TRANSCRIPTION

cpsi Canadian Patient Safety Institute
iscp Institut canadien pour la sécurité des patients
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President & CEO, Institute of Safe Medication Practices Canada

[0:00:10] I'm David U and I'm the president and CEO of the Institute for Safe Medication Practices Canada. Our organization, ICMP Canada, actually receives a lot of voluntary reports from actual practitioners who were involved in error. I remember the time that I started the organization way back in 2000, and it's all finger pointing and the culture of blame is very, very prevalent at that time. And now we encourage, you know, folks to talk about their problems.

[0:00:47] Well, today, I want to share, you know, a couple of stories that really impressed me and really intrigued me into the work that I'm doing as a pharmacist, as a provider, and also as someone who's actually involved maybe indirectly into, you know, medication error that affects the nurse or the pharmacist. One case is the inadvertent administration of potassium chloride that a nurse was involved. And I was very much moved by what happened. And knowing that this is a whole system issue that caused the error, I feel so sorry and so traumatic for the provider, the nurse.

[0:01:40] That was way back in 2003 that I was requested by the chief coroner's office to be the expert witness in a inquest of the event of inadvertent administration of potassium chloride, a concentrate.

[0:02:05] I noticed that that she actually was a very caring nurse. She's about maybe 40 years old, very, very caring nurse. She was actually trying to use normal saline to flush a line and later on noticed that it was concentrated potassium chloride. Actually, the patient died almost immediately. The ampoules of concentrated potassium chloride and sterile water and normal saline are almost identical. It's very, very easy to mix up. When I look at those situations and the conditions and how, you know, it's so terrible that it's a loss of life, but at the same time, I just feel terrible for the nurse.

[0:03:00] I can see that this is not the nurse's, you know, performance issue or any mistake on her own. So I just couldn't help, you know, the tears coming out from my eyes when I looked at all those documents and really, you know, tells me that I need to do something about it. One is, all hospitals in Canada should ensure that no concentrated potassium chloride be assessable to any staff outside the pharmacy department. And the second recommendation that we made, which is already fully implemented, that Health Canada should work with the industry, the manufacturer, to make sure that potassium chloride concentrate got to be redesigned in such a way that they're very distinguishable from other products.

[0:03:54] I've been working on another case, actually a couple of years later, again, the outcome was fatal. It was on a miscalculation of the infusion rate causing a chemo drug to be infused much more rapidly than was intended. The nurse set the pump, supposed to be infused over four days, the rate. Somehow, it's a lot of other issues involved, and she set it to 4 hours.

[0:04:26] I don't see the family had a lot of check-ins with the provider, which is a good thing, you know, because I think we all know that they're actually the second victim. I think in both cases, you know, the nurses left the profession.

[0:04:48] We also work to improve the whole administration of Vincristine [ph], which is another chemo drug that has been quite a few times, not just in Canada, but all across the globe, that Vincristine was administered interfecally [ph] instead of intravenously. The oncologists or anesthetists actually injected to the wrong route. The best solution is more like a forcing function that connectors or the connection to both IV and to the fecal space or the spinal base have to be very different. It's like a key and lock. You know, if the connections are different, it's unique and not changeable, then you cannot fit it in.

[0:05:35] ICMP Canada has been viewed by nationally and even internationally about something that we actually do some good work and then make some difference. One of the things that we do and do well is to connect with providers, the actual staff, nurses, pharmacists, or even physicians, who contacted us either by phone or email or in a report program that we created for individual practitioner reporting, is to tell their story. We keep that information confidential, encourage them to talk to me or to ICMP Canada, and then we will use the information to try to correct the system, because that would also be part of their goal, that nothing of this kind will happen again. And I think this kind of support, a personal call and reassurance that we can do something about it, would go a long way because, you know, nothing would go to a black hole from a provider perspective. And this is what they want. They want changes. They want support. If I have one message to share a provider, if they encounter or come across some mishap or event which is not a good outcome, tell yourself that you have done your best and try to report it. And collectively, we can make sure that things would get changed. And don't be afraid.

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