

News Release

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Alberta Cancer Board launches immediate action on recommendations from medical error review

Recommendations from two reviews of the August 22, 2006 death of Cross Cancer patient Denise Melanson from medical error will begin immediately, according to Dr. Tony Fields, Alberta Cancer Board Vice President, Medical Affairs and Community Oncology.

The Alberta Cancer Board contracted the international Institute for Safe Medication Practices (ISMP Canada) to conduct a review in addition to a review by the Health Quality Council of Alberta (HQCA). "We intend to minimize opportunities for this type of error to reoccur, here or anywhere else," says Fields. "These substantive reviews will help us do that. We are briefing staff at our 17 Alberta Cancer Board facilities today and have hired a senior pharmacist to lead the implementation of recommendations immediately."

As well, Fields says full copies of the reviews will be available to other health facilities throughout the province and to all cancer centres in Canada. "One of the hardest findings to hear was that this mistake had been made elsewhere and resulted in deaths elsewhere," says Fields. "We were not able to learn from the mistakes of others, but we'll ensure others can learn from ours."

David U, President and CEO of the Institute for Safe Medication Practices, said the death was not the result of a single cause. "In this case," says U, "a combination of actions and conditions, which on their own would not have caused the death, happened simultaneously with tragic result."

U said three primary causal chains led to Ms. Melanson's death: The overdose of prescribed fluorouracil, the design of the chemotherapy protocol and the inability to mitigate from the lethal dose of fluorouracil with the other drug administered, cisplatin. "We found several causal chains leading to each of these primary areas," says U.

Dr. John Cowell, CEO of the Health Quality Council of Alberta, said the Council reviewed the incident and developed its recommendations from a system-wide quality improvement perspective based on the six dimensions of quality identified in the Alberta Quality Matrix for Health: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety. "Protecting patient safety and preventing medical errors is a high priority in Alberta's health system so it is vital that we take what we learn and share it so others can learn."

"The reviews confirmed one thing we already knew," says Fields. "Our staff members are professional, competent and compassionate. Our failing was in a system that left openings for human error. We intend to fix that."

Full copies of the review are available online at www.albertacancer.ca

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The Alberta Cancer Board is the provincial health authority responsible for coordinating and providing cancer prevention, research and care. Facilities operated by the Alberta Cancer Board include the Cross Cancer Institute in Edmonton, the Tom Baker Cancer Centre in Calgary and 15 associate and community care centres throughout the province.

The Institute for Safe Medication Practices (ISMP Canada) is an independent national not-for-profit agency committed to the advancement of medication safety in all health care settings. ISMP Canada's mandate includes collecting, reviewing, and analyzing medication incident and near-miss reports, identifying contributing factors and causes, and making recommendations for the prevention of harmful medication incidents.

The Health Quality Council of Alberta (HQCA) is an independent organization legislated under the Regional Health Authorities Act that is engaged in gathering and analyzing information and collaborating with health regions and boards, professions and government to translate that knowledge into practical actions to improve the quality and safety of Alberta's health system.