patients are included as full partners in reform initiatives, and learning can be used to inform systemic quality and safety improvements".[8]

Experience with incident reporting programs suggests that consumers can provide information that is useful in detecting problems in the medication use system. In the United Kingdom, the National Patient Safety Agency (NPSA) allows patients and the public to report patient safety incidents through its National Reporting and Learning Service. The NPSA gives the following example: "patients have helped us find ways of reducing the risk of taking too much methotrexate." The NPSA notes that this has led to publication of "patient information to tell people about the risks, and [the Agency is] also working with the drug manufacturers to redesign the packaging."[9] A recent report of the Australian Commission on Safety and Quality in Health Care noted that consumer reporting is contributing to the identification of previously unrecognized adverse events.[10] ISMP (US) engages consumers through a dedicated website that provides consumer-focused medication safety information and a mechanism to report medication errors.[11] Consumer reporting in Canada is expected to result in important contributions to CMIRPS.

Moving Forward

The CMIRPS consumer-focused medication safety website is scheduled for pilot release in 2010. The website will include a link to a test version of the online form for reporting medication incidents. Although it is anticipated that the majority of consumers' reports will be sent through the web-based system, an option for telephone reporting will also be available for consumers who are unable to access the website and submit a report electronically. The reporting program for consumers will be aligned with the existing reporting program component for practitioners to ensure compatibility of data for comparative purposes.

In order to have an impact on the safety of their care, consumers must be both empowered and informed. The

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*The term "consumers" is defined here to mean patients, family members, caregivers, or any other individuals who may be acting for, or in support of, a patient or client who is receiving healthcare.[1]

†The term "medication incident" is widely used to represent the preventable subset of potential and actual adverse drug events. It is also recognized as an alternative term for "medication error".[3]

pilot website will offer a selection of consumer-friendly educational materials designed to support a proactive role for consumers in medication safety.

An evaluation tool will seek consumers' input on key features of the site, for example, the user-friendliness of the online reporting form and the value of the educational content. ISMP Canada will develop mechanisms to allow ongoing consumer input into the site itself and program design and content. Key stakeholders, including consumer and patient groups, have provided input on a consultation document, available at www.ismp-canada.org/cmirps.htm. We welcome additional input on this strategy document, and to the program as a whole, by telephone at 1-866-544-7672 or by email at cmirps@ismp-canada.org.

ISMP Canada will respond to issues identified through consumer reporting by working with consumers, healthcare professionals, and medication safety experts to develop strategies for preventing errors and mitigating harm. The knowledge generated will form the basis of consumer-focused medication safety bulletins and will also be used in bulletins and alerts directed to healthcare professionals. Ultimately, the knowledge gained through the analysis of incidents reported to CMIRPS by consumers will be translated into health system improvements.

Acknowledgements

ISMP Canada expresses sincere appreciation to all of the organizations and individuals who have so far provided input to the CMIRPS consumer reporting and learning strategy. ISMP Canada is also grateful to the many consumers, healthcare professionals, and organizations who have shown initiative and demonstrated support for a culture of safety and learning, as exemplified by their willingness to share information about medication incidents and related findings.

Please refer to page 3 for references.

Medication Incident Involving Tamiflu (oseltamivir) at Transition of Care

ISMP Canada received a report about a school-aged child who inadvertently received Tamiflu (oseltamivir) 150 mg orally twice daily, instead of the appropriate weight-based dose of 60 mg twice daily, for the treatment of an H1N1 influenza-like illness. Tamiflu is an antiviral agent that has had a rapid increase in clinical use for the treatment of moderate to severe cases of pandemic H1N1 influenza and in situations where the patient is at risk of complications.

In this case, the child had received 3 days of Tamiflu therapy in hospital, and a prescription written at discharge read "Tamiflu 2 capsules BID × 2 days". The community pharmacist dispensed the 75 mg capsules, unaware that this drug is available in multiple strengths. A hospital pharmacist reviewing the discharge orders the day after discharge identified the risk for error, confirmed that an error had occurred (by viewing a provincial database), and contacted the community pharmacy. The community pharmacy in turn contacted the patient's family to correct the situation, and the patient experienced no adverse effects.

This report is a reminder of the need to specify the exact medication dose in every prescription, as well as the need to assess the appropriateness of every medication during dispensing. It also shows exemplary follow-up on the part of the hospital pharmacist, and highlights the value of access to electronic health information along the continuum of care. ISMP Canada gratefully acknowledges the reporting practitioner for sharing information about this case to alert others of the potential for similar errors.

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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.

Medication Incidents (including near misses) can be reported to ISMP Canada:
(i) through the website: http://www.ismp-canada.org/err_report.htm or (ii) by phone: 416-733-3131 or toll free: 1-866-544-7672.
ISMP Canada can also be contacted by e-mail: cmirps@ismp-canada.org. ISMP Canada guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

A Key Partner in the Canadian Medication Incident Reporting and Prevention System