Promoting primary care medication error reporting

Dr Desirée Kunac
New Zealand Pharmacovigilance Centre

MERP

HQSC Medication Safety Forum, Wellington
16 October 2014

NZ Pharmacovigilance Centre
(NZPhvC)

- National monitoring centre established in 1965
- **CARM**
  - Monitors patient harm from Adverse Drug Reactions
  - CARM database, established 1965, over 90,000 reports
  - Valuable national resource
    - NZ-specific patterns and trends
    - rare events that may otherwise go unrecognised
- Supports Medsafe to ensure product safety

NZPhvC MERP Medication Error Reporting Programme

History of MERP

2007: Proposal for MERP

- Extension of NZPhvC activities
- Coordinated national approach for medication error
- Complementary to CARM not duplicating

2009 - 2011: Medication Error Project (MoH)

- Develop and pilot MERP in primary care

Oct 2014: Preferred Medicines Centre Inc (PreMeC) funding

- To facilitate expansion of MERP in primary care
- Strengthened relationship with HQSC
  - Custodian of funds
  - Alignment with national Medication Safety Programme agenda
  - Clinical expertise of HQSC Medication Safety Expert Advisory Group

About MERP

Web-based, voluntary, anonymous
actual and 'near miss' errors

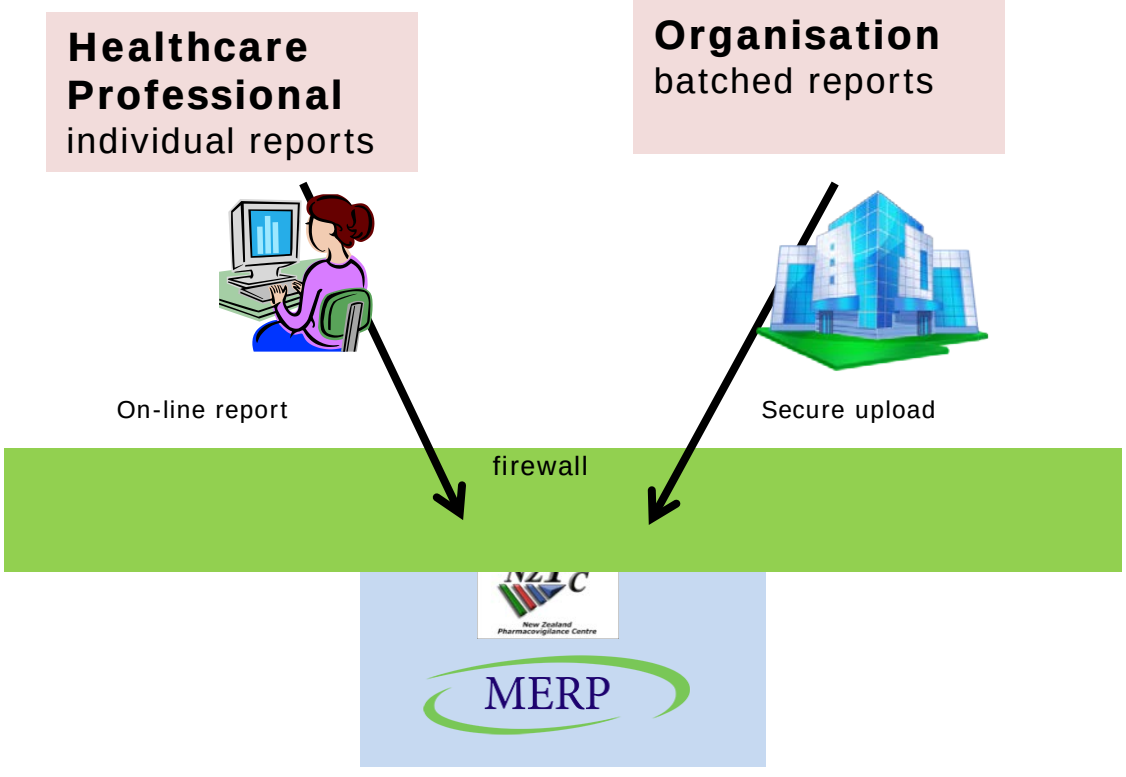
- Medication error "any unintentional error in the use of a medicine or vaccine"
- Utilises minimum dataset to capture critical information
  - Trends/patterns
  - System-based causes
- Common platform for recording and analysing ME
  - Ensures consistency
  - Facilitates analysis

Underlying principles

- Voluntary, confidential, anonymous if preferred
- Non-punitive, systems focused
- Operate within a secure data environment
- Encourage reporting of both potential and actual errors
- Easy to use – electronic system
- Utilise a minimum core dataset
- Provide useful and timely information of its findings and observations
- Be an integral component of an overall national patient safety programme

NZPhvC MERP Medication Error Reporting Programme

MERP: sources of reports



MERP - Medication Error Reporting Programme

a service provided by the NZ Pharmacovigilance Centre

Follow Up

All fields are optional but please complete as many fields as possible as the more information you provide, the more useful the report. Information submitted will be handled in confidence. Please do not supply identifying information (e.g., patient name or date of birth, pharmacy name, or healthcare provider names).

Please advise who is making this report	Please select...
Please advise your DHB region	Select a DHB — Show map
Date event occurred	October 2014 Su Mo Tu We Th Fr Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 07-Oct-2014 OR ☐ date unknown
Time event occurred	Unknown
Event Type	Select...
Medication system stages involved (select all that apply)	☐ prescribing ☐ dispensing ☐ administration ☐ monitoring / follow up ☐ supply/purchasing ☐ presentation/packaging ☐ delivery ☐ not applicable (unable to determine one or more of the listed stages)
Medications	**Incorrect medicine** Medication name

MERP: pilot findings

Online reporting by healthcare professionals
8 month period

Recruited
38 general practices
28 community pharmacies
Dispensing error claims - Pharmacy Defence Association

376 reports

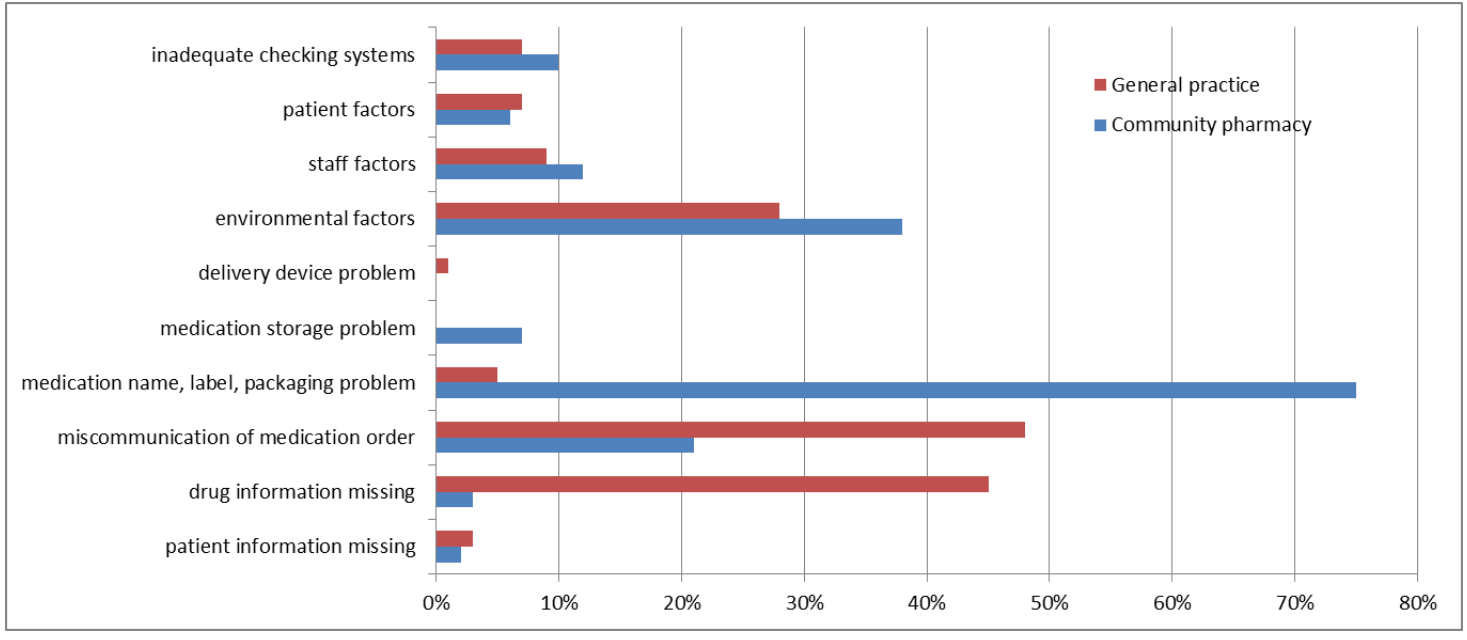
- Patient harm 15%
- Wrong dose 25%, wrong medicine 22%
- MERP easy to use
- Standardised data enabled rapid analysis
- Weaknesses in system (contributing factors) readily identified

NZMJ 2014;127(1401):69-81

NZPhvC MERP Medication Error Reporting Programme

Factors contributing to errors

community pharmacy vs general practice



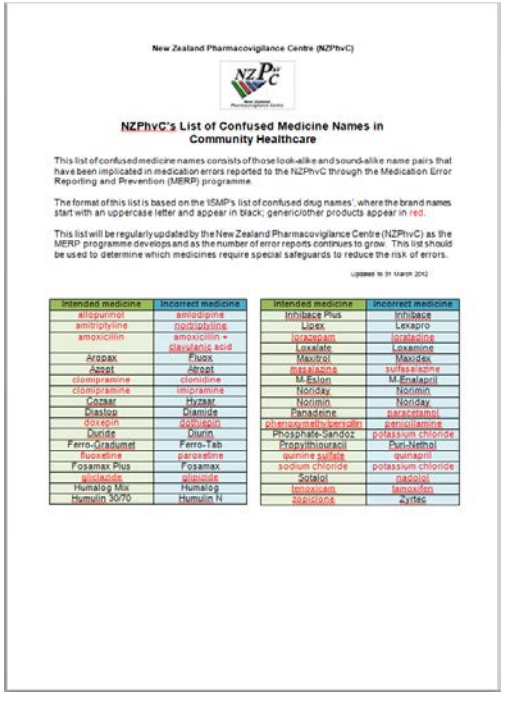
- Environmental factors important cause in both settings
- Community pharmacy – product name and packaging problems
- General practice – problems in process of prescribing

NZPhvC MERP Medication Error Reporting Programme

NZMJ 2014;127(1401):69-81

NZPhvC

List of confused medicine names



New Zealand Pharmacovigilance Centre (NZPhvC)

NZPhvC's List of Confused Medicine Names in Community Healthcare

This list of confused medicine names consists of those look-alike and sound-alike name pairs that have been implicated in medication errors reported to the NZPhvC through the Medication Error Reporting and Prevention (MERP) programme.

The format of this list is based on the ISMP's list of confused drug names', where the brand names start with an uppercase letter and appear in black; generic/other products appear in red.

This list will be regularly updated by the New Zealand Pharmacovigilance Centre (NZPhvC) as the MERP programme develops and as the number of error reports continues to grow. This list should be used to determine which medicines require special safeguards to reduce the risk of errors.

Updated to 31 March 2012

Intended medicine	Incorrect medicine
allopurinol	amlodipine
amitriptyline	nortriptyline
amoxicillin	amoxicillin + clavulanic acid
Arapax	Fluox
Azopt	Atropt
clomipramine	clonidine
clomipramine	imipramine
Cozaar	Hyzaar
Diastop	Diamide
doxepin	clofazimine
Duride	Diurin
Ferro-Gradumet	Ferro-Tab
fluoxetine	paroxetine
Fosamax Plus	Fosamax
glistazide	glipizide
Humalog Mix	Humalog
Humulin 30/70	Humulin N

Intended medicine	Incorrect medicine
Inhibace Plus	Inhibace
Lipex	Lexapro
lorazepam	loratadine
Loxalate	Loxamine
Maxitrol	Maxidex
mesalazine	sulfasalazine
M-Eslon	M-Enalapril
Noriday	Norimin
Norimin	Noriday
Panadeine	paracetamol
phenoxymethylpenicillin	penicillamine
Phosphate-Sandoz	potassium chloride
Propythiouracil	Purl-Methol
quinine sulfate	quinapril
sodium chloride	potassium chloride
Sotalol	nadolol
tenoxicam	lamotrigine
ziprasidone	zyrtec

Health Quality & Safety Commission

Medication Safety Watch

Medication Safety Watch

Issue 2 – May 2012

What's new?

Tall Man lettering

Medication Safety Watch

Medication alerts

Up and Away and Out of Sight

NZPhvC

MERP Medication Error Reporting Programme

MERP: next steps

NZPhvC / Commission expansion into primary care

- **Promote reporting**
  - Online form NZPhvC website https://nzphvc.otago.ac.nz/
  - Re-activate pilot sites, wider participation by primary care clinicians
  - Develop linkages with other organisations
- **Analysis by NZPhvC**
  - Individual report: triage high priority reports
  - Descriptive analysis
  - Aggregate analysis of clusters of reports eg high risk
    - medicine or class (opioids)
    - patient groups (paediatrics)
    - processes (compounding or reconstitution of medicines)
- **Wider learning / prevention**
  - Findings to support HQSC Medication Safety EAG
    - To inform areas for continuous QI initiatives
    - Develop and disseminate bulletins, alerts, other resources
- **Funding**
  - Consider innovative approaches for sustainability (co-funding partnerships)

MERP: conclusion

- **Useful tool to help impact medication safety in primary care**
  - Voluntary, proactive approach
  - Becoming a valuable national resource
    - generating NZ specific data - trends, causes
    - Currently 1500 reports in MERP database
- **Standardised framework provides national platform**
  - Collecting and collating medication error information
  - Facilitates timely analysis
- **Inform and align with HQSC national safety initiatives**
- **Complements CARM programme**
  - Wider perspective of medicine-related patient harm
  - Synergy of CARM / MERP are a unique to NZ resource

MERP = Reporting 4 learning
2 prevent patient harm

NZPhvC MERP Medication Error Reporting Programme

NZPhvC New Zealand Pharmacovigilance Centre

University of Otago Te Whare Wānanga o Otāgo New Zealand

https://nzphvc.otago.ac.nz/

merpnz@otago.ac.nz

Welcome to NZPhvC

The New Zealand Pharmacovigilance Centre consists of synergistic monitoring programs that contribute to and support the safety of medicines and related products in New Zealand through voluntary reporting of adverse events

Centre for Adverse Reactions Monitoring

CARM

Report an Adverse Reaction

Medication Error Reporting Programme

MERP

Report a Medication Error

Pyschoactive Substances, Recreational Substances & Legal Highs

Report a Reaction

News

IMMP

The IMMP closed in December 2013. Visit the archived site

https://nzphvc.otago.ac.nz/

merpnz@otago.ac.nz

Acknowledgements

Pilot participants	from General practice and Community pharmacy
NZPhvC	Simon Watt (IT expertise)
MERP steering group	Michael Tatley (NZPhvC) Mary Seddon (Quality Improvement) Maureen Gillon (College of GPs) Gillian Bohm (HQSC) Enver Yousuf (Medsafe)
ISMP-Canada	David U
ISMP-US	Mike Cohen
Key organisations	Lucy Shieffelbien (National Poisons Centre) Carolyn Hooper (Pharmacy Defence Association) Tony Fraser (BPaC) Averill Frew (ACC)

NZPhvC MERP Medication Error Reporting Programme