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National Survey on Drug Shortages Reveals Serious Impact on Patient Safety

Horsham, Pa--- A national survey of more than 1,800 healthcare practitioners has uncovered high levels of frustration as well as low levels of patient safety caused by recent drug shortages. The survey, conducted by the Institute for Safe Medication Practices (ISMP) during July through September 2010, received more than 1,800 responses--many suggested that the problem has risen to the level of a national public health crisis.

Survey participants were alarmed by the ever-increasing volume of critically important medications in short supply, and the resulting use of less desirable, unfamiliar alternative drugs where available. They felt that shortages have significantly increased the potential for errors and patient harm caused by absent or delayed treatment or preventable adverse drug events associated with alternative drugs or dosage forms.

Near Misses, Errors and Adverse Outcomes

Approximately one in three (35%) respondents said that their facility experienced an error that could have led to patient harm during the past year due to a drug shortage. About one in four reported errors that reached patients and one in five reported adverse patient outcomes. However, many respondents commented that errors and adverse outcomes are difficult to quantify due to factors such as voluntary reporting methods, and felt the frequency of adverse events due to drug shortages is actually much higher.

Respondents described more than 1,000 errors and adverse patient outcomes during the past year related to more than 50 drugs on the shortage list that became abruptly unavailable, often without adequate notice. Especially troubling is that most drugs involved in the shortages are high alert medications more likely to cause serious patient harm when involved in an error, such as propofol, heparin, morphine, neuromuscular blocking agents, and chemotherapy agents.

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Other Difficulties Identified

During the past year, more than half of survey respondents reported *frequently* or *always* encountering every one of the following potential difficulties associated with drug shortages:

- Little or no information available about the duration of a drug shortage
- Lack of advanced warning from manufacturers and suggested alternatives
- Little or no information about the cause of the drug shortage
- Substantial resources spent investigating the shortage and developing a plan of action
- Difficulty obtaining a suitable alternative product
- Experience a significant financial impact
- Lack of a suitable alternative product
- Substantial resources spent preparing and/or administering the alternative products
- Risk of adverse patient outcomes
- Internal hoarding of medications associated with impending shortages
- Physician anger towards pharmacists/nurses/hospitals in response to a drug shortage

Next Steps

ISMP and the American Society of Health-System Pharmacists (ASHP) are exploring the idea of a public meeting with the Food and Drug Administration (FDA) and other key stakeholders representing the pharmaceutical industry, healthcare practitioners, and medication safety experts to explore the scope of this problem and develop a plan to reduce the occurrence of drug shortages and better manage them when they occur. ISMP also plans to provide guidelines to help healthcare organizations cope with drug shortages on a local level.

This week's edition of the *ISMP Medication Safety Alert!*® newsletter includes a special report with a detailed analysis and summary of the results of ISMP's survey of healthcare practitioner concerns about drug shortages. For a copy of the article, go to: http://www.ismp.org/Newsletters/acutecare/articles/20100923.asp

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