

# Launch Webinar Strengthening Medication Safety in Long-Term Care

June 23, 2021





### Land Acknowledgement

We acknowledge we are hosted on the lands of the Mississaugas of the Anishinaabe, the Haudenosaunee Confederacy and the Wendat. We also recognize the enduring presence of all First Nations, Métis and the Inuit peoples.

Nous reconnaissons que nous sommes accueillis sur les terres des Mississaugas des Anichinabés, de la Confédération Haudenosaunee et du Wendat. Nous voulons également reconnaître la pérennité de la présence des Premières Nations, des Métis et des Inuit.

https://www.tdsb.on.ca/Community/Indigenous-Education/Resources/Land-Acknowledgement

Find your land acknowledgement at <a href="https://native-land.ca/">https://native-land.ca/</a>





### Learning Goals

#### Following this presentation, participants will understand:

- What tools, education, and coaching resources are available through the Strengthening Medication Safety in Long-Term Care initiative and how participants can access them;
- How residents and families can help increase the safety of the medication management system in the Home;
- How the Quality Improvement curriculum enables Homes to improve medication safety; and
- How changes made to the Medication Safety Self-Assessment program will help Homes to evaluate their medication systems, plan improvements and monitor progress over time.





### Why do we need this initiative?

Residents are prescribed more medications than individuals in any other setting in order to treat multiple medical conditions

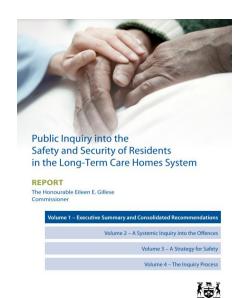
As the number of drugs prescribed to a resident increases, the risk of adverse drug events and harm also increases.

Medication management is complex and resource-intensive in the LTC environment and is a key area of risk and opportunity to enhance safety and quality of life for LTC residents





### New Initiative to Support the Long-Term Care Sector



The 3-year initiative is funded by the Ontario Ministry of Long-Term Care

This work will include addressing Justice Gillese's specific recommendations with respect to detecting potential medication incidents that would otherwise go unnoticed

http://longtermcareinquiry.ca/wp-content/uploads/LTCI Final Report Volume1 e.pdf

Views expressed are the views of ISMP Canada and do not necessarily reflect those of the Province





### ISMP Canada LTC Team



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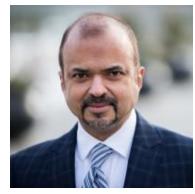
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### Initiative Goal

## Reduce harm associated with medication management errors within Long-Term Care





### Imagine a future...

## Imagine a future where no resident experiences preventable harm related to medications





### 4 Key Areas of Collaboration and Support

#### **Medication safety**

education and model practices

Build knowledge and ability to take action

Use QI methods to understand and improve medication processes

Teaching and coaching in quality improvement

Workshops and facilitation in *medication* incident analysis

Use incident analysis to understand key risks at the home and target actions for improvement

Use tools/indicators to help target actions for improvement and evaluate progress

Updated tools/indicators for measuring and evaluating medication safety





### Foundational Principles

 All activities integrate across the 4 key areas to reinforce capability and capacity building

All activities undertaken collaboratively with the sector

 Focus on resident and family engagement/ participation as part of interdisciplinary quality improvement teams





### Resident and Family Engagement





### A Resident's Perspective



Devora,
Resident in
long-term care,
Ontario





### Online Toolkit



Created by Flatart from Noun Project





### Culture

```
change
          systems commitment
   reputation
                response
                            education
         SAFETY CULTURE
                                   service
success
                 behaviour
   philosophy
                             improvement
                   empowerment
       standards
                        teamwork
                results
```

http://www.westeve.com/safety/our-safety-culture





### Resident Education Module



Your Voice Matters: Residents and Families Have an Important Role in Medication Safety.

Strengthening Medication Safety in Long-Term Care





#### Why Should I Watch this Video?

- Did you know that mistakes with medications happen sometimes?
- In this video, you will learn how residents and their family caregivers can play an important role in the medication safety team.
- You will learn how to make your voice heard so that you can be part of important decisions about your care.



Strengthening Med Safety in Long-Term Care







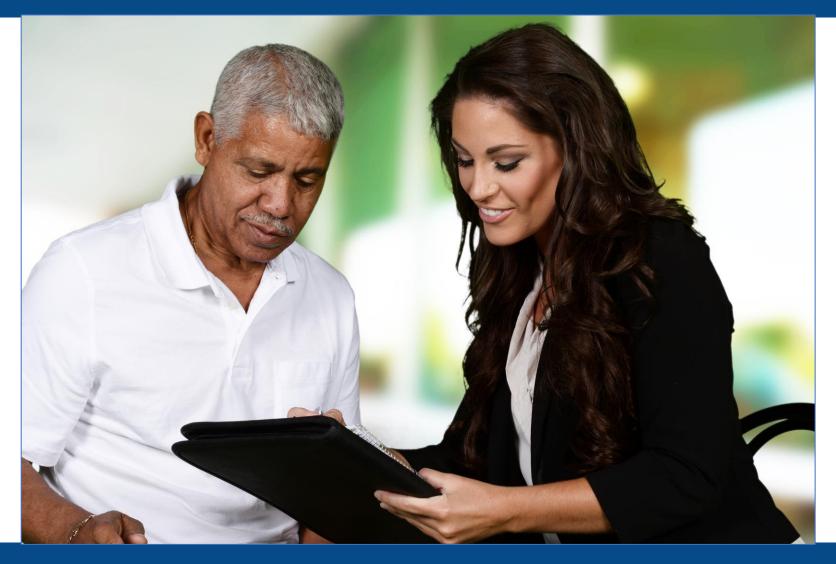


Barry and Devora, Residents in long-term care, Ontario





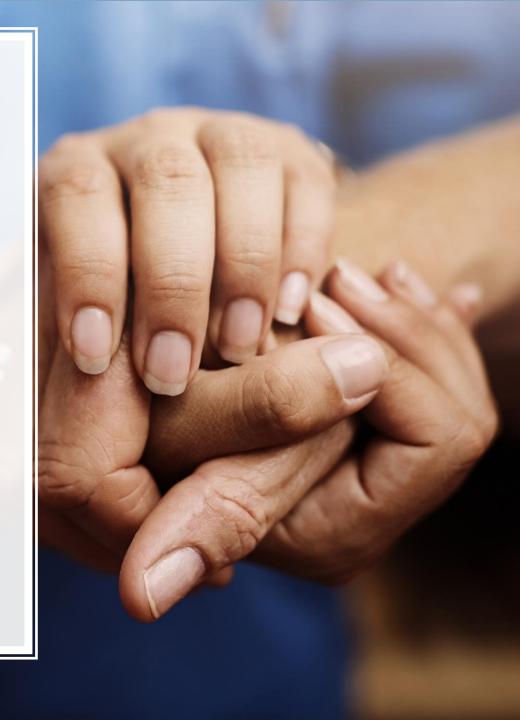
### Engage





## Leading Practice: Medication Reconciliation (MedRec) in LTC

- Developing best practice resources for front line
  - Model policy and template for MedRec
- Developing an e-Learning module about medication safety at transitions of care
- Helping teams establish a standardized process for MedRec and solving related problems.





#### Medication Safety at Transitions - Why is this important?

- WHO Global Patient Safety Challenge: Medication Without Harm - medication safety at transitions: a key action area
- Medication error rates of 21% or more have been reported in transitions from hospital to LTC
- Up to 60% of these incidents are serious, life-threatening or fatal
  - Anticoagulants, opioids and insulin are top list of medications involved

Grissinger (2016)
ISMP Canada Safety Bulletin 2010





### A Real MedRec Story

LTC to hospital

- Resident transferred to hospital for acute dehydration
- Past Medical History: dysphagia, CVA, PVD

Hospital medication order

- Potassium chloride 40 meg q4h PO x 2 doses
- "DC" with discontinuation date was on the Medication Administration Record (MAR)

LTC admission

- Returned to LTC after 2 days
- Potassium chloride unintentionally continued at LTC for 17 days
- Resident readmitted with hyperkalemia (K+ > 9 mmol/L) and subsequently died

ISMP Canada Safety Bulletin 2007





Medication Management Clinical Medication Review Medication Reconciliation **Best Possible** Medication History

The BPMH is the fundamental cornerstone for medication management.

Image adapted from: https://www.ismp-canada.org/medrec/images/medRec\_medManagement.gif





### Quality Improvement

- Quality Improvement initiatives are successful when everyone is engaged and has a stake in their success.
- Engagement is brought about by a combination of Awareness-building, Education/Training, and Coaching in a structured program, which is what "Strengthening Medication Safety in Long-Term Care" is designed to be.





### The Approach for QI Education

### **Basic - Short Online Modules (For Everyone)**

- Introduction to the Quality Improvement Method
- Workplace Organization (5S)
- Mistake-proofing processes
- Visual Work Instructions
- Process Mapping
- Basic Data Analysis
- Spaghetti Diagrams
- Impact-Effort Analysis

#### **Advanced Workshops (For Teams)**

- Mapping the medication process to identify strategies to improve medication safety
- Designing tests of change (PDSA) for selected strategies to improve medication safety
- Sustaining the improvements made in medication safety through Process Controls and Change Management





### QI Coaching and Implementation Support

- Year One
- Work with ten LTC sites across Ontario to improve medication safety and refine strategies to:
  - Measure and map existing medication management processes (baseline)
  - Analyze and identify critical levers of change
  - •Identify and test a few critical changes and measure impact on medication safety outcomes.

- Years two and three
- Based on knowledge and experience gained in year one, scale and spread the improvements to the other sites in the province. This process would involve:
  - •Education sessions to large number of teams (including best practices and from peer sites)
  - •Conducting multiple small tests of change at each site while having access to experts





### Some excerpts from e-learning modules

#### 90,000 +

#### Medication-related injuries happen in Ontario nursing homes every year

#### How many of those do you think, are preventable?

(Choose from below, and press "Continue" after you've selected the correct answer)



CONTINUE

https://pubmed.ncbi.nlm.nih.gov/15745723/





From the most common causes of Medication errors, select the one that you feel is most relevant to your site/team



CONTINUE





#### THE PROBLEM

You are being asked to help the (imaginary)
City of Grandewin solve the problem of
unacceptably high number of car crashes at
a busy intersection XX

START





#### THAT's RIGHT! DID YOU KNOW?

Teams that write down <u>Specific</u>, <u>Measurable</u>, <u>Achievable</u>, <u>Relevant and Time-Bound (S.M.A.R.T) Goals, develop an Action plan, and share them with others are</u>

42%

More likely to achieve them

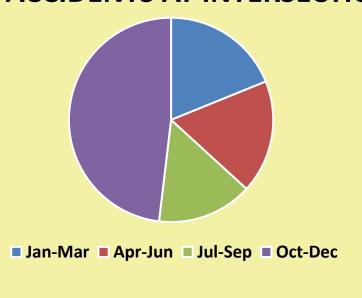
CONTINUE







# After looking at the data that your team has collected, which section will you select for further investigation? 2019-20 ACCIDENTS AT INTERSECTION XX



CONTINUE







## Along with the team, you decided to go to the intersection, between 4-8 pm, to understand the WHYs

Why do you think most accidents happen in the Fall (Oct-Dec)?

**Human Error** 

Possibly poor visibility





The team brainstormed ideas and came up with these actions to solve the Glare problem. Which one would you select to actually do?

**Install Electronic anti-glare screens** 

Redesign intersection to change traffic pattern during evening rush hour

Reposition Billboard that's causing the glare







Translating this to your site, who would you want on your team (Type Roles) to reduce Medication Errors?



CONTINUE





### QI is a Team Sport — Let's Play!



**Clearly state the** Goals (S.M.A.R.T.)



Analyze the data and the Causes



**Experiment, Improve** and Evaluate

CONTINUE





### Measurement







### Prescriber and Team Engagement







### Medication Safety Self-Assessment (MSSA-LTC)





Auto-évaluation de l'utilisation sécuritaire des médicaments en

soins de longue durée

Version III canadienne

Canadian Version III, 2021 – NOW AVAILABLE!

- 176 assessment items
  - 53 new items
  - 75 revised items from the MSSA-LTC Canadian Version II (2012)
  - 48 items from the MSSA: Focus on Never Events in ITC
- Available in English and French





### MSSA-LTC — Content Sources

#### **New content:**

- Recommendations from the Gillese Report
- ISMP Canada and ISMP (United States) resources and learning from analysis
- Literature search conducted by the Canadian Agency for Drugs and Technologies in Health Care (CADTH)
- User feedback
- Focus on medication system technologies; e.g., electronic prescribing, clinical decision support systems, automated dispensing cabinets







### Validation Testing

### Field testing:

- 20 sites completed the pilot version
- 16 sites submitted a separate detailed content evaluation survey

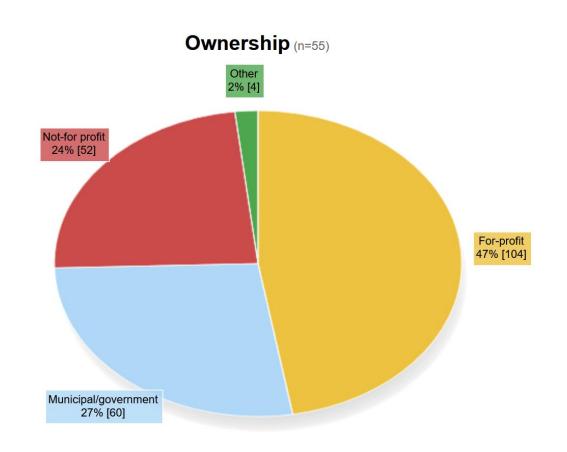
### **Cognitive Interviews:**

- ACE group conducted interviews with 11 individuals in 4 sites following completion of the MSSA-LTC
- Each assessment item was reviewed for understanding, clarity and relevance

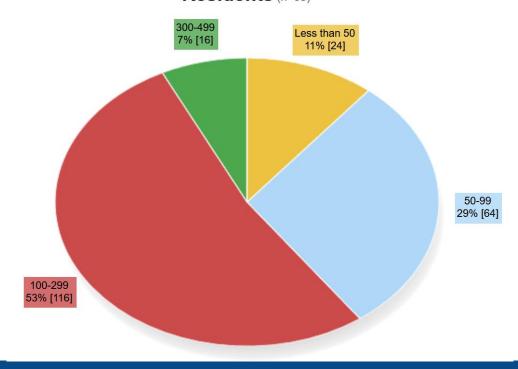




## MSSA-LTC Uptake



- To June 22<sup>nd</sup>, 54 Ontario sites have completed the MSSA-LTC
- More than 200 have registered Residents (n=55)

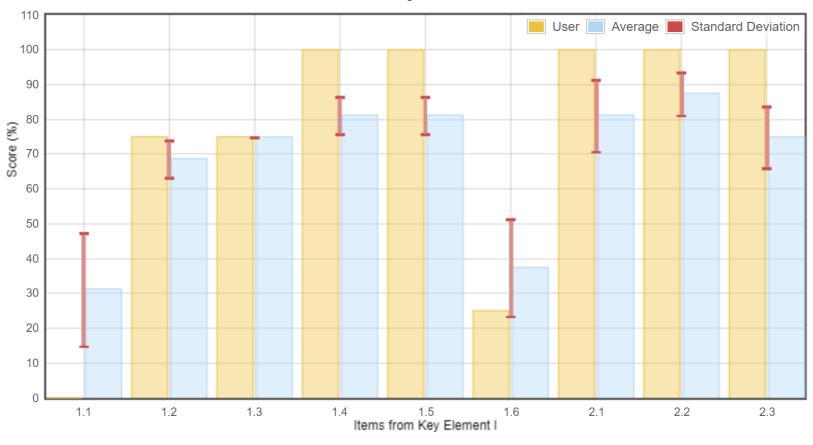






## Individual Level Results

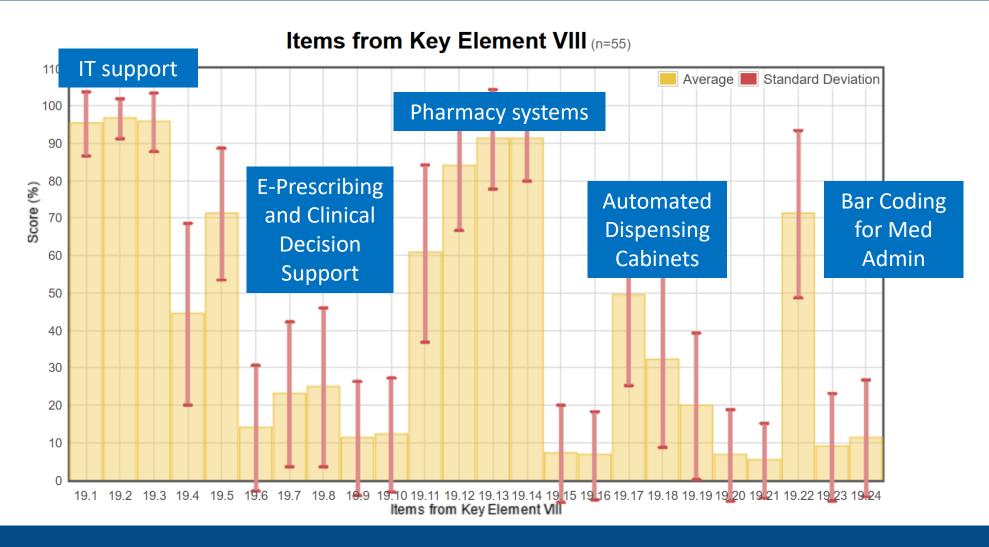








## Preliminary Results - Technology

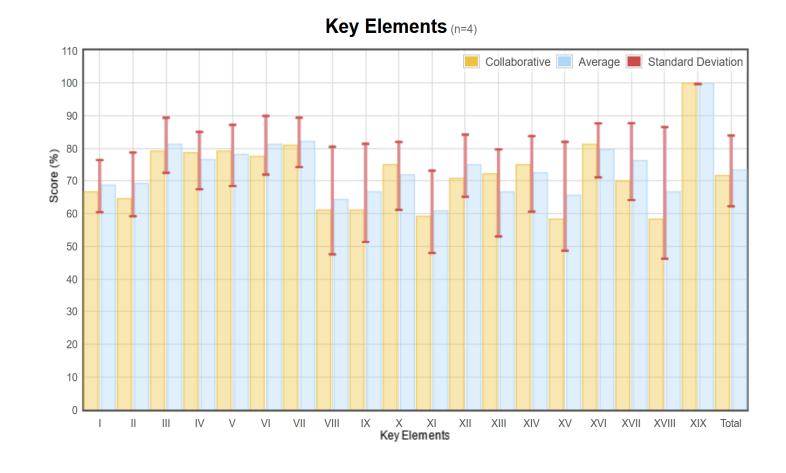






### New Feature: Collaborative Groups

- Organizations with multiple Homes can set up collaborative groups
- Individual sites can compare their own results to the collaborative, or to the full aggregate dataset
- Collaborative leads can compare their group's results to the aggregate







# Collaborative Groups (cont'd)

Code	1.1	1.2	1.3	1.4	1.5	1.6	2.1	2.2	2.3
ltc1	0	2	3	3	3	0	2	3	2
ltc2									
ltc3	2	3	3	3	3	2	4	4	3

The collaborative lead can also view the results for individual sites, to identify strengths and Improvement opportunities within the group.





### Next Steps: User Guide



- Will provide additional information to support Homes to optimize the use of their results
- Will include a sample presentation template for sharing results





# Development of Leading Practice Model Policies



HIGH ALERT MEDICATIONS



MEDICATION STORAGE



AUTOMATED DISPENSING CABINETS



MEDICATION RECONCILIATION



MEDICATION INCIDENT

ANALYSIS





# Medication Incident Analysis

Overall objective is to enhance resident safety through a continuous improvement cycle of:

REPORT > LEARN > IMPROVE > SHARE

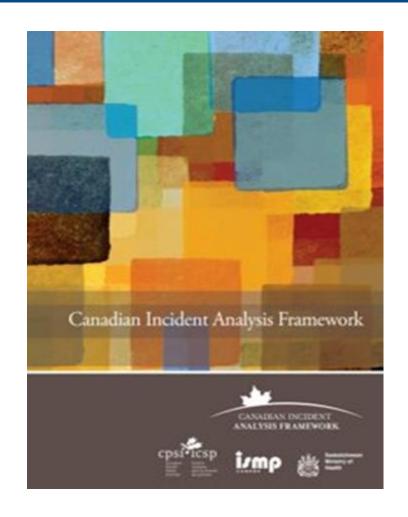
Practitioners can report via our website:







### Medication Incident Analysis Continuum









# Some Keys to Success

Just culture of medication incident management

Analysis Team including multiple perspectives

Repeatedly asking WHY?





# How can we support you?

ISMP Canada can offer support in the medication incident analysis through:

### **Interactive Virtual workshops**

- Teach concepts of incident analysis
- Practice scenarios using the tools and resources

### **Email support**

Reach out to us for general queries at <u>LTC@ismpcanada.ca</u>





# Coming Soon!

### Call for Expression of Interest 10 Homes to be Champion Sites for the Initiative

Are you interested in dedicating time, energy and resources to becoming a Champion Site?

ISMP Canada will work with these sites to obtain baseline self assessments, map med processes, analyze med incidents, adapt and implement model policies/practices, and take targeted action to improve med safety.

Call for interest will be issued in July. All registered participants for the webinar will receive info and details will be on ismpcanada.ca

10 sites will be selected of various sizes, geographic locations, and other criteria.



### Thank you!

Please continue to share your questions and comments in the chat box

For more information: ismpcanada.ca or LTC@ismpcanada.ca



