Instituut Verantwoord Medicijngebruik

Medication incidents & Medication errors: the situation in the Netherlands

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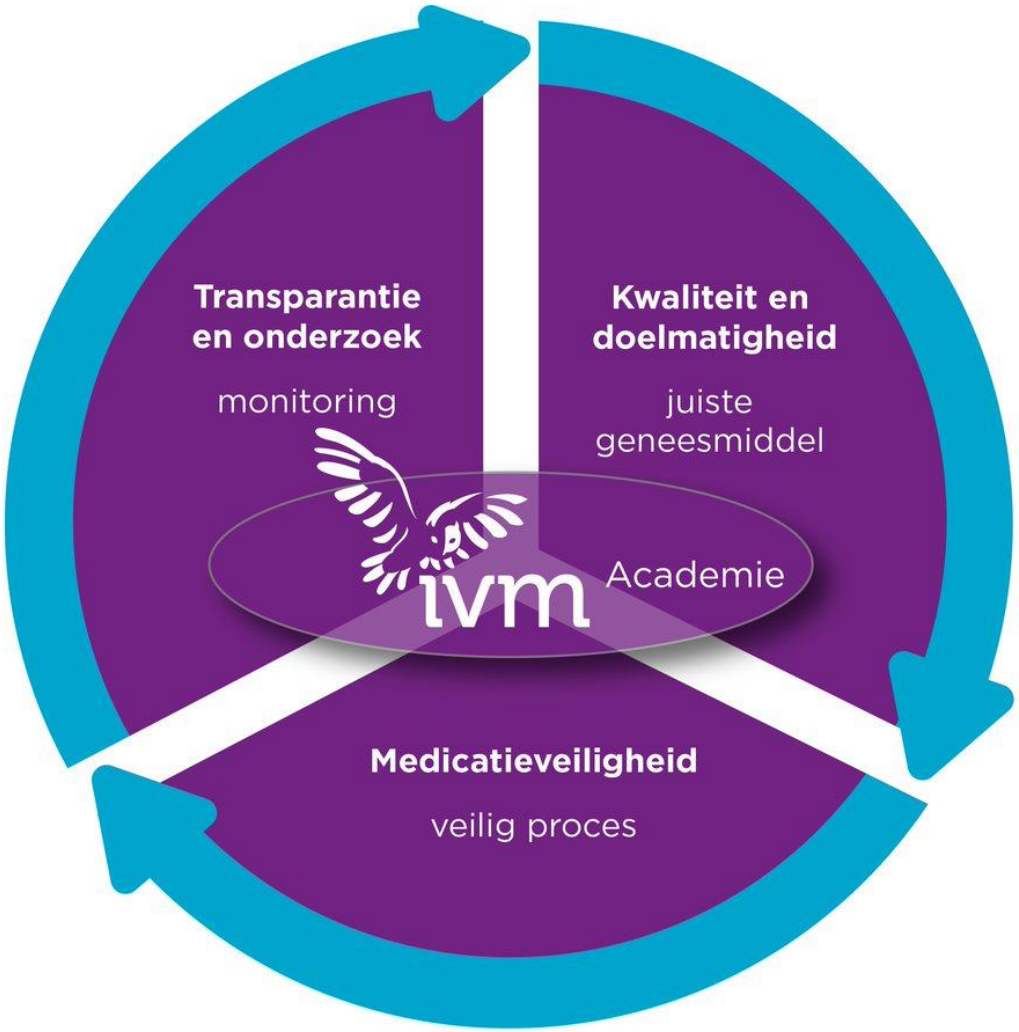
IMSN annual meeting, 2022

VMI: embedded in the Dutch Institute for Rational use of Medicine (IVM)



IVM

Goals

Ensure that everyone receives good and safe medication, sound knowledge about the use , prescription and delivery of medication

Employees

(hospital)pharmacists, physicians, specialised nurses

VMI- constituent of medication safety

Goals

Preventing medication incidents from happening again and learning from them.

VMI collaborations in the field

Association of pharmacists and others

Medicines Evaluation Board

Eudravigilance

VMI Monitoring Incidents

Monitoring Side Effects Lareb

Practice stings
Annual overview of medication ‘swapping’ incidents

VMI: Trusted Third Party to reporters for (near) medication incidents

- **Anually a number of 20.000 medication incidents are reported to VMI (>95% incidents from Hospitals)**

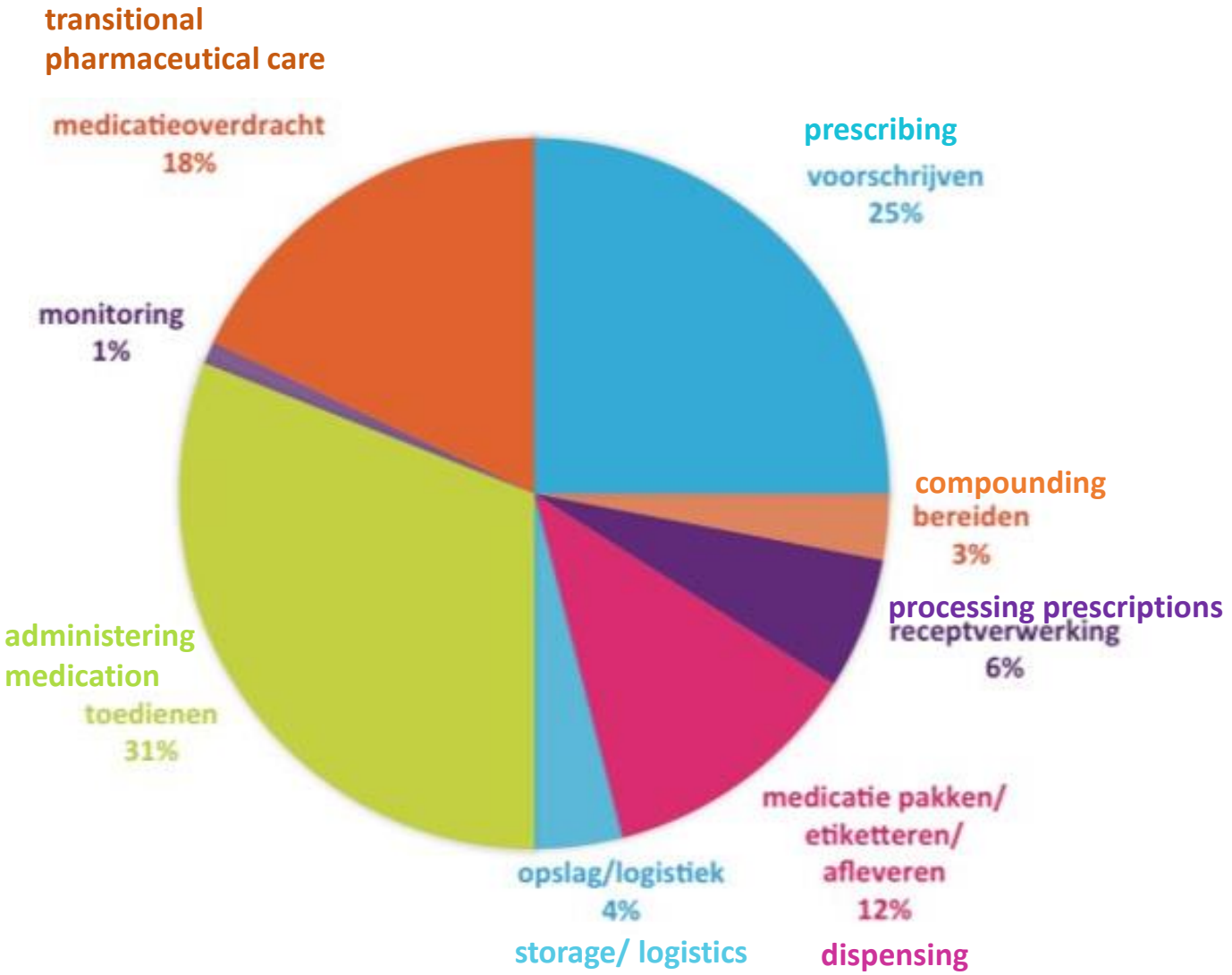
- **VMI offers a broader potential to support medication safety**
  - **Near incidents may have the same cause and potential for harm as calamities do**

Calamity

Incidents with harm done

Errors in medication process
Near incidents &
Incidents without harm
(but with the potential for doing harm)

Incidents in medication process and the ranking of drug groups involved



Antibiotics (J01)
Antitrombotics (B01)
Antineoplastic & immunomodulating agents (L01 L02 L03 L04)
Opioids (N02A)
Drugs used in diabetes (A10)

Products by VMI

Practice sting 2021-18

Practice sting Importance of derived contraindications in medication monitoring

Medication monitoring using the derived contraindication (CI) makes sense because in practice relevant CIs are not always known. The following notification makes this evident.

Notification

A medical consultant prescribes ofloxacin to a patient taking lacosamide (Vimpat®) for epilepsy. The pharmacy assistant dispenses ofloxacin but does not inform the patient that he has an increased risk of epileptic seizures. The patient starts taking ofloxacin and has an epileptic seizure.

Analysis

In the community pharmacy, after processing the prescription for ofloxacin, no CI signal 'epilepsy quinolones' appeared, despite the fact that lacosamide only has the indication epilepsy. This signal did not appear because the pharmacist had turned off the generation of the derived CI for the whole group of 'other antiepileptic drugs' due to the large numbers of false positive monitoring signals. The pharmacist assumed that most medicines in this group are indicated for indications other than epilepsy, or that the patient also receives an anti-epileptic drug from another group. During the daily prescription check, the pharmacist did not notice that a patient taking lacosamide had been given ofloxacin.

Recommendations

For pharmacists:

- To avoid irrelevant signals, keep the CIs to be recorded per patient up to date. In

intmedsafe.net/resources/newsletters/

+ ISMP Brasil
+ ISMP Canada
+ ISMP España
+ ISMP USA
+ ivm Voorkomen Medicatie-Incidenten (VMI)
+ Morocco Poison Control and Pharmacovigilance Centre (CAPM)