



# Mental Health and Patient Safety: The Beginning of Our Journey

## Medication Safety Panel Discussion

OHA Conference in partnership with CPSI  
Marriott Eaton Centre, Toronto  
September 19, 2008

Sylvia Hyland  
Institute for Safe Medication Practices Canada

# ISMP Canada

Independent, not-for-profit, national organization

Purpose: To identify risks in medication use systems, recommend optimal system safeguards and advance safe medication practices.

# Presentation Outline

- National and provincial medication reconciliation/medication review programs
- National and provincial initiatives for reporting adverse events

# ISMP Canada's Role in Medication Reconciliation

- Lead medication reconciliation implementation intervention for Safer Healthcare Now! Campaign
- Prepared Getting Started Kits and tools to support teams across the country
  - Acute care
  - Long Term Care
- Co-lead for Homecare pilot project

# *Safer Healthcare Now!*

## Enrollment by Intervention

Intervention	Number of Teams
Deploy Rapid Response Teams	56
Improve Care for Acute Myocardial Infarction	121
Prevent Adverse Drug Events through Medication Reconciliation	333
Prevent Central Line-Associated Bloodstream Infection	92
Prevent Surgical Site Infection	175
Prevent Ventilator-Associated Pneumonia	117
Antibiotic Resistant Organisms (AROs)/MRSA	18
MedRec (Long Term Care)	49
Venous Thromboembolism	10
National Collaborative on Falls in Long-Term Care	33
<b>Total</b>	<b>1004*</b>

\*Total at July 29, 2008

# Reach of Medication Reconciliation

- Accreditation Canada requirements
- WHO Action on Patient Safety - High 5s
  - 5 common problem areas in patient care and proposed solutions
    - Assuring medication accuracy at transitions in care
  - Supported by six countries: Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States
- Inclusion in University curricula

# MedsCheck

## Personal Medication Record

MedsCheck

### PERSONAL MEDICATION RECORD

Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list.

Patient

\_\_\_\_\_

Primary Physician (Phone)

\_\_\_\_\_

After any hospitalization, check with your doctor or pharmacist to review this medication list.

Pharmacist and Pharmacy (Phone)

\_\_\_\_\_

Date Prepared

\_\_\_\_\_

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
			Quantity	Route	Frequency	Food			
dd/mm/yyyy	Brand & Generic Name								

Allergies: No known allergies

Product	Reaction

\_\_\_\_\_  
Pharmacist Signature

\_\_\_\_\_  
Patient Signature

# Ontario *MedsCheck* Program

Ministry of Health and Long-Term Care

- Funded by MOHLTC
- One-on-one 30 minute appointment with the community pharmacist
  - Reviews all the patient's medications
  - Helps patients better understand their medication therapy and ensure that medications are taken as prescribed.

# Who is eligible for a *MedsCheck*?

- **All** Ontarians are eligible
- Provided they are taking 3 or more medications for a chronic condition.
- Community Pharmacist is reimbursed for their professional services.

# Linking

## *MedsCheck to MedRec*

Pilot Project 2008

- 10 hospital sites
- Pre-admission surgical clinic - elective patients
- Requesting a *MedsCheck* from patients prior to the pre-admission clinic appointment.
- Gather the Best Possible Medication History (BPMH) in hospital
  - Using MedsCheck as the primary source of information
- Measure the value and impact of the *MedsCheck* program to MedRec in hospital

June 2008

Dear Surgeons, Anaesthesiologists, Obstetricians and Receptionists,

**Re: *MedsCheck* and Hospital Medication Reconciliation**

(Insert hospital name), in collaboration with ISMP Canada and supported by the Ministry of Health and Long-Term Care, is introducing a new process to facilitate medication ordering for surgical admissions.

*MedsCheck*, is a provincially funded initiative, which allows a patient to have their medications reviewed by their community pharmacist and also receive a complete list of their current prescription and over-the-counter medications. As the community pharmacist is well positioned to provide patients with this information, a **new** recommendation is for pre-operative elective patients to try to arrange a *MedsCheck* appointment with their community pharmacist 1-2 weeks prior to their pre-admission clinic appointment. The *MedsCheck* information will be included in the pre-admission clinic process for obtaining the patient's medication history.

Please include the enclosed revised patient information leaflets when providing your patients with the pre-admission information packages.

**We need your help to remind patients to try to arrange a *MedsCheck* appointment.**

**Time:** 1-2 weeks prior to their pre-admission appointment.

**Who:** Pre-elective surgical patients with an Ontario Health card on 3 or more medications for a chronic condition.

**Where:** Patient's community pharmacy.

Thank you for your support in improving the medication information available during transitions in care.

Sincerely,

Director of Pharmacy

Hospital  
Logo



# Linking

## *MedsCheck to MedRec*

Coordinate MedsCheck and medication reconciliation in Ontario to:

- Integrate initiatives
- Contribute to seamless transfer of accurate information
- Contribute to the success of MedsCheck
- Save time in admission medication reconciliation

# Canadian Medication Incident Reporting and Prevention System

- Canadian Institute for Health Information
- Health Canada
- ISMP Canada responsibilities include interdisciplinary analysis that considers practice concerns, clinical significance, systems issues, and potential preventive measures.
  - Individual Practitioner Reporting Program  
([https://www.ismp-canada.org/err\\_report.htm](https://www.ismp-canada.org/err_report.htm))

# Ontario Medication Incident Database

- Capturing medication incident reports from Ontario institutions and facilities since 2000
- 30,612 voluntarily reported medication incidents (as of April 30, 2008)
- 58 institutions and facilities
- 1169 medication incidents (3.81%) with an outcome of "Harm" or "Death"

## Top 5 Medications Reported as Causing Harm or Death through medication error

Medications	No. of Incidents	Percentage (n = 1169)
Insulin	115	9.84
Morphine	103	8.81
Hydromorphone	89	7.61
Heparin	55	4.70
Fentanyl	46	3.93

# Ontario Medication Incident Database

## **Psychotherapeutic Medications** - AHFS Category: Antidepressants and Antipsychotics

Sample of reports (n=42) with an outcome of "Harm"  
(n=39) or "Death" (n=3)

# Example findings of interest:

Type of Incident	Reported Contributing Factors
Incorrect medication	<ul style="list-style-type: none"><li>• Look-alike/sound-alike medication names<ul style="list-style-type: none"><li>➤ Luvox and lovenox</li><li>➤ Carbamazepine and chlorpromazine</li><li>➤ Apodoxy and Apodoxepin</li></ul></li></ul>
Incorrect patient	<ul style="list-style-type: none"><li>• Pre-pouring medications</li></ul>
Overdose	<ul style="list-style-type: none"><li>• Drug-drug interactions</li><li>• Drug-disease interactions</li><li>• Adverse drug effects can mimic illness</li></ul>
Other	<ul style="list-style-type: none"><li>• Complex orders due to cross-tapering;</li><li>• PRN orders requiring subjective assessments</li></ul>