



SafeMedicationUse.ca



*Mistakes with Medicines Happen.
Are they Preventable?*

Jennifer Turple

Medication Safety Specialist, ISMP Canada

November 1st, 2012



About ISMP Canada

ISMP Canada is an independent not-for-profit organization dedicated to reducing preventable harm from medications.

Our goal is the creation of safe and reliable **systems** for managing medications in all environments.

www.ismp-canada.org

We encourage you to report medication incidents



Consumer Reporting

www.safemedicationuse.ca/

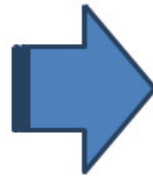


Health Care Provider

Reporting [https://www.ismp-
canada.org/err_report.htm](https://www.ismp-canada.org/err_report.htm)

Questions

1. Raise your hand. If you have a phone icon by your name we will un-mute your phone and you can ask your question



2. Type your question in the chat box



A screenshot of a webinar software interface. The top section is titled 'Participants' and shows a list of participants. The first participant is 'ISMP Canada (Host)' with a red square icon next to their name. Below the list are buttons for 'Make Presenter', 'Audio', and 'Mute'. The bottom section is titled 'Chat' and shows a 'Send to:' dropdown menu set to 'All Participants'. Below the dropdown is a text input field with the placeholder text 'Select a participant in the Send to menu first, type chat message, and send...' and a 'Send' button.

3. Email your question to webinars@ismp-canada.org

Speaker



Jennifer Turple
ISMP Canada,
Medication Safety Specialist



SafeMedicationUse.ca



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Today's Audience

Where are you located?

International
(inscrivere ici)



Learning Objectives

To better understand:

- the meaning of “medication incident”
- how to report a medication incident
- how to navigate the information on www.SafeMedicationUse.ca
- ways consumers can reduce their chances of being harmed by a medication incident

Medication Incident

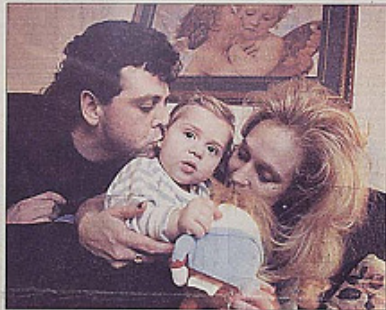
A medication incident is a *mistake with a medicine* or a problem that *could cause a mistake with a medicine*



Another baby is given morphine by mistake

Boy survives after same hospital that gave infant fatal overdose makes second drug error

By Tracy Reisman and Cal Miller
A second baby has been misdiagnosed with meningitis at Shingler's Pool Memorial Hospital. A doctor at the hospital gave 50 milligrams of morphine to an operating room, just before the baby was sent surgery to repair a hernia. Feb. 11, Julian Levine, the hospital's chief medical officer, said the parents are "worried about future health problems for our son."



SHARI PARSHIK, Shari and Soham Parshik say they got "a little bit of a dose" of what Trevor Landry's parents felt when their son Julian was given morphine by mistake.

The nurse wouldn't get a prescription, so I got really upset with her and said I knew about the Landry story and didn't want the same thing to happen to my son."



DOCUMENTATION: Doctor's progress in part shows drug error.

Julian had had implemented procedures to prevent such medication errors from happening again. "I had a pharmacist," said Shari Parshik, who was by her son's side last week when doctors noticed the baby in distress and sending oxygen. "I knew something wasn't right. I immediately thought of the Landry case."

The 30-year-old mother said she didn't know what had happened, but she later told her son had been given the wrong drug.

The mistake was noted at nearby Shingler on the doctor's orders and progress report.

Parshik received medical care in the operating room at 10:30. Her son's heart rate was 100. "I explained to mother that medication error occurred and that Julian would be

were able to obtain copies of their son's records from the hospital a couple of days later that they saw a notation that Julian had been given three milligrams of morphine. According to the Canadian Society of Pharmacists and Dispensaries, the appropriate dose of morphine for a baby of Julian's weight would be between 0.5 milligrams and 1.8 milligrams, the same procedure.

Dr. Ben Dehaan, the hospital's chief of medicine, said the incident likely shows Julian's case because the parents didn't get a written progress indication, he suggested drug and medication are both are a part of life at hospitals around the world.

"It's a universal problem and the use of drug error will never be eliminated. It's not a medical possibility, but we will always try to reduce the potential for it."

Using the media is one way to find out errors involving drugs and drawing parallels between cases administered in the past.

After the latest death, however, the coroner's office decided it was time to emphasize the danger. "It was felt that an inquest might be the best way to get the information out," Dr. Porter said.

The medical community knows surprisingly little about its own errors. A newsletter published last month by the Institute for Safe Medication Practices Canada recorded five cases in which patients

Wrong injection causes death

BY GRAEME SMITH

A drug used to execute death-row prisoners was mistakenly injected into an elderly woman, whose death in a Peterborough, Ont., hospital will be examined in a coroner's inquest.

Bonita Porter, Ontario's deputy chief coroner of inquests, announced yesterday that a jury will look at why Frances Marie Tanner, 84, died at the Peterborough Regional Health Centre on Jan. 21.

The cause of Ms. Tanner's death is already known: Somebody injected a dose of potassium chloride into her vein. Small quantities of the drug can cure potassium deficiencies, but larger amounts are poisonous.

At least three other Canadians have died after receiving the same drug, sometimes from nurses who thought it was a different medicine.

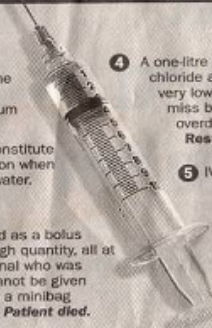
Some doctors blame these accidents on manufacturers who sell potassium chloride in plastic ampoules and vials that closely resemble containers of sterile water, saline solution, and other harmless solutions.

Others say hospitals need stricter controls over potentially deadly substances. Ontario's chief coroner sent a memo to hospitals last year specifically warning them that potassium chloride has been wrongly

Litany of errors

Incidents involving potassium chloride in Canada:

- 1 Potassium chloride (KCl) was administered via direct IV when the intended action was to flush an intravenous line with diluted sodium chloride. **Result: Patient died.**
- 2 KCl concentrate was used to reconstitute a drug for parenteral administration when the intended diluent was sterile water. **Result: Error was noted before administration.**
- 3 KCl concentrate was administered as a bolus injection — an injection given in high quantity, all at once — by a health-care professional who was unaware that KCl concentrate cannot be given as a bolus but must be diluted in a minibag and given as an infusion. **Result: Patient died.**
- 4 A one-litre IV solution was prepared with potassium chloride and although it was administered at a very low rate, the incident was felt to be a near miss because of the potential for accidental overdose. **Result: Error was noted during administration.**
- 5 IV solutions containing KCl were administered as a fluid replacement in a patient requiring several litres of fluid in a short time frame. **Result: Hyperkalemia, patient died.**
- 6 Frances Marie Tanner, 84, received an intravenous injection of potassium chloride at the Peterborough Regional Health Centre on Jan. 21, 2002. **Result: Patient died.**



SOURCE: INSTITUTE FOR SAFE MEDICATION PRACTICES REPORT, MAY, 2002. IMAGE: PHOTODISC THE GLOBE AND MAIL



Source: Globe and Mail, June 2002

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THE PUBLIC LIBRARY
AS MODERN-DAY
SALON

ARE YOU CLUELESS
ABOUT MONEY?

IN CUBA,
YOU ARE
THE ONE PERCENT

THE WALRUS

WALRUSMAGAZINE.COM • PUBLISHED BY THE WALRUS FOUNDATION

APRIL 2012

**WHY
24,000
CANADIANS
WILL DIE
THIS YEAR
BECAUSE OF
MEDICAL
ERROR**
BY RACHEL
GIESE

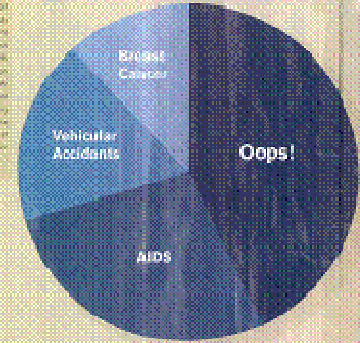
PLUS
**JENNIFER
BAICHWAL,
MARGARET
ATWOOD,
AND DEBT**

PRICE \$6.95
VOLUME NO. 9, ISSUE NO. 3



0 56698 70498 0 04

MAJOR CAUSES OF DEATH IN THE UNITED STATES:



Heart Disease is the leading cause of death in the United States, accounting for nearly 25% of all deaths. It is a complex condition that can be prevented or delayed through lifestyle changes and medical intervention.

Cancer is the second leading cause of death, with a wide variety of types. Early detection and treatment are key to improving survival rates.

Vehicular Accidents are a leading cause of death, often preventable through safe driving practices and improved road infrastructure.

AIDS remains a significant cause of death, particularly among young adults. Consistent use of antiretroviral therapy can significantly reduce the risk of complications and death.

Oops! This category represents a significant portion of deaths, often due to preventable medical errors, falls, or other accidents. Many of these deaths could be avoided through better patient safety protocols and error prevention strategies.



Examples of medication incidents include:

- Being given a prescription for a medication you are allergic to (e.g. You have an allergy to penicillin and you are prescribed a penicillin type medication)
- Picking up your prescription at your pharmacy and the vial contains the wrong medication
- Being given too much of a medication while in hospital
- Taking the same medication twice by accident

Incidence of Incidents

- One in ten adult Canadians with health problems reported receiving the wrong medication or wrong dose while filling a prescription or when hospitalized within the last two years.
- In a 2004 Canadian study, 7.5% of adults admitted to the hospital experienced an adverse event (including medical and medication errors)

Sources:

-Commonwealth Fund 2008 International Health Policy Survey of Sicker Adults. 2008 [cited 2009 May 24]. Available from:
http://www.commonwealthfund.org/~media/Files/Surveys/2008/The%202008%20Commonwealth%20Fund%20International%20Health%20Policy%20Survey%20of%20Sicker%20Adults/IHP2008_CMWF_DSQ_for_web%20pdf.pdf
- Baker, Norton et al, CMAJ, May 2004

Healthcare is extremely complex.

We are human.

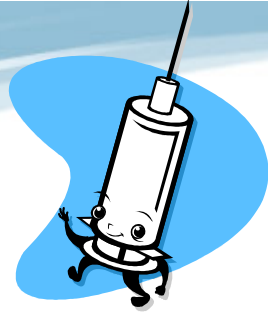
Errors are inevitable.

ISMP Canada works to prevent harmful errors.

You can play a role.

About ISMP Canada

At ISMP Canada, we review incident reports submitted by health professionals and consumers and look for ways to prevent harmful errors.



Medication incidents may involve use of prescription and non-prescription medications, natural health products, imported products and devices or equipment used to administer medications.



Where do medication incidents occur?



- At your doctor's office when a medicine is prescribed



- At your local drug store or community pharmacy

- When a prescription is filled
- When you select an over-the-counter medicine



- In your home, when you take or use the medicine

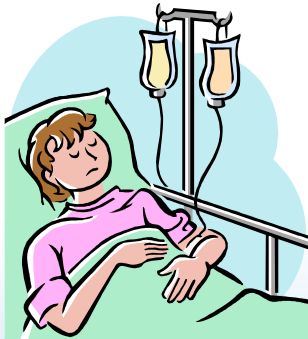
Where do medication incidents occur?



- In the hospital, when medicines are prescribed (e.g. admission & discharge)



- In the hospital pharmacy, when medicines are dispensed



- At your bedside, when medicines are given/taken

Adverse Drug Reactions

www.healthcanada.gc.ca/medeffect

- Adverse drug reactions are **not** medication incidents.
- **Adverse drug reactions**
 - are also known as side effects
 - are unwanted effects that happen when drugs are used under normal conditions.
 - generally do not involve mistakes and typically cannot be prevented
 - can be serious or not serious
- Adverse Drug Reactions should be reported to Health Canada's Canada Vigilance Program at:

www.healthcanada.gc.ca/medeffect



POLL # 1

Please take a moment to answer the
poll questions

The good news..

The incorporation of safe medication practices may help to reduce your likelihood of being harmed by a medication incident.

SafeMedicationUse.ca

Information on the program

SafeMedicationUse.ca

Goal

To strengthen Canada's capacity to enhance medication safety by increasing the involvement of consumers in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)

CMIRPS

Canadian Medication Incident Reporting and Prevention System (CMIRPS) Program

REPORT
a Medication Incident



SafeMedicationUse.ca
Supported by Health Canada

Site went "live" March 2010



ISMP Canada Activities for the CMIRPS:

- Reporting Systems for Medication Incidents
- A consumer medication safety reporting and learning program: SafeMedicationUse.ca
- Safety bulletins and alerts by ISMP Canada about medication incidents and prevention strategies
- Medication Safety Self-Assessment programs
- Root Cause Analysis workshops and frameworks
- Failure Mode and Effects Analysis workshops and frameworks
- Responding to queries on medication safety (email or telephone)
- Medication safety workshops and webinars

The key partners in the development and implementation of CMIRPS are Health Canada, ISMP Canada, Canadian Institute for Health Information (CIHI), and with recent support from the Canadian Patient Safety Institute (CPSI)

Purpose of the CMIRPS

The **purposes** of the CMIRPS program are to:

- Coordinate the capture, analysis and dissemination of information on medication incidents;
- Enhance the safety of the medication use system for Canadians; and
- Support the effective use of resources through the reduction of potential or actual harm caused by preventable medication incidents.

The **goals** of the CMIRPS information system are to:

- Collect data on medication incidents;
- Facilitate the implementation of reporting of medication incidents;
- Facilitate the development and dissemination of timely, targeted information designed to reduce the risk of medication incidents (e.g. ISMP Canada Safety Bulletins); and
- Facilitate the development and dissemination of information on best practices in safe medication use systems.

Why Report?

Your reports can make a difference!

For example, ISMP Canada may:

- Approach a manufacturer to suggest that the label of a product be changed,
- Suggest safer ways for health professionals to handle medications,
- Remind consumers of things they can do to avoid making mistakes with medication,
- Identify special projects, such as a project on labeling and packaging of medications that is currently underway with Health Canada.

Why Include Consumers and Patients?

Patients and Consumers:

- Have a strong desire to convey information that may help others from being harmed
- May be aware of errors and hazards that are unknown to healthcare professionals
- Can provide insight into underlying contributing factors
- Can offer potential solutions
- Can play an important role in preventing errors, when receiving care and at home

SafeMedicationUse.ca



“This is the second time an error has occurred at this pharmacy in the past year. I did not report the first one and frankly have no idea to whom I should report these errors.”

Suggested approach

Speak to your care providers
or a patient care representative

Report to
 **SafeMedicationUse.ca**

Notify provincial professional regulatory authorities when you
have specific concerns about a care provider's conduct

Contact the ministry or department of health in the province where you
received your care.

Appeal to provincial/territorial ombudsman or a similar advocacy body.

As needed to resolve your
concern

SafeMedicationUse.ca

How to Report Medication Incidents

In place of the live website demo (as seen during the live webinar & on the recording), a selection of screen shots have been added.



A pilot project of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Preventing harm from medication incidents is a responsibility of health professionals. **Consumers like you** can also play a vital role.

Reporting Medication Incidents benefits all Canadians.



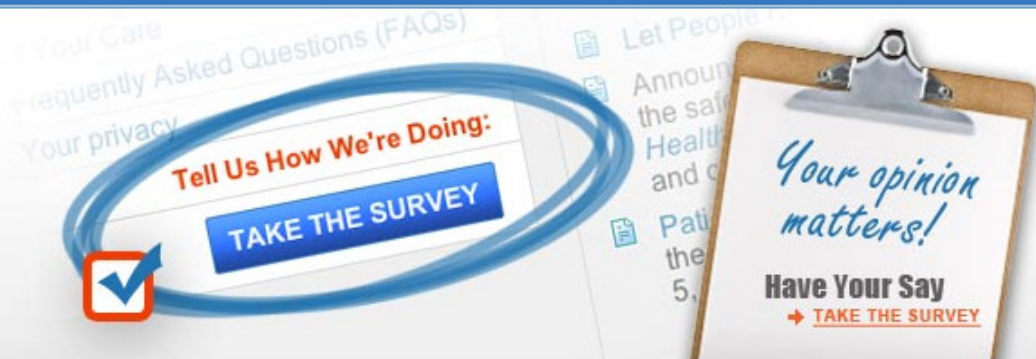
REPORT NOW

- [About SafeMedicationUse.ca](#)
- [About Medication Incidents](#)
- [Why Report?](#)
- [Resolving Concerns About the Safety of Your Care](#)
- [Frequently Asked Questions \(FAQs\)](#)
- [Your privacy](#)

Sign up to receive the latest Alerts and Newsletters:

Your Email

SIGN UP



Latest News and Resources

SHARE

- [Take Care with Medicine Patches!](#) 2012-07-04
- [Health Canada Endorsed Important Safety Information on the Dangers Associated with the Use of Counterfeit Drugs](#) 2012-06-22
- [Preventing Harm from Drug Interactions: Consumers Can Play an Important Role](#) 2012-06-14
- [Check Labels Carefully When Selecting Gravol Products!](#) 2012-05-04
- [Consumer Catches Error Involving Similar Medicine Names](#) 2012-05-01
- [Cough and Cold Preparations: Use with Care!](#) 2012-03-26
- [Health Canada is advising Canadians that Sandoz Canada is recalling a partial lot of 2mg/mL \(1 mL\) Morphine Sulfate Injection](#) 2012-03-22
- [Health Canada is informing Canadians of Vita Health Products' voluntary](#)



Incident Report:

NOTE: Red Asterisks * indicate which fields are REQUIRED.

| | | |
|---|---|------------------------|
| 1. Date of Incident | January | 2011 |
| 2. Province or Territory | | |
| 3. What type of medication incident are you reporting? * | | |
| 4. Where did the incident happen? * | | |
| 5. At what stage(s) of the medication system did the incident occur? (Choose all that apply.) * | <input type="checkbox"/> Prescribing <input type="checkbox"/> Documentation/computer entry <input type="checkbox"/> Preparation/dispensing <input type="checkbox"/> Administration <input type="checkbox"/> Monitoring <input type="checkbox"/> Other <input type="checkbox"/> I don't know | |
| 6. Name of medication(s) involved in this incident * | Medication: * | Dosage Form: Strength: |
| | | |
| 7. Who discovered the incident? * | | |

SafeMedicationUse.ca

- Over 100 reports received as of October 2012
- 21 newsletters and 20 alerts now available on site
- Majority of newsletters and alerts based on actual reports from Canadians
- Additional pro-active alerts and newsletters
- Selected Health Canada Advisories are also posted on Alerts page

SafeMedicationUse.ca

Review of the website

In place of the live website demo (as seen during the live webinar & on the recording), a selection of screen shots have been added.



I would like to: [START A REPORT](#)

Get Medication Safety Alerts

→ [Newsletter](#)

Sign up to receive the latest Alerts and Newsletters:

Your Email

[SIGN UP](#)

Medication Safety Alerts

- [Reminder: Take Care with Clear Care!](#) 2012-10-31
- [Health Canada has released an Information Update about a potential interaction between methotrexate and Proton Pump Inhibitors](#) 2012-10-19
- [Health Canada Endorsed Important Safety Information about potential device failure with Pulmicort Turbuhaler](#) 2012-07-26
- [Take Care with Medicine Patches!](#) 2012-07-04
- [Health Canada Endorsed Important Safety Information on the Dangers Associated with the Use of Counterfeit Drugs](#) 2012-06-22
- [Check Labels Carefully When Selecting Gravol Products!](#) 2012-05-04
- [Cough and Cold Preparations: Use with Care!](#) 2012-03-26
- [Health Canada is advising Canadians that Sandoz Canada is recalling a partial lot of 2mg/mL \(1 mL\) Morphine Sulfate Injection](#) 2012-03-22
- [Health Canada is informing Canadians of Vita Health Products' voluntary recall of the "combo pack" of Rexall Extra Strength Sinus Relief Daytime and Nighttime](#) 2012-03-12
- [Health Canada Endorsed Important Safety Information on Domperidone Maleate](#) 2012-03-07
- [Health Canada is advising Canadians of Novartis Consumer Health Inc's recall](#)



I would like to: [START A REPORT](#)

2010-2012

→ Alerts

Sign up to receive the latest Alerts and Newsletters:

Your Email

[SIGN UP](#)

SafeMedicationUse Newsletter

[SHARE](#) [f](#) [t](#) [e](#) ...

- [Take Steps to Prevent Mix-ups with Pets' Medicines!](#) 2012-10-9
- [Are You Taking the Right Amount of Water With Your Medicine?](#) 2012-08-27
- [Preventing Harm from Drug Interactions: Consumers Can Play an Important Role](#) 2012-06-14
- [Consumer Catches Error Involving Similar Medicine Names](#) 2012-05-01
- [Know What to Do if You Are Allergic to a Medicine!](#) 2012-03-08
- [Medication Reconciliation Can Help to Reduce the Chance of Errors with Medicines!](#) 2012-01-11
- [What's In a Brand Name?](#) 2011-11-30
- [It's Important to Speak Out!](#) 2011-10-31
- [Preventing Errors with Children's Medicines: Part 3 - Over-the-Counter Medicines](#) 2011-08-31
- [Preventing Errors with Children's Medicines: Part 2 - At Home and Away from Home](#) 2011-07-27
- [Preventing Errors with Children's Medicines: Part 1 - At the Doctor's Office and Pharmacy](#) 2011-06-27
- [Safe Disposal of Medications](#) 2011-03-15



A pilot project of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Would like to: **START A REPORT**

Medication Safety Tips

- Develop a Medication List
- Medication Safety Practices
- Frequently Asked Questions (FAQs)
- Health Canada Medication Safety Advisories
- Medication Information Centres in Canada
- Useful Links
- Resources
- Newsletter

Medication Safety Tips

- Safe Practices for Medication Use (Take Charge of Your Medicines!)
- Spotlight on Acetaminophen
- Poison Look Alikes - Lamp Oil is a Hazardous Product!
- Have a Safe Trip - Avoid Problems with your Medications!
- Home Safety: Prevent Poisonings That Occur at Home
- Do You Need to Worry About Items In Your Medicine Cabinet?

This information was adapted with the permission of the Institute for Safe Medication Practices, using material originally published on the site www.consumermedsafety.org

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SafeMedicationUse.ca

Safe Medication Practices and Tips

Tip # 1

Keep an up-to-date list of every medication you take, including over-the-counter medications and supplements.

Keep the list with you at all times and show the list to your doctor, nurse, pharmacist or other healthcare professional any time you receive health care.

Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 3, Issue 1

Newsletter

January 11, 2012

Medication Reconciliation Can Help to Reduce the Chance of Errors with Medicines!

SafeMedicationUse.ca has received a report from a consumer who noticed potential problems on two occasions while receiving care in an emergency department. Each time, the consumer spoke up after noticing that healthcare providers had incomplete information about a medicine the consumer was taking at home. On one occasion, information that was obtained from a computer system did not include the current dose of the consumer's medicine warfarin. On another occasion, the computer system did not have current information on the consumer's dose of candesartan cilexetil (brand name Atacand). Warfarin is a blood thinner. Candesartan can be used to treat high blood pressure or heart failure. A mistake with either of these medicines could cause harm. Fortunately, the consumer spoke up and made sure that the healthcare providers got the right information. [Read more about speaking out when you have concerns](#)

(www.safemedicationuse.ca/newsletter/newsletter_speakout.html)

Whenever you receive healthcare, it is important that you and your healthcare provider have complete information about all your medicines. Healthcare providers may use more than one source of information to prepare a complete list of your medicines. This list is sometimes called a "best possible medication history" or BPMH. Making a BPMH is the key step in a process known as "medication reconciliation". When a BPMH is being created, it is ideal for you or your family to participate.

You can help your healthcare providers to prepare the BPMH by bringing your own list of medicines and all of your medicine bottles with you whenever you receive healthcare. These steps can be a big help because it may be difficult for you to remember the information yourself, especially if you are feeling sick. Ideally, you should include all types of medicine that you take at home, including over-the-counter drugs and herbal medicines. Tell your healthcare provider how you take each medicine. These details are important because healthcare providers may not always

What is Medication Reconciliation?

Medication reconciliation is a way to make sure that information about your medicines is passed on when you move from one setting of care to another. During medication reconciliation, a healthcare provider makes a list called the "best possible medication history". This list contains information about your medicines that is as complete and correct as possible. All of your healthcare providers can use this list when they are making decisions about your medicines and other types of care. Medication reconciliation works best when patients and families are partners in the process.

Medication reconciliation may happen when you are admitted to hospital, when you are transferred from one area to another while you are in hospital, and when you are discharged from hospital. Medication

Tools

- For those with an iPhone, iPad or an iPod touch, there is an “app”, called **MyMedRec**, available free at the iTunes store.



- Online printable tools available at “Knowledge is The Best Medicine” website:

www.knowledgeisthebestmedicine.org

- Useful forms and a wallet card are available on the "It's Safe to Ask" site

http://safetoask.ca/?page_id=145

Available in multiple languages also at:

http://www.nps.org.au/consumers/tools_and_tips/medimate/medimate_brochure/keep_an_up-to-date_medicines_list

Tools

- In many local pharmacies, you may set up a meeting with the pharmacist to help you document your list of medicines (and to make sure you are getting the most benefit from your medicines).

MedsCheck

ADVANCED
MED REVIEW



Tip # 2

Before taking any new medicine, check with your pharmacist to be sure it won't interact with something else you are taking. This is important even for medicines that you buy without a prescription. Even natural products, like herbal remedies, could interact with your medication.

SafeMedicationUse.ca

Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 1, Issue 6

Newsletter

September 15, 2010

Minerals May Interact with Some Medicines Don't Forget — Keep a List of Your Medicines!

A Canadian who had the bad luck to get pneumonia in Florida almost had a second dose of bad luck because of a drug interaction. A doctor wrote a prescription for the antibiotic moxifloxacin (brand name Avelox) and a pharmacist then prepared the medicine. However, the doctor and the pharmacist didn't know that the patient was already taking a product that contained multivitamins and minerals. Mineral supplements can keep the body from absorbing some drugs, including Avelox. This means that the drugs can't do their jobs. In this case, the patient took all of the Avelox exactly as the doctor instructed, but the pneumonia was not cured. When the doctor prescribed Avelox again, the pharmacist told a family member that it was important to stop taking any minerals while taking Avelox. The patient stopped taking the minerals while he was taking the Avelox and the pneumonia was cured.

Consumers who are asked for a list of their medicines sometimes forget to mention nonprescription medicines. Some people may not think of vitamins, minerals, and other natural products as medicines. Other things that might be overlooked are medicines that are inhaled, injected, or applied to the skin, eyes, ears, or nose. Even medicines that are taken only once in a while can be important.

When you are sick, it is easy to forget things. That's one reason that ISMP Canada suggests making a list of all your medicines and how you take them. Your list should include your name and other important information like your medical conditions, your allergies, and previous drug reactions.

Keep the list with you at all times. Show the list to your doctor, nurse, pharmacist, or any other healthcare professional every time you receive care. That way, your healthcare professional will know

Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 3, Issue 4

Newsletter

June 14, 2012

Preventing Harm from Drug Interactions: Consumers Can Play an Important Role

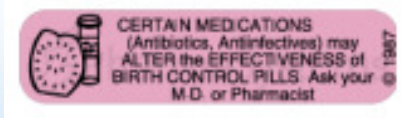
SafeMedicationUse.ca has received a report from a consumer who was given two medicines that are known to interact with each other. This type of problem is known as a drug interaction. A drug interaction occurs when the actions of one medicine affect the actions of another medicine.

The consumer had received a prescription for tamoxifen from a cancer specialist. Tamoxifen is a medicine that is used to treat certain types of breast cancer. Later, the consumer's family doctor prescribed duloxetine (brand name Cymbalta) to treat depression. Duloxetine can reduce the effectiveness of tamoxifen. The consumer took both of these medicines for several months before finding out about the drug interaction during a follow-up visit with the cancer specialist. The cancer specialist told the consumer to stop taking the tamoxifen and prescribed a different breast cancer medicine that does not interact with duloxetine.

Drug interactions can occur with many types of medicines, including over-the-counter and natural or herbal medicines, as well as prescription medicines. Some medicines may also interact with specific foods or alcohol. Drug interactions can be harmful. Some drug interactions require that a different medicine be prescribed, as in the example described here. On the other hand, not all drug interactions mean that you have to stop taking the medicines that interact. Sometimes, you can keep taking the medicines, but a different dose will be prescribed. Sometimes the potential drug interaction will be managed with monitoring by you and your healthcare provider. This monitoring depends on the medicines involved, but may include more frequent assessments to identify if you are experiencing a side effect or if your medicines are working as intended.

Drug Interactions-Consumer Role

- Use the same pharmacy for all prescriptions
- Keep a list of all your medicines
- Read printed material, listen to pharmacist
- Read labels carefully; note auxiliary labels
- Consult with pharmacist when selecting non-prescription medicines
- Seek advice before making changes to your medicine



Tip # 3

- Always check your medicine(s) before leaving the pharmacy. Have your pharmacist go through the instructions on the prescription label with you. This gives the pharmacist another opportunity to double check the information with you directly. Tell your pharmacist if you have any concerns or if any of the information does not match what you were expecting to see or hear.

Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 3, Issue 3

Newsletter

May 1, 2012

Consumer Catches Error Involving Similar Medicine Names

SafeMedicationUse.ca has received a report from a consumer who identified a mistake involving two similar medicine names. This consumer had been treated for an autoimmune disease, a type of disease that can occur when a person's immune system attacks normal body cells. Following a hospital stay of several weeks, the consumer was sent home with a prescription for the medicine cyclophosphamide. Once at home, the consumer noticed that the medicine dispensed by the pharmacy was labeled "cyclosporine". Fortunately, the consumer realized that the wrong drug had been dispensed and did not take the cyclosporine.

Cyclophosphamide and cyclosporine are two different medicines that are used for different reasons. Cyclophosphamide is commonly used to treat some forms of cancer and certain autoimmune diseases. Cyclosporine is commonly used to help prevent organ rejection in people who have had an organ transplant. Cyclosporine may also be used to treat certain autoimmune diseases, but for people with this type of condition, the two medicines are not interchangeable.

Similarities in the appearance of generic or brand names of medicines can cause confusion. In the example described here, the drug names cyclophosphamide and cyclosporine both begin with "cyclo". In addition, these two medicines are available in dosage forms of the same strength. Sometimes, the names of medicines can sound alike when spoken. Although healthcare providers try to provide consumers with the correct medicine, occasionally factors like these can lead to mistakes.

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Help Prevent Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Volume 1, Issue 2

Newsletter

March 10, 2010

Consumers Can Help Prevent Mistakes with Medication – Check Your Prescription!

Are you wondering how consumers can help prevent mistakes with medications? Here is an example of how ISMP Canada used information reported by a consumer to help prevent medication incidents.

A consumer had a prescription for insulin, to be injected every morning and every evening, using an insulin pen. After a morning dose of insulin, the person was found sweating and nearly unconscious. Fortunately, someone recognized the symptoms of low blood sugar and gave the person sugar, followed by more food.

What had happened? The consumer had recently picked up some boxes of insulin at a pharmacy. Most of the boxes were correct, but one box contained a fast-acting brand of insulin. No one had noticed that the wrong box was mixed in with the other boxes. The consumer reported the incident to ISMP Canada, in the hope of preventing the same mistake from happening again.



Insulin products are often stored close together in the pharmacy fridge and ISMP Canada saw that the packages and labels of the two insulin products were very similar. Also, even though the pharmacy used a bar code system to check medications, only one box (which happened to contain the right product) had been scanned. ISMP Canada realized that a mistake like this could happen in any pharmacy. They sent out a safety bulletin to remind other pharmacies of how important it is to check and scan every package when drugs are being dispensed, and to suggest that pharmacies review the way they store insulin in their

Tip # 4

- Don't be afraid to speak up if you think you are about to receive the wrong medicine from a pharmacy or when you are in hospital. Be sure that you are satisfied with how your concerns have been addressed before taking any medicine

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Volume 3, Issue 2

Newsletter

March 8, 2012

Know What to Do if You Are Allergic to a Medicine!

SafeMedicationUse.ca has received reports from consumers who were given medicines to which they were allergic. One report involved a consumer who was allergic to the antibiotic penicillin. People who are allergic to penicillin should not take antibiotics in the penicillin family, such as amoxicillin. The consumer reported the allergy at the dentist's office, but did not write this information in the correct spot on the form. The consumer also informed the pharmacy about the allergy, but the information was not kept on file. Later, the dentist prescribed amoxicillin for the consumer, and the pharmacy dispensed the medicine. Fortunately, the consumer read the information that the pharmacy supplied with the medicine and realized that a mistake had been made. The consumer spoke up, and a different antibiotic was prescribed.

A second report involved a consumer who was allergic to another antibiotic, called levofloxacin. This consumer reported the allergy on a list of medicines that was given to healthcare providers when the consumer came to a hospital for treatment. Despite taking this precaution, the consumer was given levofloxacin. The report sent to SafeMedicationUse.ca stated that the consumer "could not get breath at all, almost died".

Tips for Consumers with Allergies

- Seek advice if you notice unexpected or bothersome effects from a medicine
- Know generic and trade names of medicines that you are allergic to
- Keep a list of medicines and be sure to note allergies
- Read printed material that comes with medicine
- Before accepting any medicine, ask what you are being given

Tip # 5

Leave all medicines in their original containers.

Removing Medicines from Original Packaging Can Lead to Errors

A consumer, who occasionally suffers from allergies and nasal congestion, took 2 caplets of Allegra-D. Shortly afterwards the consumer felt anxious, experienced trembling, and had a very dry mouth. The consumer later realized these symptoms had been caused by taking the wrong dose of Allegra-D. Instead of taking 2 caplets, the consumer should have taken only one caplet.

How did this mistake happen? Many medicines are supplied in blister packs, inside an outer box. Information about how to take the medicine properly is on the outer box, but not on the blister pack. The consumer had removed the blister pack of caplets from the outer box to make it easier to carry and store the medicine. This meant that the consumer was not able to check how much medicine to take. The consumer had not taken the medicine for several months and had forgotten the correct dose.

It is important to take the correct dose of any medicine. The wrong dose may lead to the medicine not working properly, or to unpleasant and even dangerous side effects. To avoid mistakes, it is best to check the label and read dosing instructions every time you take a medicine. For this reason, ***always keep your medicines in their original packaging.***



Outer package with directions for use.



Blister packs do not typically include directions for use.

Tip # 6

Check expiration dates. Potency may be affected in expired drugs and certain expired medications can be harmful to your health.

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Volume 2, Issue 2

Newsletter

March 15, 2011

Safe Disposal of Medications

SafeMedicationUse.ca has received a report from a consumer who had difficulty finding a safe way to dispose of old medicines. This newsletter provides information on how and why to discard medicines safely.

Most medicines have an expiry date on the label. Once the expiry date has passed, a medicine may not be fully effective and should not be used. Taking expired medicines may even cause harm. Everyone should sort through their medicine cabinets at least once a year. Any medicine that has expired and any drugs that are no longer needed should be discarded. It is important to use a safe method of disposal.

In the past, it was common for people to flush old medicines down the sink or throw them in the toilet. Other people would throw old medicines in the garbage. These methods of disposal could be harmful to the environment or could create a danger before garbage pick-up. Proper disposal of medicines protects the environment and also protects children and pets. It also prevents old medicines from falling into the hands of people who might misuse them.

Programs for safe disposal of medicines vary across the country. If you live in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, or Prince Edward Island, you can take advantage of provincial programs. In these programs, certain community pharmacies take back your old medicines and dispose of them in an environmentally safe manner.

More info at: <http://www.medicationsreturn.ca/>



POLL # 2

Please take a moment to answer the
poll question

Tip # 5

Carefully read the labels on over-the-counter medicines and natural products.



Look-Alike Graval Ginger Product Causes Confusion for Consumers

SafeMedicationUse.ca has received 2 incident reports of confusion between the natural-source Graval product containing the active ingredient ginger and the original Graval product containing the active ingredient dimenhydrinate (Figures 1 and 2).

In the first incident, a patient taking oral chemotherapy had been advised to take Graval. The patient later returned to the clinic reporting ongoing nausea. At that time, she mentioned that she was taking "nondrowsy" Graval. The pharmacist realized that the patient had been taking the Graval ginger product, instead of the Graval product containing dimenhydrinate.

The second incident involved a consumer who in the past had used the Graval product containing dimenhydrinate to control nausea from migraine headaches. The consumer's husband bought the product containing ginger instead of the product containing dimenhydrinate. He did notice that the product label included the word "ginger" but assumed that the tablets were ginger-flavoured. The consumer vomited and felt a severe burning sensation in her esophagus shortly after taking the Graval product. A family member examined the label and realized



Figure 1: Package for "Graval Natural Source" tablets containing ginger as the active ingredient.



Figure 2: Package for Graval tablets containing dimenhydrinate as the active ingredient.

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Help Prevent Medication Incidents

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Volume 3, Issue 3

Alert

May 4, 2012

Check Labels Carefully When Selecting Graval Products!

SafeMedicationUse.ca is informing consumers of another example of products with similar brand names that contain different ingredients.

In 2010, SafeMedicationUse.ca published an [alert](#)¹ that described confusion between the original Graval product and a Graval Natural Source product that contains ginger. Now, a new Graval Natural Source product, called Graval Multi-Symptom, is also available.

The original Graval product contains the medicine dimenhydrinate. Graval Natural Source products do not contain any dimenhydrinate. Graval Ginger lozenges and tablets contain ginger. Graval Multi-Symptom contains ginger and willow bark. Willow bark contains a number of compounds, including salicin, one of a class of medicines known as “salicylates”. Acetylsalicylic acid (also called ASA or Aspirin) is one well-known example of a salicylate.



POLL # 3

Please take a moment to answer the
poll question

Examples of Reported Incidents

Community Pharmacy

- Errors with dose calculations in children
- Confusion with gradually lowering doses of prednisone
- Lyrica/Lipitor mix-up occurred when patient called for refill using drug name instead of Rx number

Examples of Reported Incidents

Community Pharmacy

- Mix up between spouses' medications (trazodone and warfarin)
- Mix up between Coversyl Plus HD and Coversyl Plus
- Labeling mix-up between two strengths of warfarin

Examples of Reported Incidents

At Home/In the Community

- Consumer took a double dose of pseudoephedrine, due to discarding outer package of a blister packaged medicine
- School staff unfamiliar with how to administer an epinephrine auto-injector to a child experiencing an allergic reaction
- Elderly consumer took medicine twice (forgot taking first dose)

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Examples of Reported Incidents

At Home/In the Community

- Consumer accidentally took spouse's medicines (mixed up pill organizers)
- Consumer accidentally took veterinary medicine intended for pet
- Confusion between look-alike medicines at home (multivitamins and ibuprofen)

Examples of Reported Incidents



In Hospital

- Calculation error when regular strength ibuprofen substituted for extra strength. Patient questioned dose but took the medicine anyway.
- Morphine overdose due to programming error of the pump that delivers the medicine directly into bloodstream

SafeMedicationUse.ca

Your role

Can you help?

- Encourage friends and family and colleagues to interact with SafeMedicationUse.ca
 - Report medication incidents to us
 - Sign up to receive email notices of newsletters and alerts, and complete our survey
 - “Like” us on  :
www.facebook.com/MedicationSafety
 - “Follow” us on  : @SafeMedUse

“I think the website is really amazing and its finally nice to have one central location to find alerts and information on medications and not have to wait to see it on the news or be told by someone else.”

Questions?



ISMP Canada Contacts

- Webinars: webinars@ismp-canada.org
- Workshops: education@ismp-canada.org
- Consultations: consults@ismp-canada.org
- CMIRPS: www.ismp-canada.org/cmirps.htm
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