

Consumer Reports Submitted to SafeMedicationUse.ca Provide Insights into Opportunities to Enhance Safety

In March 2010, the Institute for Safe Medication Practices Canada (ISMP Canada) initiated a pilot consumer reporting and learning program, SafeMedicationUse.ca, as a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS). The goal of this program is to strengthen Canada's capacity to enhance medication safety by providing a consumer-friendly mechanism to support the involvement of consumers in CMIRPS. (For more information on CMIRPS, see www.cmirps-scdpim.ca.) This *Safety Bulletin* presents an overview of the reports received by SafeMedicationUse.ca and highlights selected opportunities to apply learning from consumer reports toward the enhancement of safety in the medication-use system.

SafeMedicationUse.ca is supported by funding from Health Canada. The SafeMedicationUse.ca program includes a website offering a consumer-friendly electronic medication incident reporting system, as well as a selection of educational materials designed to support a proactive role for consumers in medication safety. Patients for Patient Safety Canada (www.patientsforpatientsafety.ca) provided input into the strategy for the program and participated in the media launch of the website.

Between March 2010 and October 2011, a total of 70 medication incidents were reported through the SafeMedicationUse.ca program (with a range of 1–9 reports/month). Many of the reported incidents have provided insights into factors identified as potentially contributing to medication errors. The following examples demonstrate how learning from incidents reported by consumers can be used by healthcare professionals and consumers alike to enhance medication safety.

Mix-up Between Spouses' Medications

A consumer obtained refills of her own prescription for warfarin and her spouse's prescription for trazodone at a community pharmacy. Later, the consumer noticed that she was experiencing unexpected drowsiness and fatigue, while her spouse was not receiving the usual benefit from his medication. By calling the pharmacy to question why these issues might be occurring, the consumer was able to alert the pharmacy that an error might have occurred. When the pharmacy investigated, they found that the labels on the

spouses' medications had been switched. The consumer's vial, which was labelled as warfarin, actually contained trazodone. Her spouse's vial, which was labelled as trazodone, actually contained warfarin. Fortunately, neither the consumer nor her spouse experienced any long-term harm. A SafeMedicationUse.ca newsletter advised consumers of the importance of checking their prescriptions and of contacting a healthcare professional if they experience any unexplained side effects. The newsletter also provided consumers with information about the steps to take to avoid mixing up medications belonging to different family members who live in the same home.¹

This report also offers important learning for community pharmacies, including the need for additional safeguards when dispensing high-alert drugs such as warfarin and the benefits of establishing systems to avoid mix-ups when prescriptions for 2 or more family members are being filled at the same time.

Mix-up Between Two Strengths of an Oral Anticoagulant

A consumer who had prescriptions for 2 different strengths of warfarin (to facilitate titration of doses) was experiencing unusual results upon international normalized ratio (INR) testing. When cutting a tablet from a bottle labelled "warfarin 1 mg" in half, the consumer noticed that the tablet was marked with the number 5. Upon further investigation, the consumer realized that the tablets in the bottle labelled "warfarin 5 mg" were marked with the number 1. When the patient visited the pharmacy where the warfarin had been dispensed, a staff member confirmed that an error had occurred and that the 2 strengths of warfarin had been switched. Fortunately, because the consumer's INR levels were being closely monitored, no long-term harm occurred. A SafeMedicationUse.ca newsletter provided advice to consumers on how to reduce the chances of being harmed by an error with warfarin.²

For healthcare professionals, this report is a reminder that when unexpected INR results cannot be explained by other factors, the possibility of a medication error should be considered. This report also highlights the need for additional safeguards when dispensing multiple strengths of any medication for the same patient, particularly when the drug in question is a high-alert drug such as warfarin.

Incorrect Dose of Medication Administered in Hospital

A consumer reported receiving too much ibuprofen in hospital. The doctor had prescribed 2 tablets of Extra Strength Advil (which contains 400 mg of ibuprofen in each tablet, for a total of 800 mg), but the consumer received six 200 mg ibuprofen tablets instead (for a total of 1200 mg). The consumer questioned the dose but took the tablets anyway. Later, the consumer asked the doctor about the dose and was told that an error had occurred. A SafeMedicationUse.ca newsletter provided tips to help consumers speak out when they have concerns about their healthcare and also provided links to other patient safety sites with useful resources on this topic.³

For healthcare professionals, this report underscores the importance of encouraging patients to speak up and of taking time to fully explore any concerns that patients identify.

Inadvertent Extra Dose of Anti-Anxiety Medication Taken by Consumer

An elderly consumer with a prescription for low-dose lorazepam was not advised of the potency and potential adverse effects of the medication by her healthcare providers. The consumer took one dose of lorazepam, forgot about taking it, and then inadvertently took a second dose before attending a party. The consumer experienced temporary amnesia as a result of taking the additional dose and did not even remember attending the party.⁴

For healthcare professionals, this report highlights the importance of ensuring that patients receive appropriate information about their prescribed medications, as well as the need for systems to support consumers in remembering whether or not they have taken their medications. There has been considerable focus on approaches to improving patients' adherence with medication regimens, but the problem of patients forgetting that they have already taken a dose (and taking extra doses as a result) may not be as well recognized. Some of the suggestions provided in a SafeMedicationUse.ca alert may also be of assistance to healthcare practitioners exploring options with patients to enhance the safety of self-administration of their medications.⁴

Overview of SafeMedicationUse.ca Program Activity

Of the 70 incidents reported between March 2010 and October 2011, 42 (60%) occurred in Ontario, 12 (17%) in Nova Scotia, 6 (9%) in British Columbia, 2 (3%) in Quebec, and 1 (1%) in each of Manitoba, Saskatchewan, and Alberta. Five reports described incidents that occurred outside Canada. Efforts are continuing to promote the reporting of medication incidents by consumers in all provinces and territories and to support consumers in making the best use of the information available at this website.

The most common care area for which incidents were reported was community pharmacy (29 reports, 41%), followed by hospitals (18 reports, 26%) and the home (16 reports, 23%). Consumers also reported incidents that had occurred in doctors' offices (1 report, 1%), outpatient clinics (1 report, 1%), nursing facilities (2 reports, 3%), and other areas (3 reports, 4%). The most common type of medication incident reported was wrong dose, strength or frequency (20 reports, 29%), followed by wrong drug and "other" (each at 17 reports or 24%). Six reports (9%) were categorized as wrong quantity; other incident types reported included missed medication or dose, wrong formulation or dosage form, wrong patient and wrong route.

Of the 70 incidents reported through the SafeMedicationUse.ca site, 28 (40%) were discovered by the consumer (patient) and 18 (26%) by a family member or friend. These data highlight the important role that consumers, patients, and family members can play in identifying and preventing errors in healthcare.

According to the information provided in the reports, half of the incidents did not result in any harm to the patient, with 21 incidents (30%) identified as near misses (i.e., incidents in which the error did not reach the patient) and 14 incidents (20%) reported as resulting in no harm. An additional 16 incidents (23%) were reported as having an outcome of mild harm. Some incidents were more serious, however: 9 (13%) had a reported outcome of moderate harm, 8 (11%) of severe harm, and 2 (3%) of death.* The majority of reported incidents (55 reports, 79%) occurred with prescription medications, including 8 involving the use of narcotics and controlled drugs. Thirteen (19%) of the reported incidents involved over-the-counter or herbal medications, and 2 reports (3%) involved nondrug items (specifically breast milk and electroencephalography gel).

Since its inception, the SafeMedicationUse.ca program has produced 15 newsletters and 9 consumer alerts. Of these 24 publications, 16 were based on incident reports submitted to ISMP Canada and 2 were based on incidents reported in the United States. These publications described the reported incidents and provided recommendations to help consumers reduce their chances of being harmed by similar errors. (The other 6 publications were 2 notifications of risk communications posted by Health Canada, a series of 3 newsletters on preventing errors with children's medications, and a newsletter with information on using iron supplements safely.) Consumers and healthcare professionals can now sign up on the SafeMedicationUse.ca site to receive free copies of all newsletters and alerts arising from this program.

*The definition for the outcome of death in the SafeMedicationUse.ca program is "there is reason to believe that the incident may have contributed to the patient's death or hastened the patient's death".

A French-language website, www.medicamentssecuritaires.ca, offers information to French-speaking consumers on how to report medication incidents to ISMP Canada by telephone. All SafeMedicationUse.ca newsletters and alerts are translated into French and are available in the bulletin section of ISMP Canada's French-language website at www.ismp-canada.org/fr/dossiers/bulletins/. A link to the French-language publications is also available from the www.medicamentssecuritaires.ca web page.

Conclusion

Early experience with the SafeMedicationUse.ca program has provided some preliminary insights into the role of consumers and patients in improving healthcare safety. The following are just a few examples of these insights:

- Consumers are willing to participate in efforts to improve the safety of healthcare.

- Consumers are able to identify both actual and potential errors and can intervene to prevent harm.
- Collecting incident reports from consumers offers new opportunities to gather information about the types of errors occurring in the home environment and to develop system-based interventions to reduce the likelihood of these errors.

Acknowledgements

This bulletin provides an opportunity to express sincere appreciation to the consumers and patients who have submitted reports to SafeMedicationUse.ca for their initiative, efforts, and demonstrated support for a culture of learning, exemplified by their sharing of information about medication incidents.

Please refer to page 4 for references.

Engaging Consumers in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)

Consumers can play a vital role in efforts to enhance medication safety, and incident reporting is an important first step. In light of the growing interest in strengthening the role of consumers in incident reporting and prevention, the following suggestions are provided for healthcare organizations and practitioners who are seeking ways to expand the role of consumers and patients in medication safety initiatives:

- Include a link to the SafeMedicationUse.ca website on your organization's website.
- Encourage patients and clients to visit www.SafeMedicationUse.ca and to sign up to receive newsletters and alerts. Information and updates are also provided on Facebook (www.facebook.com/pages/SafeMedicationUseca/257357537623440?sk=app_112078882147346) and Twitter (<http://twitter.com/#!/SafeMedUse>).
- Display SafeMedicationUse.ca materials in client and patient waiting areas. Brochures and a promotional poster are available on the SafeMedicationUse.ca website at www.safemedicationuse.ca/tools_resources/brochures.html, or contact us at cmirps@ismp-canada.org to receive a trial supply of brochures and business-size reminder cards.

Health Canada is Working with Industry to Address Drug Shortages

Health Canada has recently announced efforts to address drug shortages. Because drug shortages have been identified as possible contributing factors in medication incidents, ISMP Canada is also sharing information about this important initiative. Health Canada is encouraging industry and associations of healthcare professionals to work toward establishing "a national, one-stop drug shortages monitoring and reporting system in 2012."¹ The posting of information on drug shortage websites is an important first step toward enhancing transparency about shortages to healthcare professionals and patients.

For more information, please visit the Health Canada website at www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/announce-annonce/shortage-rupture-eng.php.

To report a medication incident in which a drug shortage has been identified as a possible contributing factor, visit ISMP Canada's website at www.ismp-canada.org/err_index.htm.

Reference

1. Web info sheet on drug shortages. Ottawa (ON): Health Canada Drugs and Health Products [cited 2011 Dec 20]. Available from: www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/announce-annonce/shortage-rupture-eng.php

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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.

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