

Medicine mistakes often not reported

Study says mix-ups are common, but pharmacies often keep quiet

BY PETER KORN ✉

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When Oregon pharmacists learn of a medication error — known in the industry as an adverse event — they are supposed to voluntarily report the incident to the Oregon State Board of Pharmacy.

They don't.

Last year, according to Gary Schnabel, executive director of the board, there were no reports from Oregon pharmacists of adverse events involving their medications.

But adverse drug events are occurring with regularity.

In late March and early April, two Portland residents and a woman in Yakima, Wash., died after receiving a fatal dose of the drug colchicine for chronic back problems. Toxicology tests later showed that the drug, provided by a Dallas, Texas, drug supplier, had been improperly mixed and was eight to 10 times more potent than labeled.

In 2006, the Washington, D.C.-based Institute of Medicine reported that medication errors, ranging from bad medicine to confusion over similar sounding drug names, harm at least 1.5 million people every year in this country.

Schnabel's board investigates about 300 complaints of adverse drug events each year, more than half concerning pharmacists who gave out the wrong drugs or drugs with the wrong label. But those complaints come almost exclusively from patients, Schnabel said.

Schnabel said that the board has encouraged pharmacies to report adverse events, but he also understands why they don't.

"The issue that prevents somebody from reporting is not whether they're supposed to or not," he said, "but whether they'll get in trouble or not."

Confidential pilot got results

Jim Dameron, administrator of the Oregon Patient Safety Commission, is intent on taking the idea of trouble out of the equation. And he's starting with evidence that Oregon pharmacies will report mistakes and drug reactions, under the right conditions.

Last fall Dameron's commission ran a pilot project with a handful of Oregon pharmacies. The commission gave pharmacists a draft of a standardized reporting form and offered a bargain — if the pharmacists would report adverse events, the information would remain confidential, even from the state pharmacy board. There would be no risk of punishment for the pharmacist or the pharmacy.

After one month, Dameron said, every participating pharmacy had produced reports. Some involved drugs that had been given out at lower concentrations than ordered, Dameron said.

At least one was a prescription mixed at a higher dose than ordered. Dameron said he was surprised not to find reports that the commission had anticipated — of pharmacies handing out medicine to the wrong patients, a common industry error.

The Patient Safety Commission was established by the Legislature in 2003 to address the gamut of medical mistakes in Oregon health institutions.

Until now its focus has been on hospitals — 54 out of 57 Oregon hospitals have signed on for a confidential reporting system of a wide array of medical errors. This year the commission has approached nursing homes and pharmacies to join the voluntary program.

The idea behind the commission is that getting the data on mistakes is more important than knowing who performed them. The commission analyzes the reports made by hospitals and sends out alerts that it hopes will help all hospitals avoid the systemic mistakes made by some.

Drug names can cause errors

Medication mistakes account for an estimated \$3.5 billion a year in extra medical costs from drug-related injuries, according to the Institute of Medicine report.

The Institute report said that confusion caused by drugs with similar names accounts for up to 25 percent of medication errors.

Labeling and packaging mistakes caused 33 percent of errors. Also cited were mistakes made because pharmacists misread the handwriting of prescribing physicians.

A 2003 Food and Drug Administration report noted one patient died “because 20 units of insulin was abbreviated as ‘20 U,’ but the ‘U’ was mistaken for a zero.”

That same report revealed that another patient died after a physician ordered Taxol for a chemotherapy patient but the pharmacist prepared Taxotere, a different medication.

The drugs Lamictal for epilepsy and Lamisil for nail infections are other examples of medications with similar names that have been found responsible for pharmacy errors, according to the FDA report.

Those are the types of mistakes Dameron said he hopes can be avoided as pharmacies report their errors and the commission responds with statewide alerts.

Dameron said adverse-event reports from pharmacies would include summaries of the incidents and suggested fixes.

“Where did the system break down?” Dameron said. “Was it a staffing issue? Was it a distraction issue? Was it a sound-alike name?”

Penalizing pharmacists for their mistakes won’t ensure that future mistakes aren’t made, Dameron said.

“I want to assign responsibility to the environment in the pharmacy,” he said. “If I get rid of you because you made an error, the next guy is probably going to make the same error.”

Voluntary status could change

The legislation that established Dameron's commission left him without one key piece of leverage — the reporting system is voluntary. And while hospitals have signed up, no pharmacies have yet agreed to participate.

Dameron remains optimistic. "We're going out one by one and trying to convince people of something they've never even thought about before," he said. "It's new."

Dameron recognizes that the excuse of unfamiliarity only will work for so long. He began making presentations to pharmacies in February, starting with the large pharmacy chains, and has not yet had one sign up.

"I need to show some results soon," he said. "If I don't have anything by September then we have to find more leverage or rethink the model."

Jim Thompson, executive director of the Oregon State Pharmacy Association, said he thinks Dameron will get the pharmacies on board, and that pharmacists are aware that if they don't sign up, the Legislature may well make the program mandatory.

"This was a thinly worded threat in the original legislation," Thompson said. "This was a voluntary program unless voluntary doesn't work."

Thompson said that in some states, adverse-event reporting is mandatory "and sanctions get handed out to pharmacies that do." Dameron's confidential reporting program might appear as a much less threatening alternative, Thompson said.

peterkorn@portlandtribune.com