

“ When healthcare providers work closely with patients and their families,
we can achieve great things. ”

Source: Patient Engagement Action Team. *Engaging Patients in Patient Safety — A Canadian Guide*. 2018.

National
System
for Incident
Reporting

NSIR



Canadian Institute
for Health Information
Institut canadien
d'information sur la santé

Collect. Analyze. Share. Learn.



Welcome to the quarterly National System for Incident Reporting (NSIR) electronic bulletin. This is where you can find information on medication and radiation treatment incident reporting and analysis for sharing and learning across Canada.

If you are having difficulty viewing this email, please see the attached PDF version.

Inside this issue

Highlights

Canadian Patient Safety Week

Sharing and learning

- [The importance of patients and families as partners in patient safety](#)
- [How do patients report in Canada?](#)
- [NSIR incidents detected by patients and families](#)
- [NSIR case scenarios: When patients ask questions about their medication](#)
- [How can you engage patients in patient safety?](#)
- [ISMP Canada's recent alerts and safety bulletins](#)
- [ISMP Canada Med Safety Exchange webinar series](#)

NSIR-RT

- [NSIR-RT data transfer of RT incidents from local incident reporting systems](#)

Other CIHI news

Additional information

- [Conferences of interest](#)
- [Recent CIHI releases](#)

Contact us

Appendix: Text alternatives for images

Highlights

Canadian Patient Safety Week

This year, Canadian Patient Safety Week occurred October 29 to November 2, 2018. The focus was medication safety, with the goal of reducing medication errors across Canada. The Canadian Patient Safety Institute, the organizer of this annual campaign, invites all Canadians — the public, providers and leaders — to become involved in making patient safety a priority. Event resources, podcasts and presentations are available on the [Canadian Patient Safety Week](#) page.

Sharing and learning

The importance of patients and families as partners in patient safety

The recent report [Engaging Patients in Patient Safety: A Canadian Guide](#) is an extensive resource written for a wide audience including patients and their families, health care providers and leaders. The guide helps these groups to work together more effectively to improve patient safety. It explains why engaging patients and their families is essential to patient safety and quality, and how that can only be achieved by partnering with patients and their families, while respecting their values, insights and experience.

It states that empowering patients to take an active role in their care leads to improved quality of care and safety, and enables innovative solutions inspired by their unique perspective.

This is precisely why it is so important for patients to be involved in incident reporting. As explained in the guide, studies and experience have shown that patients and families provide unique safety information and are valuable partners in patient safety.

How do patients report in Canada?

The [Canadian Medication Incident Reporting and Prevention System \(CMIRPS\)](#) collects and analyzes medication incident reports from patients, the public, providers and organizations across Canada with an aim to understand what types of incidents are occurring and to inform system changes that will reduce future incidents. There are a few [platforms for reporting incidents under CMIRPS](#):

Patient and consumer reporting

ISMP Canada's patient and consumer reporting portal (accessed via www.SafeMedicationUse.ca) provides a direct secure and anonymous method for patients and the general public to submit medication incidents in Canada. The website is an essential patient resource for information about using medication safely.

Facility-based reporting

NSIR is part of CMIRPS and collects medication incident information reported voluntarily by health care facilities. In addition to covering staff-reported incidents, these reports also include incidents where patients and/or their families have played a role in the discovery of a medication incident while receiving care at the health care facility.

ISMP Canada also collects and analyzes medication incident information from 2 sources:

Individual practitioner reporting

Incidents are reported by individual practitioners through a confidential channel; reports can serve as an early warning system. They are accepted online or by telephone.

Community pharmacy reporting

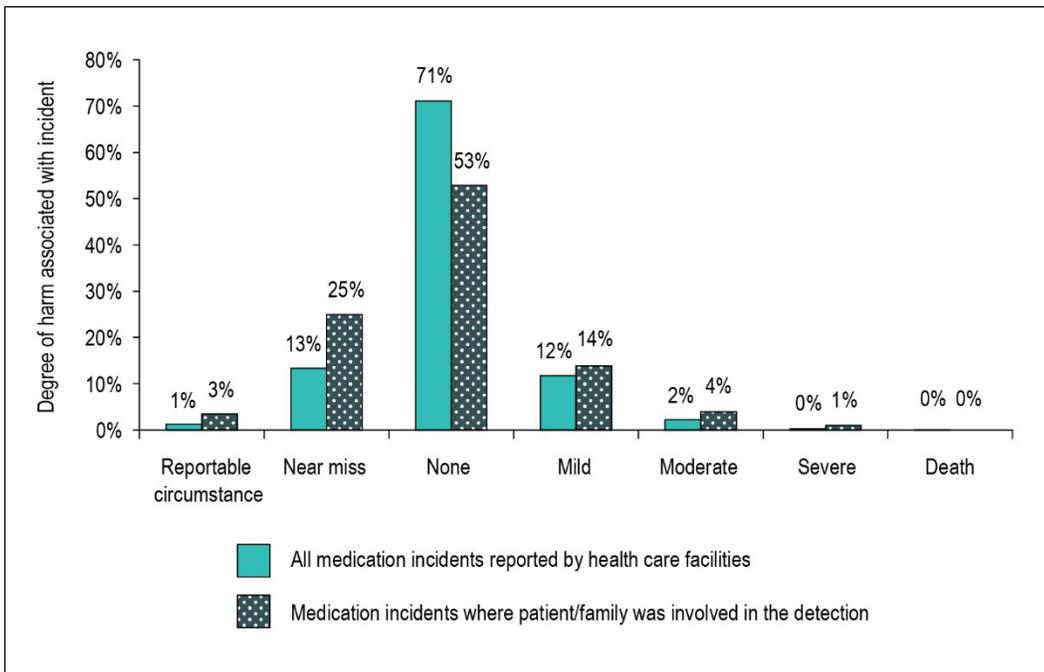
Incidents are submitted by community pharmacies to create a cohesive information-sharing system in order to better understand medication incidents and to develop more robust strategies to prevent harm.

NSIR incidents detected by patients and families

Between November 1, 2008, and September 30, 2018, 406 medication incidents — submitted to NSIR from participating health care facilities — were detected by patients or family members. Specifically, these incidents indicated that either patients or residents of the health care facilities, and/or family members, were involved in the discovery of the medication incident.

In general, incidents detected by patients and their families are not different from the incidents reported to NSIR by health care providers. They have the same problem type, involve the same drug products and have similar contributing factors. However, there is 1 distinguishing characteristic of incidents detected by patients and families: the degree of harm associated with the event. When patients and families are involved in the discovery of an incident, they catch more near misses.

Figure Percentage of medication incidents where patients and families are involved in the discovery of an incident, by degree of harm associated with the incident, November 1, 2008, to September 30, 2018



NSIR case scenarios: When patients ask questions about their medication

ISMP Canada, the Canadian Patient Safety Institute, [Patients for Patient Safety Canada](#), the Canadian Pharmacists Association and the Canadian Society for Hospital Pharmacists developed a [set of 5 questions](#) to help patients get the information they need to ensure they are using their medications properly and safely.

This effective communication tool was designed for patients, and is particularly helpful for those who are transitioning from one health care setting to another. It also provides an ideal framework to present some case scenarios highlighting the key role of patients in incident prevention. As shown in the scenarios below, these structured simple questions posed by patients allowed them to become active participants in their medication safety and, in many cases, prevented harmful medication incidents.

5 questions asked and answered

- 1. CHANGES?** Have any medications been added, stopped or changed, and why?

A patient was ordered 7 mL of methadone for palliative care. The nurse brought in 7 × 10 mL syringes. The patient's family caught the near miss when they saw the multiple syringes.

A nurse went to administer 2 medications to a patient. After completing the patient identification check, the nurse presented the medications to the patient. The patient noted that they had never taken these meds before and asked the nurse when they had been ordered and why. After reviewing the chart and discussing the case with the pharmacy, it was discovered that the medications had been ordered under the wrong patient profile.

- 2. CONTINUE?** What medications do I need to keep taking, and why?

On the day they were to be discharged, a patient was given their medications with their meals as usual. However, later in the day, the patient's family realized that the patient did not get 2 doses of the antibiotic. When they asked about the missing doses, they were told that the order for the antibiotic had been dropped because the patient was scheduled to be discharged. The patient's family inquired with other staff and the patient subsequently received the antibiotics.

A patient was perplexed because medications had been left at her bedside without her knowledge while she was out of the room. The patient also noted that Lasix, which had been put on hold in her case, was one of the medications. The patient raised this with a nurse who removed the Lasix and checked the other medications.

- 3. PROPER USE?** How do I take my medications, and for how long?

20 minutes into the infusion process, a patient alerted the nursing staff that their heparin was running too quickly at 270 mL/hr instead of 27 mL/hr. Pump programming of this high-alert medication had not been double checked.

5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS
when you see your doctor, nurse, or pharmacist.

- 1. CHANGES?**
Have any medications been added, stopped or changed, and why?
- 2. CONTINUE?**
What medications do I need to keep taking, and why?
- 3. PROPER USE?**
How do I take my medications, and for how long?
- 4. MONITOR?**
How will I know if my medication is working, and what side effects do I watch for?
- 5. FOLLOW-UP?**
Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:

- ✓ drug allergies
- ✓ vitamins and minerals
- ✓ herbal/natural products
- ✓ all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

Visit safemedicationuse.ca for more information.

Note

Image used with permission from the Canadian Patient Safety Institute and ISMP Canada.

Source

Institute for Safe Medication Practices Canada. [5 questions to ask about your medications](#). Accessed October 30, 2018.

A patient had 2 infusion lines. One was a subcutaneous line for Versed 0.5 mg and the other line was an intravenous line in with normal saline. The infusion pumps were positioned beside each other with the lines in close proximity. The patient needed some Ativan, which the nurse started to push through the subcutaneous line. The patient's mother realized the error and alerted the nurse who stopped the administration.

4. **MONITOR?** How will I know if my medication is working, and what side effects do I watch for?

A patient refused his dose of methadone 10 mg IR tab because he was feeling drowsy. He realized that his last dose had been a methadone solution instead of a tablet. The nurse confirmed with the pharmacy that he had been given the wrong form of the drug product.

Despite taking her medication, an elderly patient with pulmonary fibrosis was having increased difficulty breathing for a few days. Her family noticed that she felt much better when she received the medication through a nebulizer. The family discovered that she is unable to coordinate her movement to push the puffer and inhale the medication.

5. **FOLLOW-UP?** Do I need any tests and when do I book my next visit?

A patient knew that because of dose changes to their medication, strict vital sign monitoring was required. When the monitoring was not being done, the patient notified the nurses and other health care providers.

In addition to the 5 questions to ask, patients are also reminded to advise their health care providers of any drug allergies, as well as of other supplements (e.g., vitamins, natural health products) they are taking. The NSIR case scenario below illustrates the importance of this information in preventing adverse drug events (e.g., allergies) that may also be medication incidents (e.g., wrong drug due to incomplete documentation).

A patient returning from a procedure had a post-op order for Tylenol 3. When the nurse provided the patient with her medication, she refused to take it because of her anaphylactic allergy to codeine.

How can you engage patients in patient safety?

[Engaging Patients in Patient Safety: A Canadian Guide](#) provides the following recommendations:*

Patient safety committees

1. Regarding the incident, make sure patients and families are
 - Informed about what happened and what will be done through the disclosure process
 - Interviewed to inform the incident analysis
 - Kept updated about recommended actions
 - Asked to participate further

2. Regarding incident analysis and management, make sure patient partners
 - Receive training and information about the incident analysis process
 - Participate on teams that carry out structured incident analysis
 - Participate on a quality and safety committee that oversees monitoring and improvement at the organizational level, including follow-up from incident reviews

Health care providers

To advance patient safety in partnership with patients,

- Ensure patients and families are engaged in their care and feel comfortable voicing concerns and asking questions
- Educate patients and families about patient safety, especially those dealing with chronic illnesses
- Participate in and encourage open sharing and team learning about patient safety risks
- Listen closely to patients and families, as they are all unique
- Make sure information is accurate and understood by patients and families
- Adapt your communication to fit the needs of patients and families
- Establish collaborative work habits with colleagues and patients and families, especially around leading practices (e.g., bedside shift report, transitions of care)
- Continue to improve your communications skills

If you are involved in a patient safety incident,

- Follow the organization's procedures, practices and guidance for reporting, disclosure and incident management
- Find out who can support you and seek out practical and emotional support
- Use the advice and resources offered through your professional organizations and regulatory colleges

Leaders

- Ensure that your organization's policies, processes and resources for patient safety and incident management are used
- Ask everyone involved in a patient safety incident about their experience and how to prevent it
- Share patient safety and incident management information across the organization and incorporate improvement ideas into policies, procedures and training
- Ensure timely, honest and transparent communications with patients, families and providers.
- Visibly value and support patient engagement in patient safety
- Strive toward a safe and fair culture that is centred on patients and families

Note

* See pages 29 and 30 of the guide.

ISMP Canada’s recent alerts and safety bulletins

- [Injecting Standardization Into Vaccine Clinics](#)
- [Have Unused Medications Overstayed Their Welcome](#)
- [EpiPen \(Epinephrine USP\) Auto-Injector — Interim Order Allowing the Importation of AUVI-Q in Response to Shortages of EpiPen and EpiPen Jr](#)
- [Should I Change My Pharmacy After a Mistake?](#)
- [Antidotes and Related Agents: Recognition of Need, Availability and Effective Use](#)

ISMP Canada Med Safety Exchange webinar series

Upcoming ISMP Canada webinar Wednesday, November 28, 2018 (12:05–12:55 p.m. ET)

Join your colleagues across Canada for ISMP Canada’s complimentary bimonthly 50-minute webinars where they share, learn and discuss incident reports, trends and emerging issues in medication safety!

To register and for more information on this series, please visit [ISMP Canada — Med Safety Exchange](#).

NSIR-RT

The NSIR — Radiation Treatment (NSIR-RT) Advisory Committee met in Montréal on September 13 in conjunction with the 2018 CARO-COMP-CAMRT Joint Scientific Meeting. The committee reviewed the case study on the potential impact of scheduling delays in the delivery of concurrent chemoradiotherapy (see the review in the [Fall 2018 NSIR-RT Bulletin](#)). The committee also reviewed the data access request and use considerations.

NSIR-RT data transfer of RT incidents from local incident reporting systems

CIHI has developed the capacity to accept RT incident data from existing systems. Fast Healthcare Interoperability Resource (FHIR) standards were used in this development to allow a true system-to-system connection. Once the specifications are complete, they will be available to those who want to configure their local systems to enable data transfer of RT incident data to NSIR. The goal is to eventually expand this functionality for use in the transfer of medication incident data. For more information about this development and the steps required to align local systems, contact the NSIR team at nsir@cihi.ca.

Other CIHI news

Additional information

Conferences of interest



[Quality Improvement and Patient Safety Forum \(QIPSF\)](#)

October 16, 2018

Learn from and share experiences with others facing similar challenges at the QIPSF in Toronto. This annual conference is for those passionate about quality improvement and patient safety.

Recent CIHI releases

[Access to Palliative Care in Canada](#)

September 19, 2018

This report provides baseline information on whether Canadians, in their last year of life, have equitable and timely access to appropriate services, and where information and service gaps remain.

Contact us



Thank you for taking the time to read the NSIR eBulletin. Unless otherwise stated, the reported NSIR findings are based on the voluntary reporting of incidents at participating health care facilities across Canada. If there is anything you would like to see featured in an upcoming edition, please contact us at nsir@cihi.ca.

The NSIR eBulletin is distributed on a quarterly basis. Previous editions can be found on the [NSIR web page](#).

[Twitter](#) | [Facebook](#) | [LinkedIn](#) | [Instagram](#) | [YouTube](#)

Appendix: Text alternative for figure

Data table for Figure: Percentage of medication incidents where patients and families are involved in the discovery of an incident, by degree of harm associated with the incident, November 1, 2008, to September 30, 2018

Degree of harm	All medication incidents reported by health care facilities	Medication incidents where patient/family was involved in the detection
Reportable circumstance	1%	3%
Near miss	13%	25%
None	71%	53%
Mild	12%	14%
Moderate	2%	4%
Severe	0%	1%
Death	0%	0%