Improving quality in patient safety

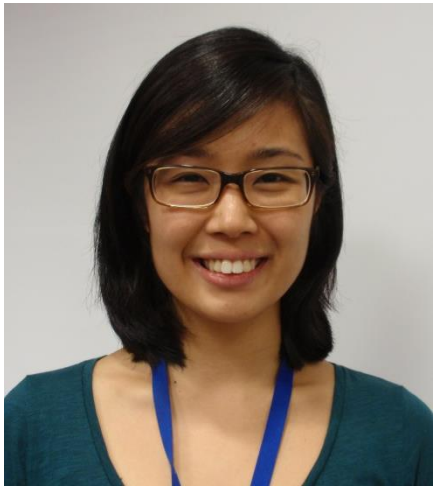
Ontario CRITICAL Incident Learning

Demystifying the Critical Incident Reporting Process

October 21, 2015

ismp CANADA

Today's Facilitator



Janica Chan
BScPhm, RPh, BCPS, CDE,
PharmD Candidate

Disclosure

There are no actual, potential or perceived conflicts of interests to declare associated with the content of this presentation.

About ISMP Canada

ISMP Canada is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings.

We work collaboratively with the healthcare community, regulatory agencies and policy makers, provincial, national and international patient safety organizations, the pharmaceutical industry and the public to promote safe medication practices.

Our aim is to heighten awareness of system vulnerabilities and facilitate system improvements.

ISMP Canada

ISMP Canada's Vision

- Canada's leading organization and advocate for medication safety through analysis and prevention of medication incidents.

Purpose

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

What is Your profession?

Physician

Nurse

Pharmacist

Technician

Manager

Administration

Other

Objectives

At the end of this session, participants will be able to:

- Recognize how critical incident reporting helps strengthen Ontario hospitals' ability to prevent or reduce the risk of harmful medication incidents.
- Understand how individual incidents are translated into learning for hospitals through the Ontario Critical Incident Learning program.
- Be able to generate high-quality incident reports.

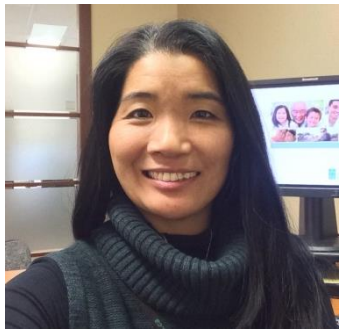
Critical Incident

- "In Reg 965 of the Public Hospitals Act (PHA), a critical incident is defined as any unintended event that occurs when a patient receives treatment in a hospital:
  - that results in death, or serious disability, injury or harm to the patient; and
  - does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment."

http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/criticalincident/update.aspx

Please Complete Our Poll

Today's Speakers



Annie Walker,
Program Lead,
Pharmaceuticals,
CIHI

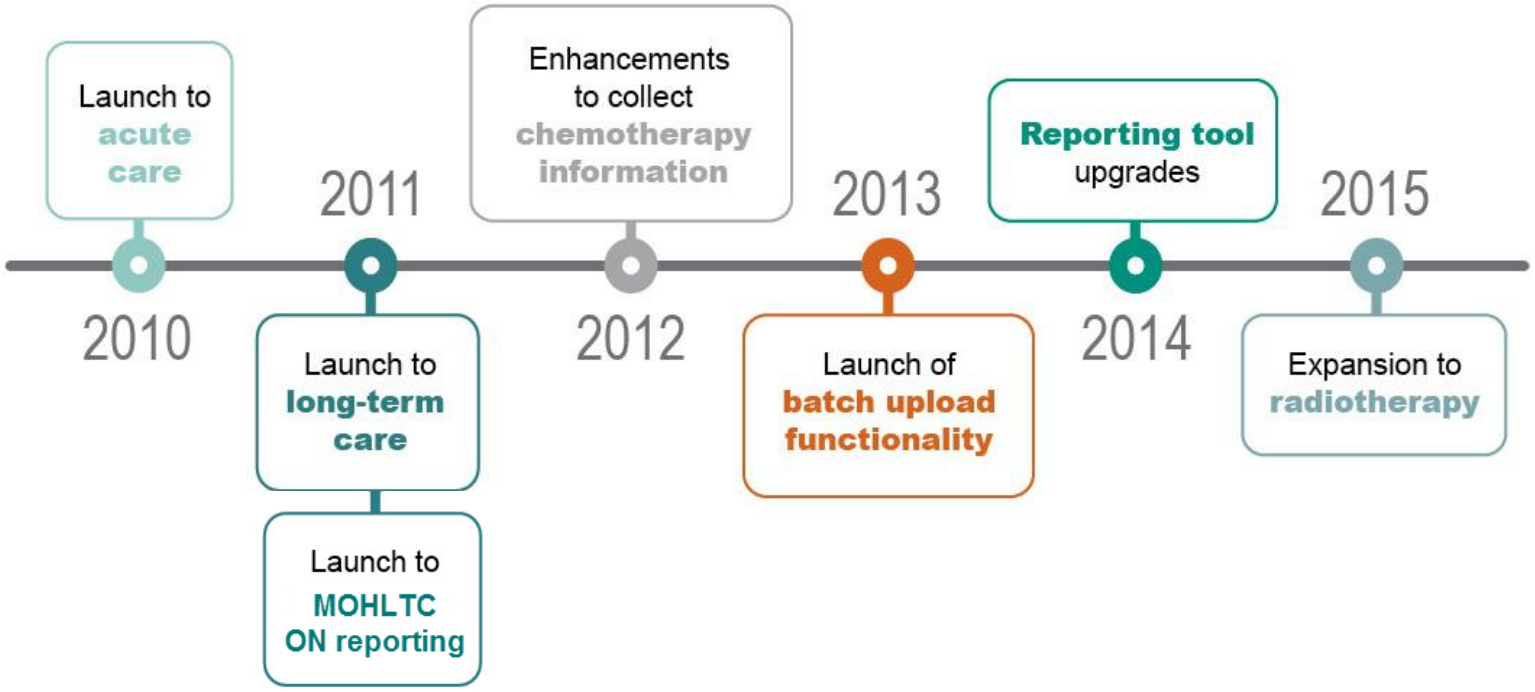
Michael Hamilton BSc, BEd, MD
Physician Lead and Medication Safety Specialist
ISMP Canada

Candace Epworth,
RN, BScN, PANC(C)
Medication Safety Specialist
ISMP Canada

Annie Walker,
Program Lead, Pharmaceuticals,
CIHI

NSIR - National System for Incident Reporting

NSIR Timeline



Medication Incident Reporting to NSIR

Welcome, mainthospital
Last logged in: 2011/09/13 at 10:41

Messages | Submit | Find | Analyze | Profile | Administer | Help | Logout

NSIR Case ID 790298972

Source | Impact | Discovery | Patient | Details | Drug | Investigation

Ward(s)/Unit(s) within Hospital Select all that apply

*** Functional Area(s) within Hospital** Select all that apply

Date and Time of Incident (Indicate Precise Time or Time period)

*** Detected Date** YYYYMMDD **Precise Time** 0000-2359 **or Time Period** Select one...

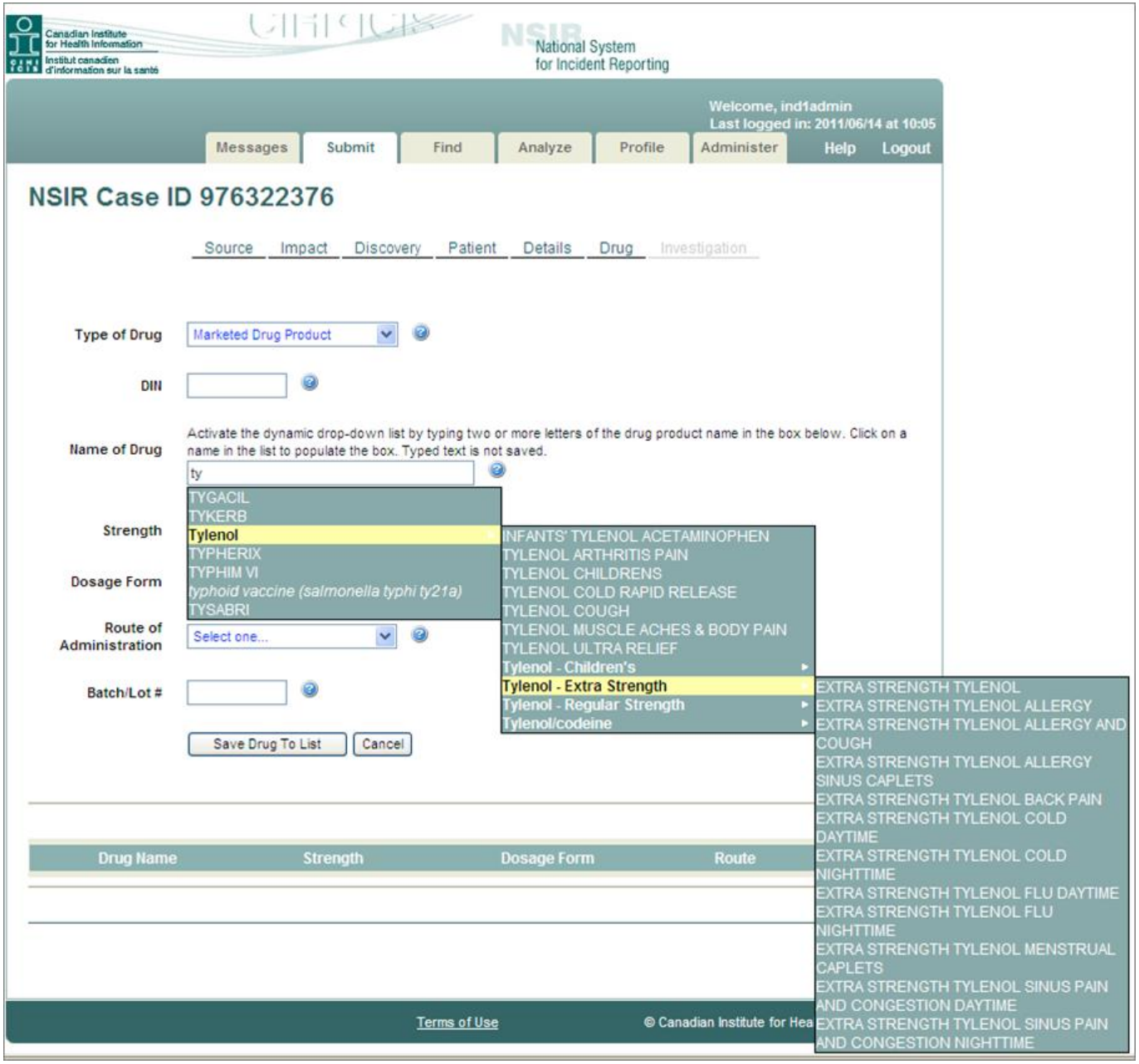
Occurred Date YYYYMMDD **Precise Time** 0000-2359 **or Time Period** Select one...

Health Care Providers and/or Others ...

Who Detected Incident Diagnostic imaging staff; Materials management staff — Change

Who Were Involved in Incident Select all that apply

Back | Next


Canadian Institute for Health Information
Institut canadien d'information sur la santé
NSIR
National System for Incident Reporting
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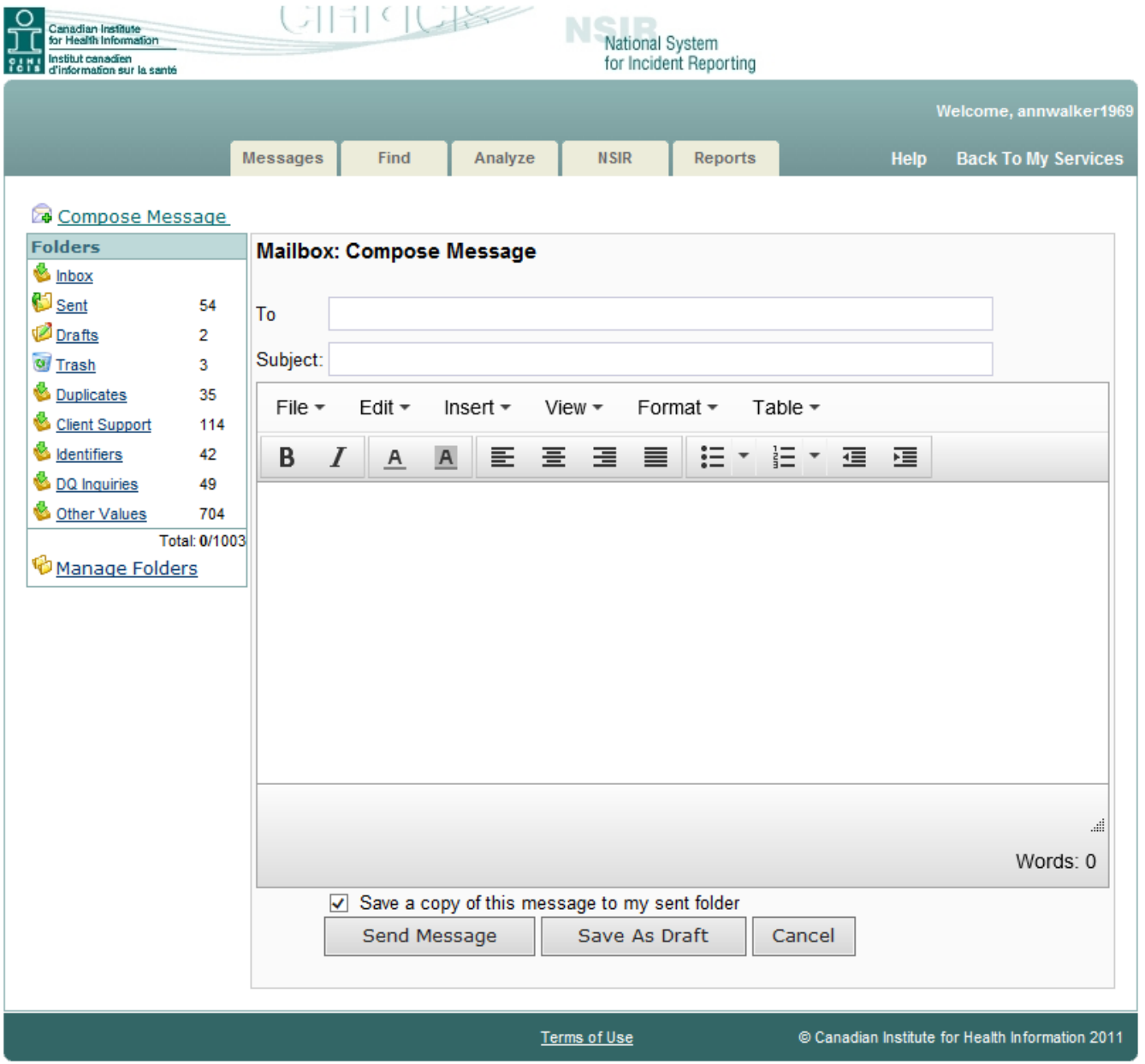
NSIR Case ID 976322376
Source
Impact
Discovery
Patient
Details
Drug
Investigation
Type of Drug
Marketed Drug Product
DIN
Name of Drug
Activate the dynamic drop-down list by typing two or more letters of the drug product name in the box below. Click on a name in the list to populate the box. Typed text is not saved.
ty
TYGACIL
TYKERB
Tylenol
TYPHERIX
TYPHIM VI
typhoid vaccine (salmonella typhi ty21a)
TYSABRI
Strength
Dosage Form
Route of Administration
Select one...
Batch/Lot #
Save Drug To List
Cancel
INFANTS' TYLENOL ACETAMINOPHEN
TYLENOL ARTHRITIS PAIN
TYLENOL CHILDRENS
TYLENOL COLD RAPID RELEASE
TYLENOL COUGH
TYLENOL MUSCLE ACHES & BODY PAIN
TYLENOL ULTRA RELIEF
Tylenol - Children's
Tylenol - Extra Strength
Tylenol - Regular Strength
Tylenol/codeine
EXTRA STRENGTH TYLENOL
EXTRA STRENGTH TYLENOL ALLERGY
EXTRA STRENGTH TYLENOL ALLERGY AND COUGH
EXTRA STRENGTH TYLENOL ALLERGY SINUS CAPLETS
EXTRA STRENGTH TYLENOL BACK PAIN
EXTRA STRENGTH TYLENOL COLD DAYTIME
EXTRA STRENGTH TYLENOL COLD NIGHTTIME
EXTRA STRENGTH TYLENOL FLU DAYTIME
EXTRA STRENGTH TYLENOL FLU NIGHTTIME
EXTRA STRENGTH TYLENOL MENSTRUAL CAPLETS
EXTRA STRENGTH TYLENOL SINUS PAIN AND CONGESTION DAYTIME
EXTRA STRENGTH TYLENOL SINUS PAIN AND CONGESTION NIGHTTIME
Drug Name
Strength
Dosage Form
Route
Terms of Use
© Canadian Institute for Hea


Canadian Institute for Health Information
Institut canadien d'information sur la santé
NSIR
National System for Incident Reporting
Welcome, annwalker1969
Messages
Find
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Back To My Services
Compose Message
Folders
Inbox
Sent 54
Drafts 2
Trash 3
Duplicates 35
Client Support 114
Identifiers 42
DQ Inquiries 49
Other Values 704
Total: 0/1003
Manage Folders
Mailbox: Compose Message
To
Subject:
File
Edit
Insert
View
Format
Table
Words: 0
Save a copy of this message to my sent folder
Send Message
Save As Draft
Cancel
Terms of Use
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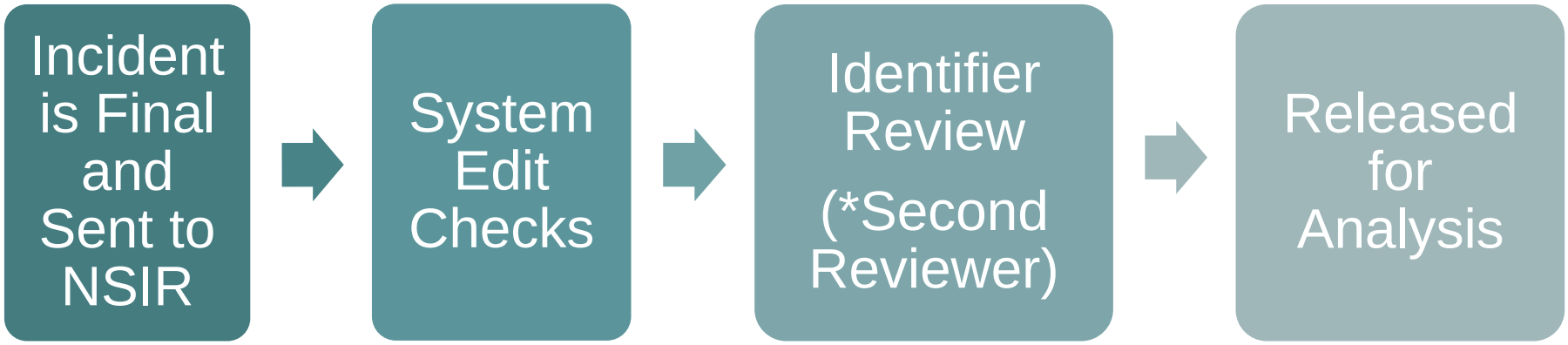
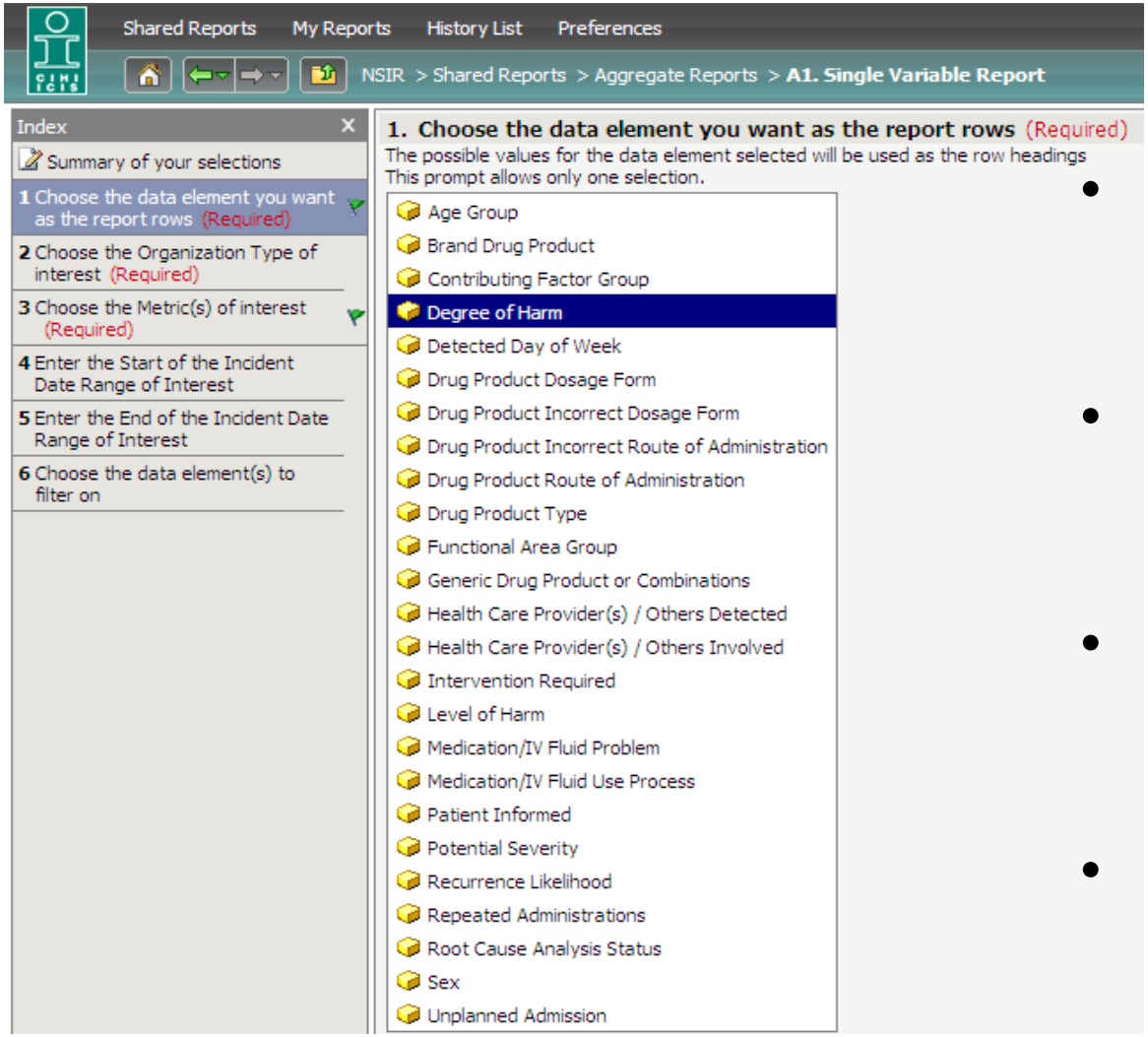
NSIR Incident Submission Processing



NSIR Analytical Tool: Learning Through Analysis and Data Use



- Template and custom reports
- Easy report creation
- NSIR partner access
- Ad hoc data requests

Contact NSIR at

nsir@cihi.ca

Michael Hamilton BSc, BEd, MD
Physician Lead and Medication Safety Specialist
ISMP Canada

What We Do at ISMP Canada

- Collect incident reports
- Collaboratively analyze critical incidents and significant near misses
- Provide safe medication practice recommendations and strategies
- Work with stakeholders to make changes
- Disseminate and share learning via publications and workshops
- Facilitate safe practice implementation

Ontario NSIR Initiative

A Collaborative Initiative of

- Ontario Ministry of Health and Long-Term Care
- Health Quality Ontario (HQO)
- Canadian Institute for Health Information
- Institute for Safe Medication Practices Canada
- Ontario Hospital Association
- You and your organization

ISMP Canada Roles in Ontario Critical Incident Reporting

- Qualitative analysis of incidents reported to CIHI NSIR program
- Development of safety strategies
- Dissemination of findings – Bulletins, Webinars, Presentations

Critical Incident

- "In Reg 965 of the Public Hospitals Act (PHA), a critical incident is defined as any unintended event that occurs when a patient receives treatment in a hospital:
  - that results in death, or serious disability, injury or harm to the patient; and
  - does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment"

http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/criticalincident/update.aspx

Critical Incident Life Cycle

- Hospital NSIR administrator must submit a critical incident into NSIR **AND** CIHI releases the de-identified incident
- ISMP Canada receives these incidents on a biweekly basis
  - Anonymous view only
  - Can only view critical incidents that have been released

Critical Incident Reporting Process

Critical Incident Reported to NSIR

Critical Incident Life Cycle (con't)

- ISMP Canada reviews incident and attempts to contact reporter for additional information and permission to share learning
  - Initially through communication tool within NSIR
  - Subsequently through an email message sent from CIHI to the hospital NSIR administrator's hospital email account

Critical Incident Reporting Process

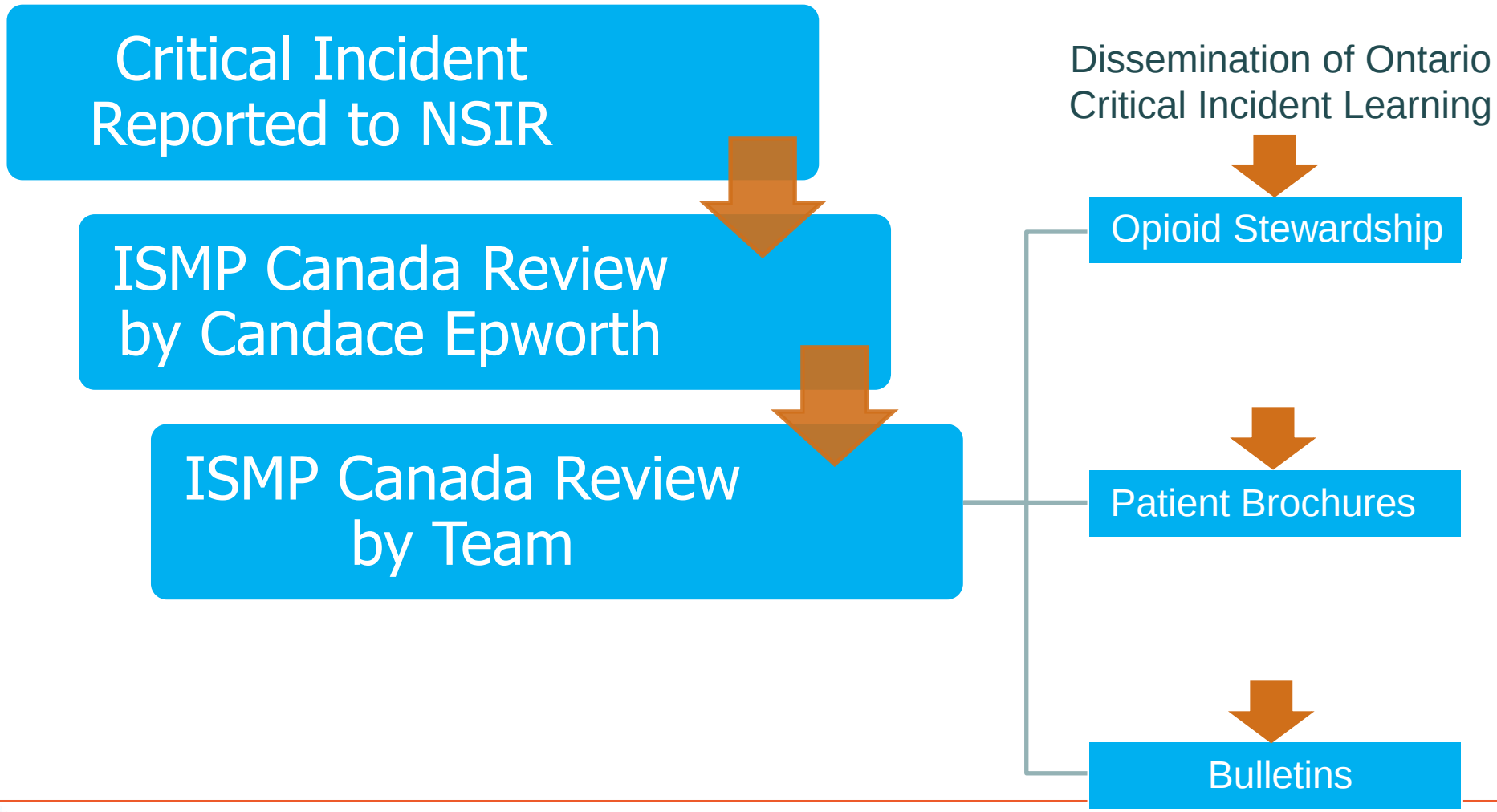
Critical Incident Reported to NSIR

ISMP Canada Review by Candace Epworth

ISMP Canada Analysis Team

Critical Incident Reporting Process

Critical Incident Reporting Process



Candace Epworth RN, BScN, PANC(C)
Medication Safety Specialist
ISMP Canada

In a Culture of Safety

Focus is on **how and when** a system will fail, not if it will fail.

Ontario CRITICAL Incident Learning

Improving quality in patient safety

Changing to a Culture of Safety

Person Approach

vs.

Systems Approach

ismp CANADA

The Person Approach

"The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness."

J. Reason, March 18, 2000, BMJ

Moving Away from "Blame & Shame"

Who did it?	→	What allowed it?
Punishment	→	Thank you for reporting!
Errors are rare	→	Errors are everywhere
Add more layers	→	Simplify/standardize

Systems Approach

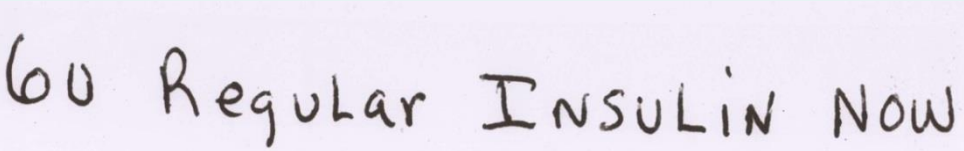
"The systems approach is not about changing the human condition, but rather the conditions under which humans work"

J.T. Reason 2001

Many Factors Lead to System Errors

Handwritten Orders	
Problematic Abbreviations	60 Regular Insulin Now **Result: 10-fold dosing error & patient harm**
Confirmation Bias	
Environmental Factors	
Multiple Distractions	

Many Factors Lead to System Errors

Handwritten Orders	 **Result: 10-fold dosing error & patient harm**
Problematic Abbreviations	
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Environmental Factors	
Multiple Distractions	

Many Factors Lead to System Errors

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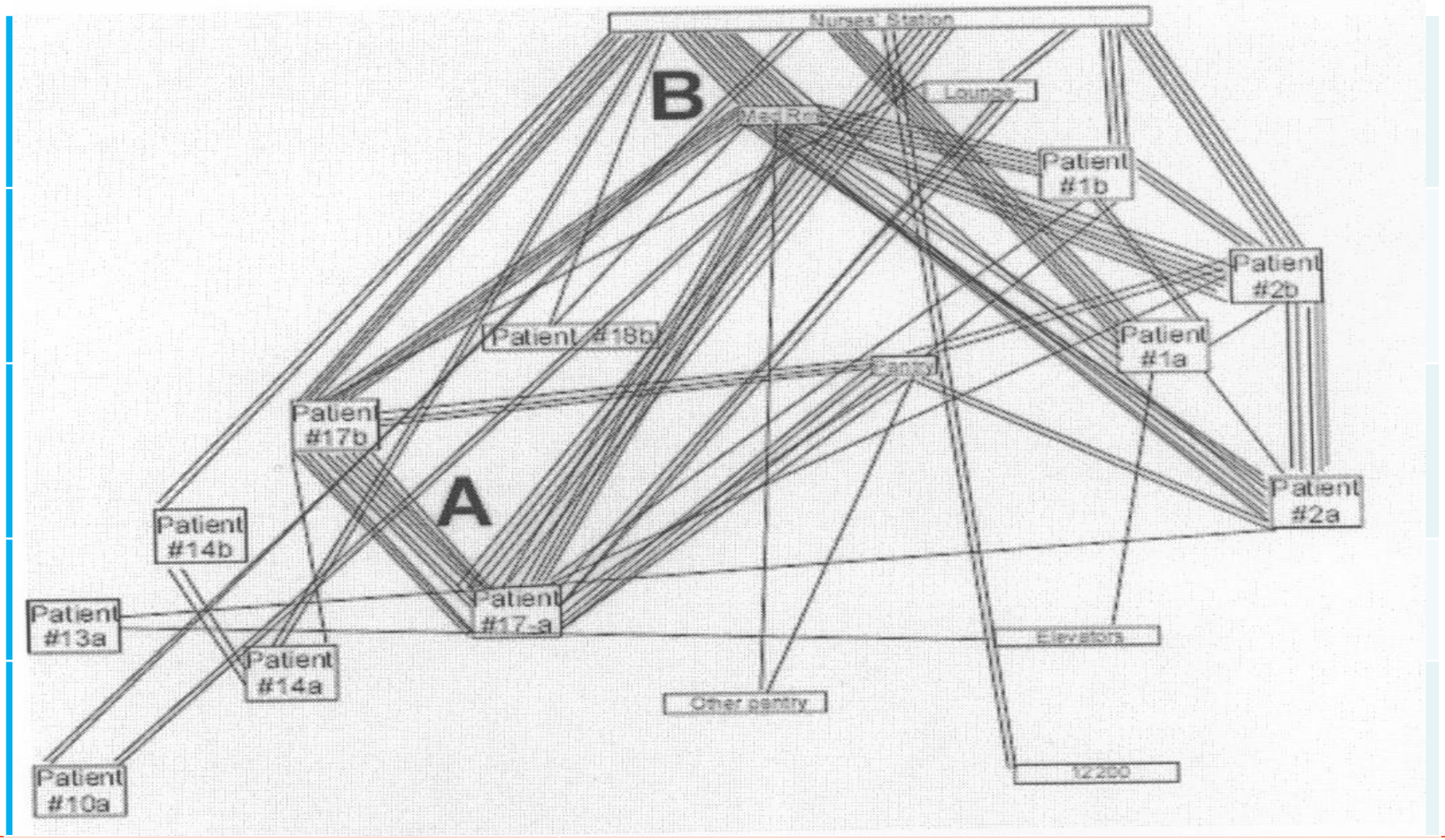
Many Factors Lead to System Errors

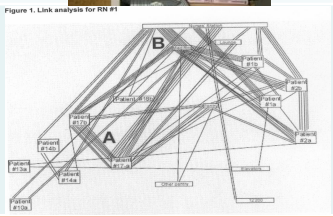
Handwritten Orders	
Problematic Abbreviations	60 Regular Insulin Now **Result: 10-fold dosing error & patient harm**
Confirmation Bias	The pweor of the hmuan mnid
Environmental Factors	
Multiple Distractions	

Many Factors Lead to System Errors

Figure 1. Link analysis for RN #1



Many Factors Lead to System Errors

Poor Handwriting	60 Regular Insulin Now **Result: 10-fold dosing error and patient harm**
Bad Abbreviations	
Confirmation bias	**The pweor of the hmuan mnid**
Environmental factors	
Multiple distractions	

Improving quality in patient safety

Ontario CRITICAL Incident Learning

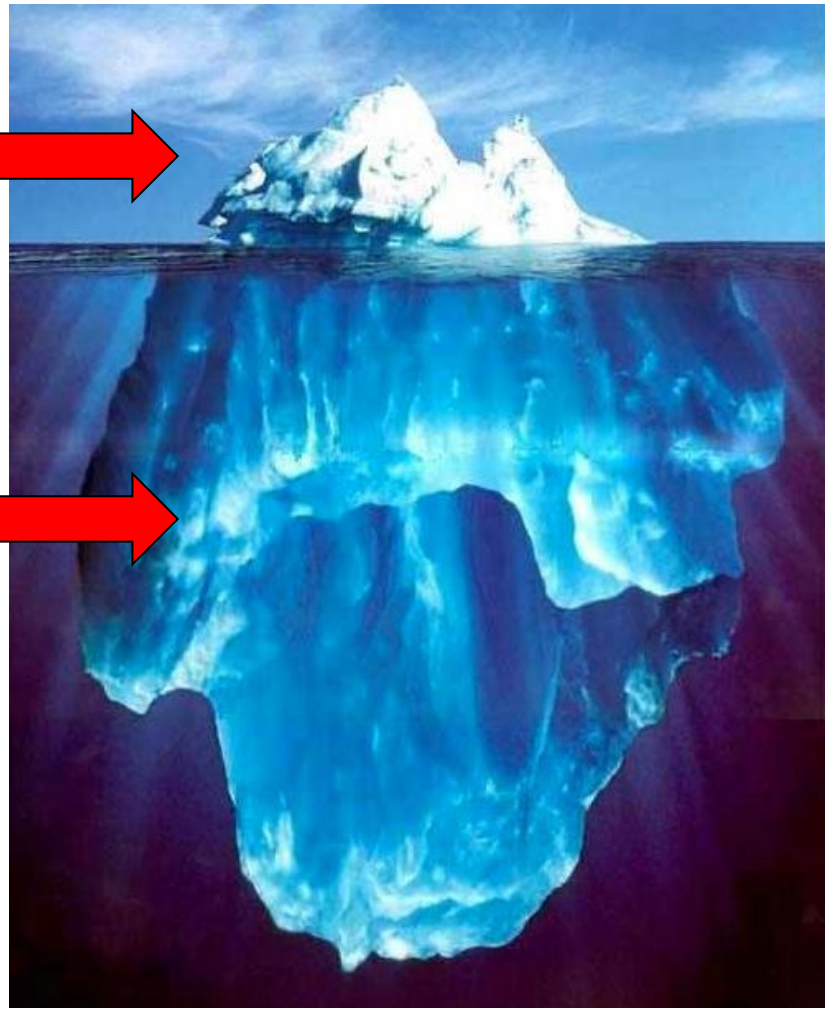
Incident Reporting

ISMP CANADA

Tip of the Iceberg

Number of Incidents Reported

Actual Number of Incidents

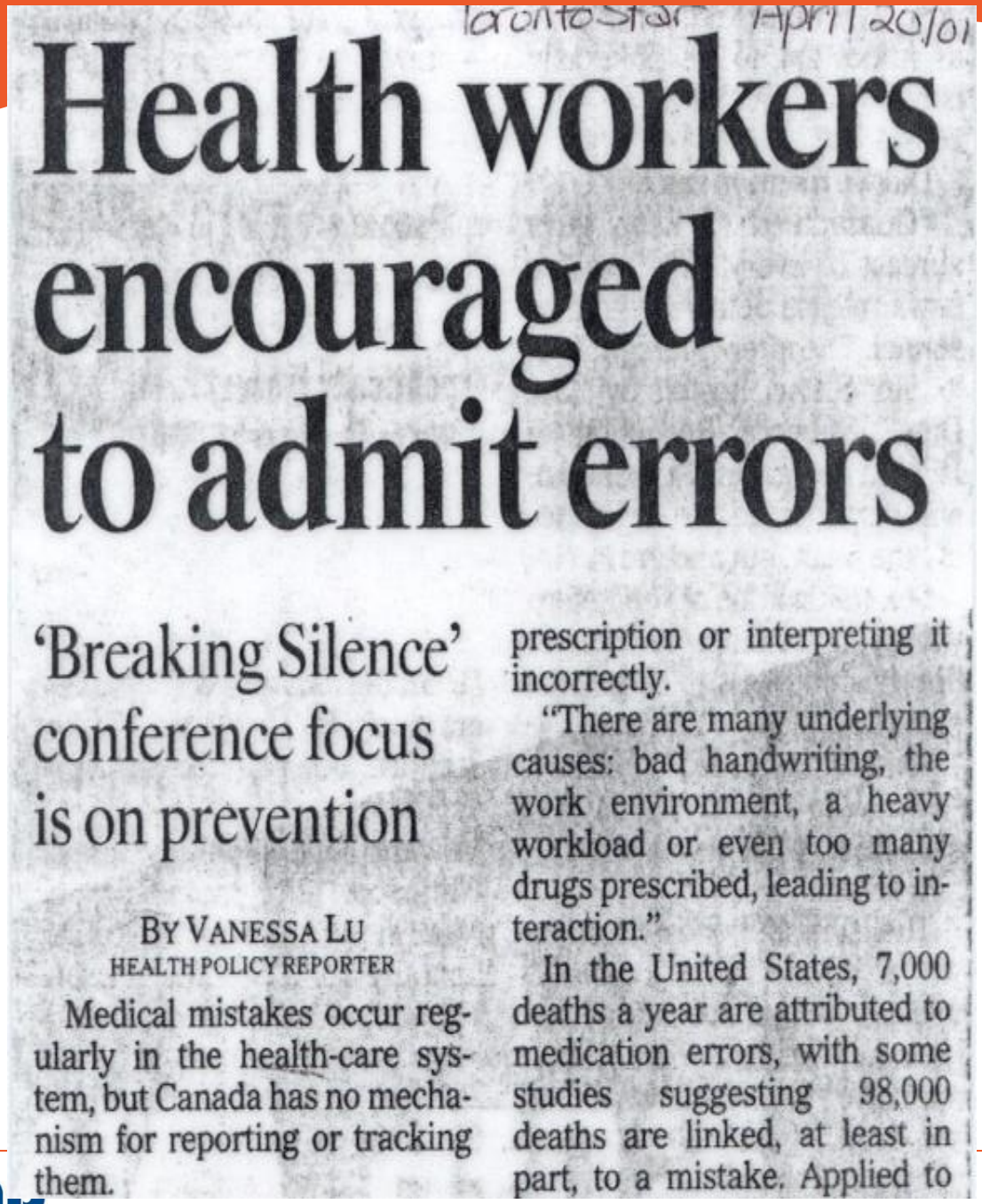


Incident Reporting

- Risk management processes needed to track all unusual occurrences / incidents
- Organizational policies needed to respond to and review critical incidents
- Endorsement from Medical Advisory Committee and Administration

Incident Review Process: Lessons for Health Care

- Transparent to all health care providers
- Fair treatment applied consistently
- Human resources processes (discipline) separated from quality review



Toronto Star April 20/01

Health workers encouraged to admit errors

'Breaking Silence' conference focus is on prevention

BY VANESSA LU
HEALTH POLICY REPORTER

Medical mistakes occur regularly in the health-care system, but Canada has no mechanism for reporting or tracking them.

prescription or interpreting it incorrectly.

"There are many underlying causes: bad handwriting, the work environment, a heavy workload or even too many drugs prescribed, leading to interaction."

In the United States, 7,000 deaths a year are attributed to medication errors, with some studies suggesting 98,000 deaths are linked, at least in part, to a mistake. Applied to

The Toronto Star
April 20, 2001

Good Reporting

- Make sure you give as much detail as possible
- If using check boxes elaborate in your story
  - I.e., check box workload – actually state in your story 2 sick calls not replaced
  - Fatigue – too many shift working short etc.
- Include strategies recommended by the reporting facility

Example of Incomplete Reporting

Description of Incident	
Describe medication error with as much detail as possible	Patient ordered Hydromorphone 2mg po q4h prn. Nurse gave 2mg IV push. Patient found unresponsive, unable to resuscitate.
Contributing factors:	distractions/frequent interruptions, attention issues-failure to remember, performance factors-unspecified, drug product confusion, work around-shortcut, delay in action.

Fictional Case

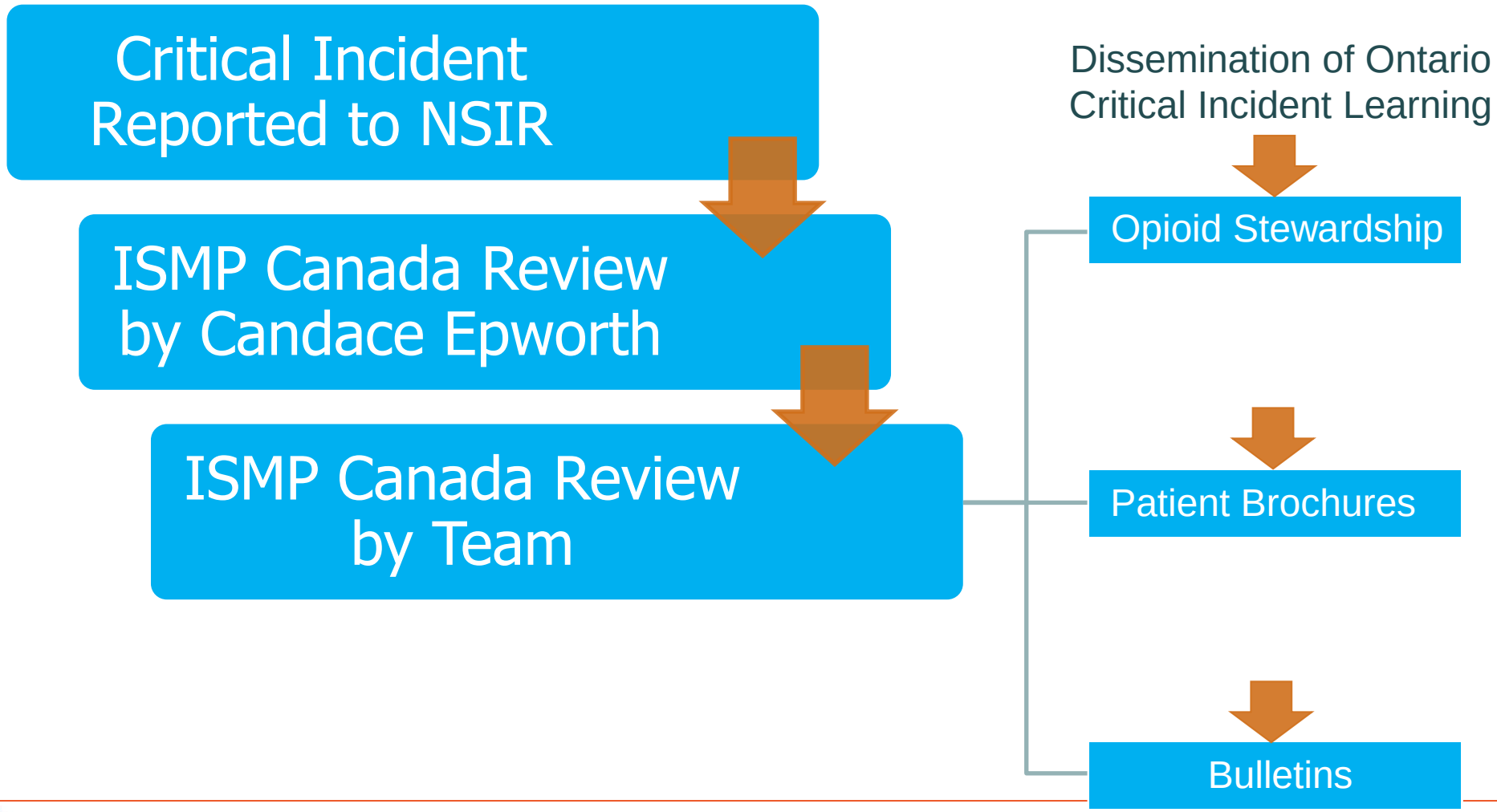
Example of Good Reporting

Description of Incident	
Describe medication error with as much detail as possible	Patient ordered Hydromorphone 2mg po q4h prn. Nurse gave 2mg IV push. Nurse also caring for disruptive patient on floor with 3 sick calls. Nurse on 4th 12 hour shift, called in as overtime shift. Unable to return to patient's room to observe for 35 minutes as a code white was called for the disruptive patient. Nurse found patient unresponsive, code blue called, unable to resuscitate patient.
Contributing factors	distractions/frequent interruptions, attention issues-failure to remember, performance factors-unspecified, drug product confusion, work around-shortcut, application of poor procedure/protocol, organizational factors, quality control-double/independent check, delay in action, shortage of staff.

Good Reporting Tips Checklist

- ✓ Pick the proper Degree of Harm
  - Severe: Outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, or shortening life expectancy or causing major permanent, long-term harm or loss of function.
  - Death: On balance of probabilities, the incident was considered to have played a role in the patient's/resident's death.
- ✓ Fill in contributing factors first
- ✓ Write your description expanding on these factors
- ✓ Try to never use "other" as a choice in reporting
- ✓ Report using a systems approach, not individual

Critical Incident Reporting Process



Improving quality in patient safety

Ontario
CRITICAL Incident Learning

Issue 4
April 2013

Distributed to:

- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy

Suggested action items:

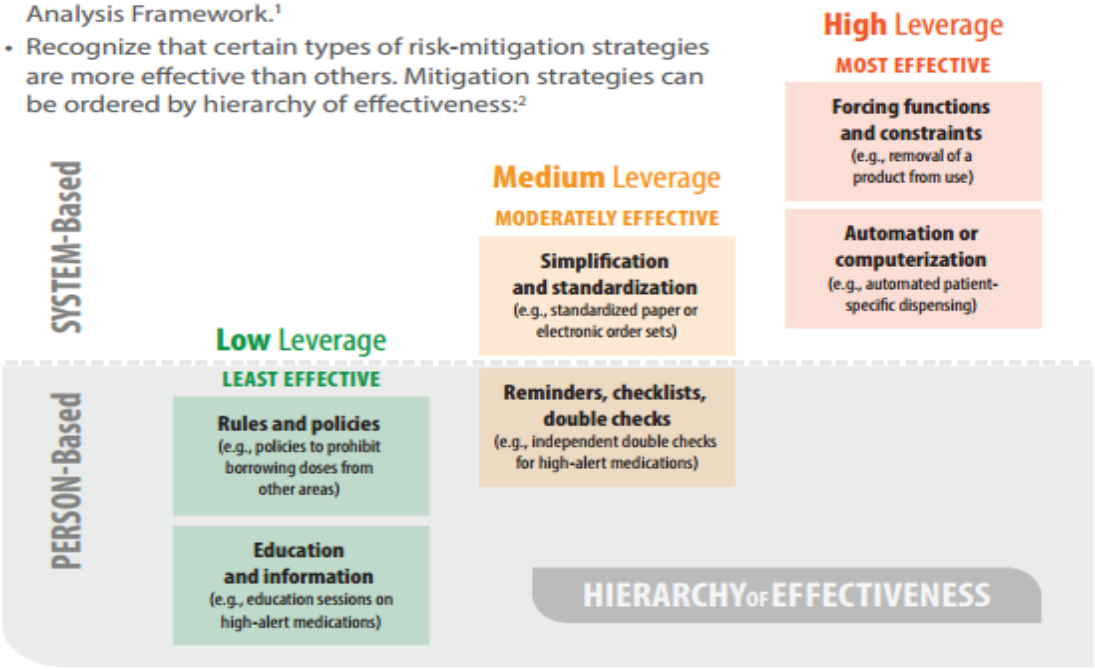
- Circulate bulletin to front-line staff and physicians
- Refer bulletin to quality and safety committees to encourage appraisal of effectiveness of hospital's recommendations and assessment of hospital's quality improvement initiatives
- Use bulletin as an educational resource in your hospital's safety huddles or rounds

Designing Effective Recommendations

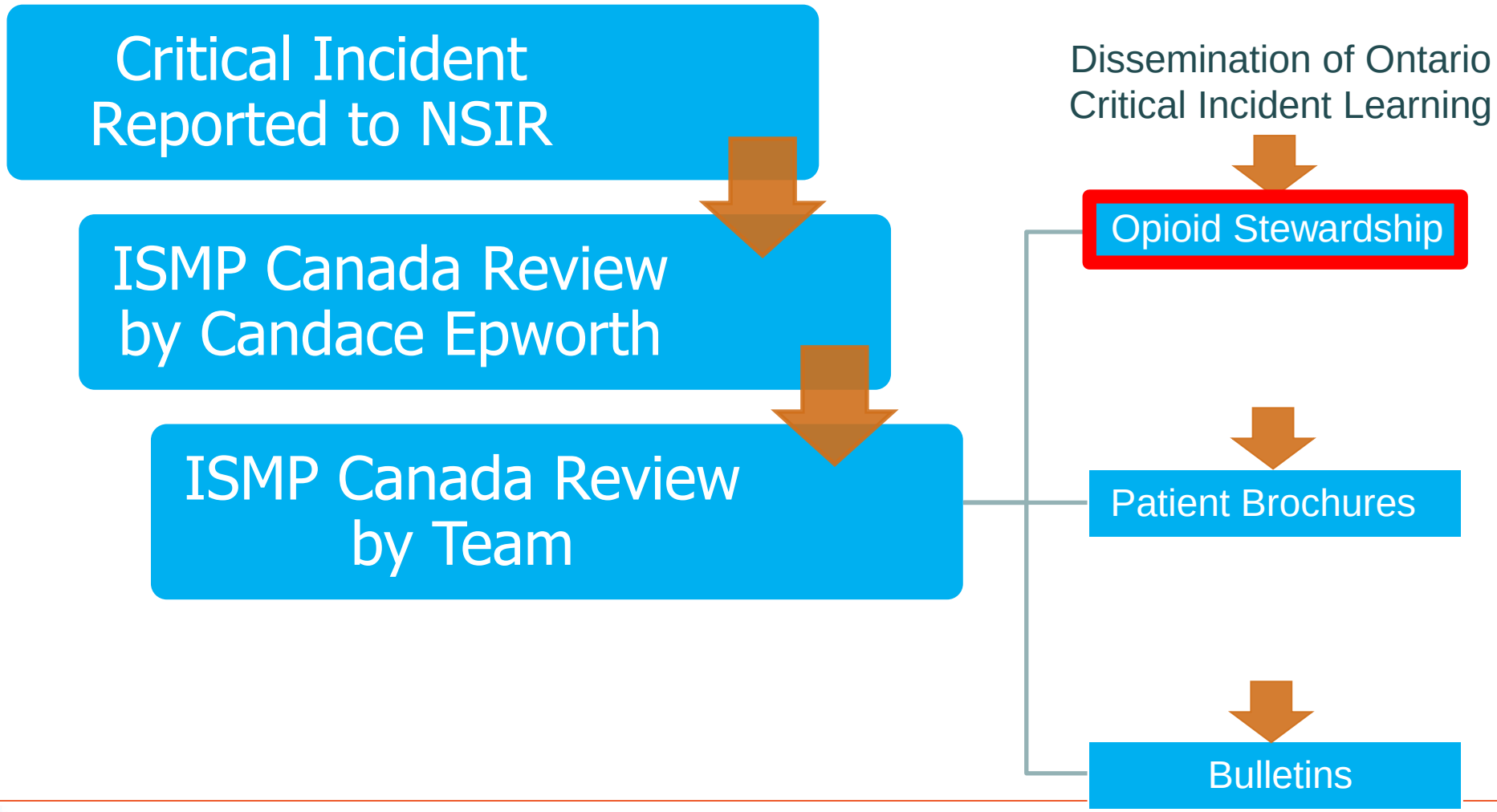
The reporting, investigation, and analysis of medication incidents are important elements in improving patient safety, but these efforts must be accompanied by effective strategies to mitigate the contributing factors leading to the incidents.

Advice for Hospitals

- Review patient safety incidents using a systematic, team-oriented approach, as described in the Canadian Incident Analysis Framework.[1]
- Recognize that certain types of risk-mitigation strategies are more effective than others. Mitigation strategies can be ordered by hierarchy of effectiveness:[2]



Critical Incident Reporting Process



Institute for Safe Medication Practices Canada

A Key Partner in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)

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Opioid Stewardship

Opioid medications are used to treat pain. Opioids are also known as narcotics. In recent years m
opioids. Along with this increased use of opioids there has also been a corresponding and alarming

ISMP Canada is the leading medication safety organization in Canada. Through our ongoing analys
including death-when they are prescribed, used or administered incorrectly or in error.

In response, we have created an **Opioid Stewardship Program** to help people to become bette
the public and health care practitioners with useful and accurate information regarding opioids.

WATCH and learn:

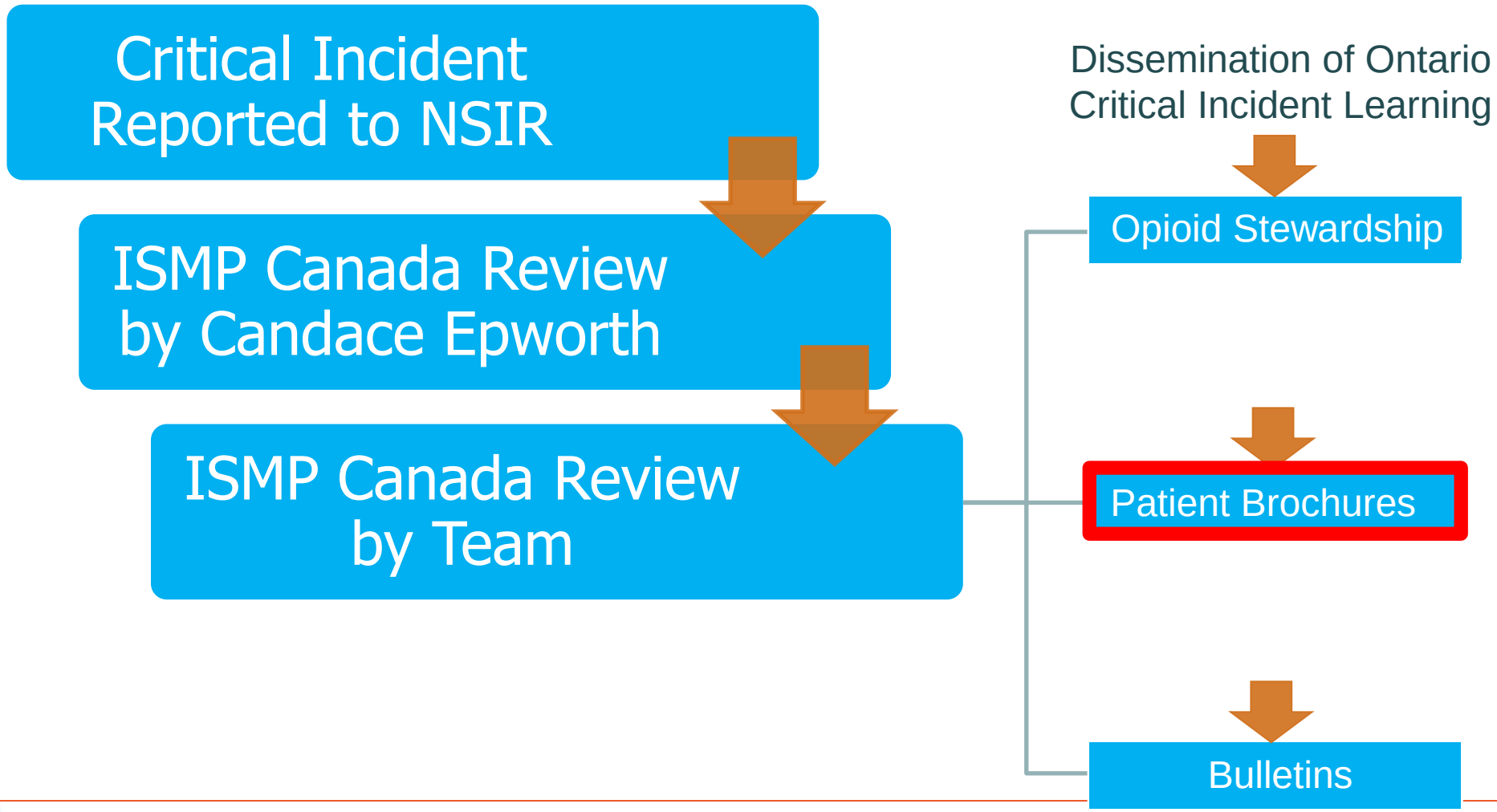
VIDEO: Consumers Can Help Prevent Harm from Opioid Use!

AS

Have ques

Email us

Critical Incident Reporting Process



Information for Patients and Families about Opioid Pain Medicines

Opioid medicines are used to treat pain. Opioids are also known as *narcotics*. These medicines may be needed while you are in hospital and also after you go home. This information sheet will review some important safety information about opioids.

Patients, family members, and other caregivers can play an important role in the safe use of these medicines by becoming better informed.

With opioids there is a fine balance between effective pain control and dangerous side effects.

GOAL

Safe balance between pain control and side effects

Requires regular assessment of opioid effect and need

Examples of Opioids

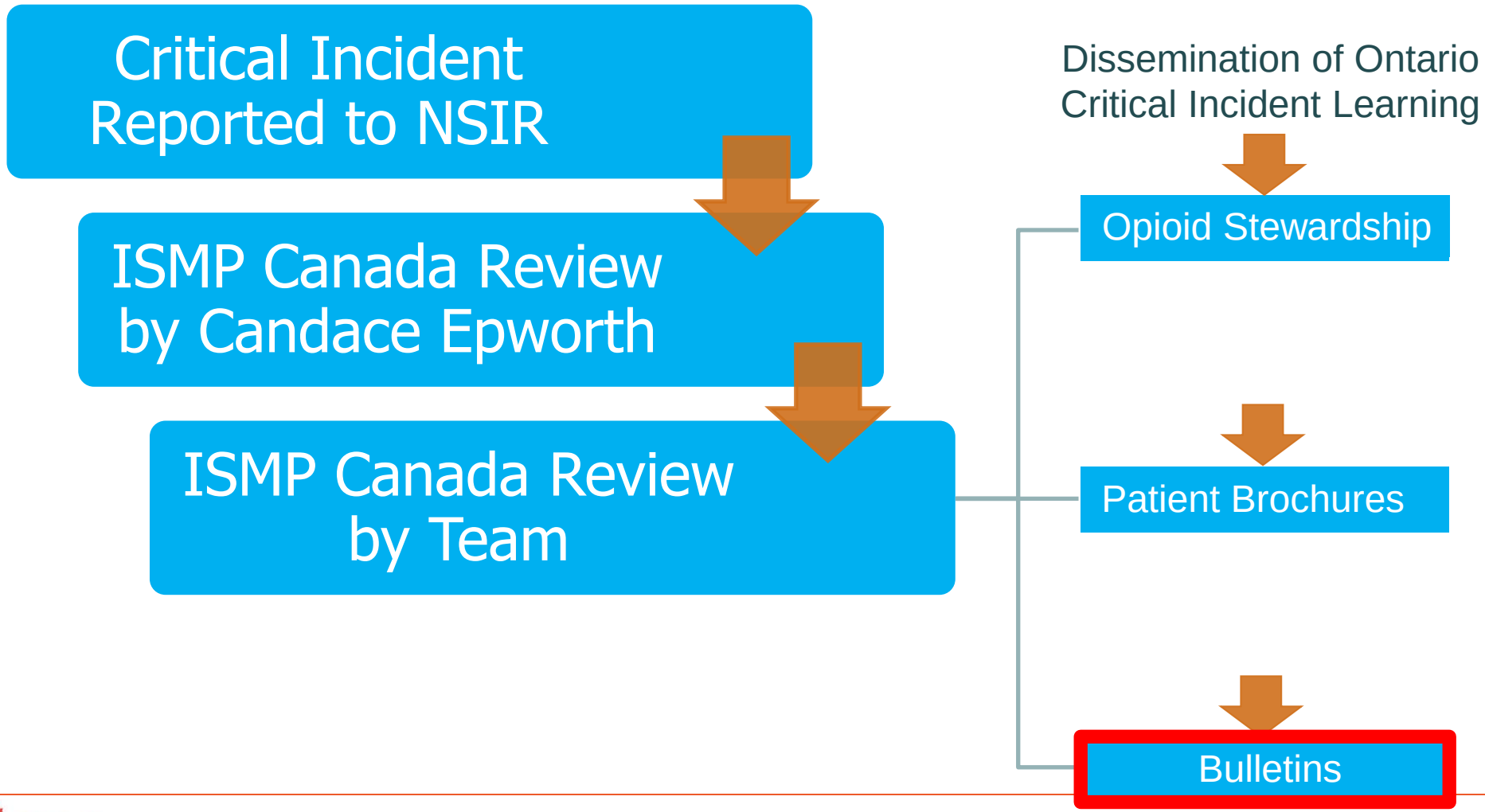
GENERIC NAME	BRAND NAMES
Codeine	Tylenol #1,2,3; Atasol 8,15,30
Fentanyl	Duragesic
Hydromorphone	Dilaudid, Hydromorph Contin
Morphine	Statex, MS Contin, M-Eslon
Oxycodone	Percocet, OxyContin, OxyNEO
Tramadol	Tramacet, Ultram, Zytram XL

How is pain assessed?

- Pain scales (e.g., 0 to10) are often used to help the healthcare team assess pain and monitor the effect of pain medicines.
- *Only you* can describe the level of pain you are feeling.

When should I contact my healthcare team?

Critical Incident Reporting Process



Improving quality in patient safety

Ontario
CRITICAL Incident Learning

Issue 2
February 2013

Distributed to:

- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy

Suggested action items:

- Refer bulletin to pharmacy and therapeutics committee for evaluation of pharmacy practices and for comment to the medical advisory committee
- Refer bulletin to nursing leadership committees for evaluation of nursing

HYDROmorphone remains a high-alert drug

The following report shares learning from a fatal HYDROmorphone incident that occurred in an Ontario hospital.

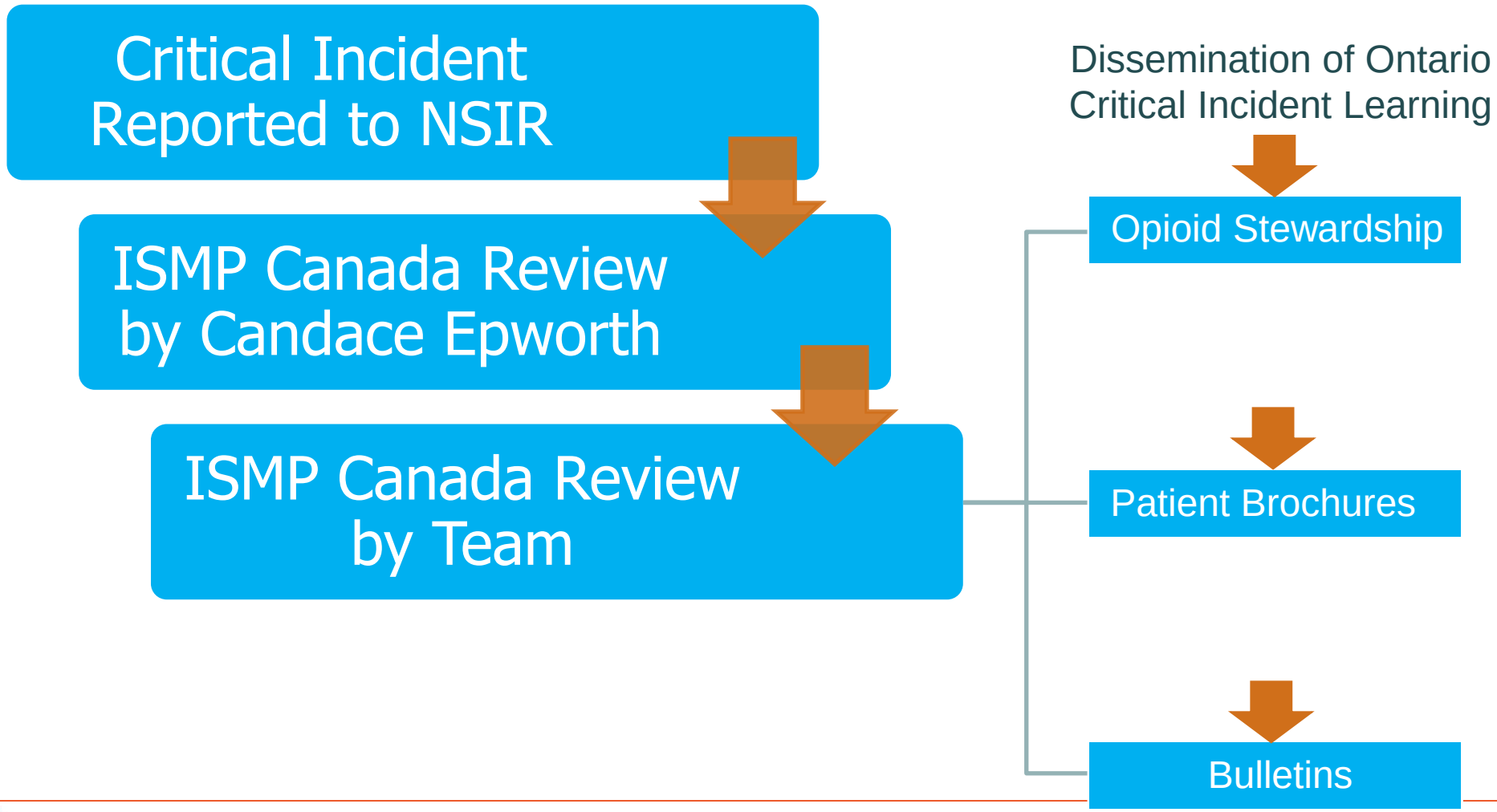
Background

- HYDROmorphone 0.2 to 0.4 mg subcutaneously every hour as needed for pain was prescribed for a patient.
- A 10-fold dosing error occurred, whereby HYDROmorphone 4 mg was administered instead of the 0.4 mg ordered.
- The dose had been drawn from a high-concentration (10 mg/mL) vial of HYDROmorphone.
- Although the facility did not maintain high-concentration HYDROmorphone as floor stock, it was not uncommon for nurses to borrow HYDROmorphone from patient-specific stock.
- The patient was found without vital signs shortly after administration of the HYDROmorphone.

Learning from Analysis

- Consistent with other reported HYDROmorphone administration errors, the availability of a high-concentration HYDROmorphone product played a significant role in the incident.[1]

Critical Incident Reporting Process



Impact of Reporting

- Connection with ISMP Canada to share incident experience and other related learning
- Receipt of timely feedback and assistance, if needed
- Learning from the incident and subsequent corrective system actions can be shared and benefited by all Ontario and Canadian healthcare facilities
- Support and encouragement of patient safety culture

Michael Hamilton BSc, BEd, MD
Physician Lead and Medication Safety Specialist
ISMP Canada

2014 Analysis Report

Ontario Hospital Critical Incidents Related to Medications or IV Fluids Analysis Report

January to December 2014

2014 Analysis Report

Overview

Critical Incidents	
Year	**Number of Reports**
2014	27
2013	29
2012	29*

*Proportional contribution from Year 2012

2014 Analysis Report

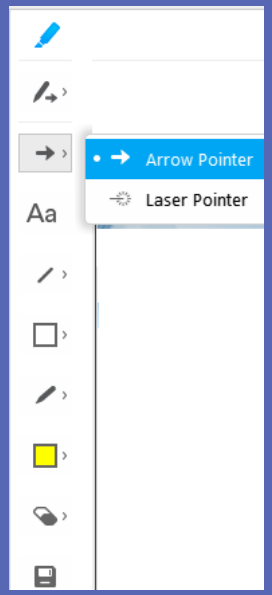
Overview

Critical Incidents by Degree of Harm		
Year	**Deaths**	**Severe harm**
2014	4	23
2013	6	23
2012	8* *Proportional contribution from Year 2012	21*

2014 Analysis Report

Medication/IV Fluid Use Process

- In 2014, at what stage in the medication use process was a critical incident most likely to occur?
  - Prescribing
  - Transcribing
  - Preparation/Dispensing
  - Administration
  - Monitoring



2014 Analysis Report

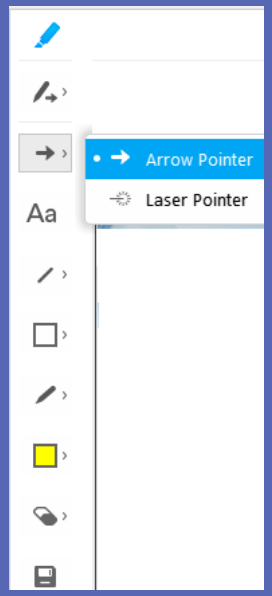
Medication/IV Fluid Use Process

- In 2014, at what stage in the medication use process was a critical incident most likely to occur?
  - Prescribing ➔ 3
  - Transcribing ➔ 5 (verification and documentation)
  - Preparation/Dispensing ➔ 3
  - Administration ➔ 12
  - Monitoring ➔ 2

2014 Analysis Report

Patient Care Areas

- In 2014, where in a facility was a critical incident most likely to occur?
  - Surgical area
  - Oncology area
  - Emergency department
  - Intensive Care Unit
  - Medical/Surgical Ward
  - Mental Health area



2014 Analysis Report

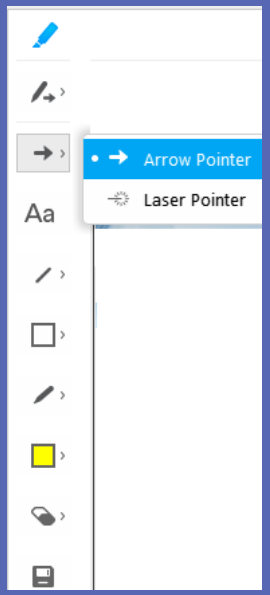
Patient Care Areas

- In 2014, where in a facility was a critical incident most likely to occur?
  - Surgical area ➔ 4
  - Oncology area ➔ 2
  - Emergency department ➔ 9
  - Intensive Care Unit ➔ 3
  - Medical/Surgical Ward ➔ 3
  - Mental Health area ➔ 2

2014 Analysis Report

Medication/IV Fluid

- In 2014, what class of drug was more likely to be involved in a critical incident?
  - Anti-neoplastic
  - Anti-coagulant
  - Thrombolytic
  - Opioids
  - Insulin



2014 Analysis Report

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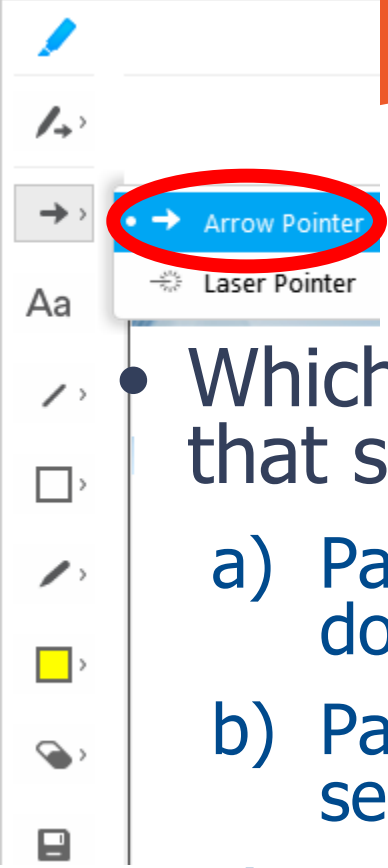
  - Anti-coagulant ➔ 2
  - Thrombolytic ➔ 2
  - Opioids ➔ 9
  - Insulin ➔ 0

Qualitative Learning from 2014 Analysis Report

Naloxone Rescue	Systematic approaches to monitoring can detect a patient at risk of opioid toxicity and trigger an appropriate response.
Patient Factors	Allergies, weight, co-morbidities, co-prescribed drugs, diet all influence how a drug behaves in a patient. This information needs to influence how we manage drugs in a patient.
Multiple Products	The standardization of medication products to ensure consistency and simplification is supported. The use of independent double checks for high-alert medications is recommended.



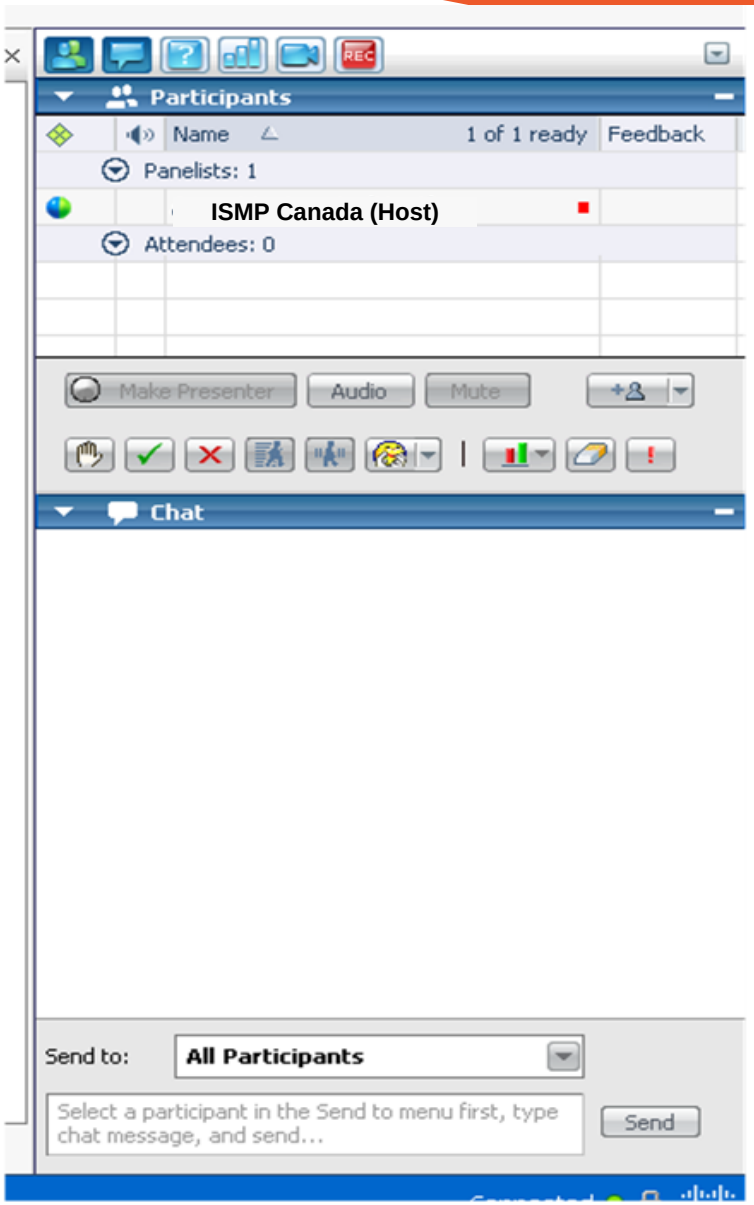
Pop Quiz

- Which of the following are critical incidents that should be reported to NSIR?
  a) Patient received penicillin despite allergy documented, and had an anaphylactic reaction.
  b) Patient sustained burns to his arm after dietary services spilled hot soup on him.
  c) Patient had a hypoglycemic incident after being given too much rapid acting insulin.
  d) Sinemet IR was given instead of Sinemet CR and the patient had uncontrollable symptoms of Parkinson's disease.

Take Home Messages

- Acute care critical incident reporting through NSIR is mandatory
- Detail and rich information is key to analysis, learning and developing prevention strategies
- Critical reporting identifies opportunities to mitigate risks and improve patient safety

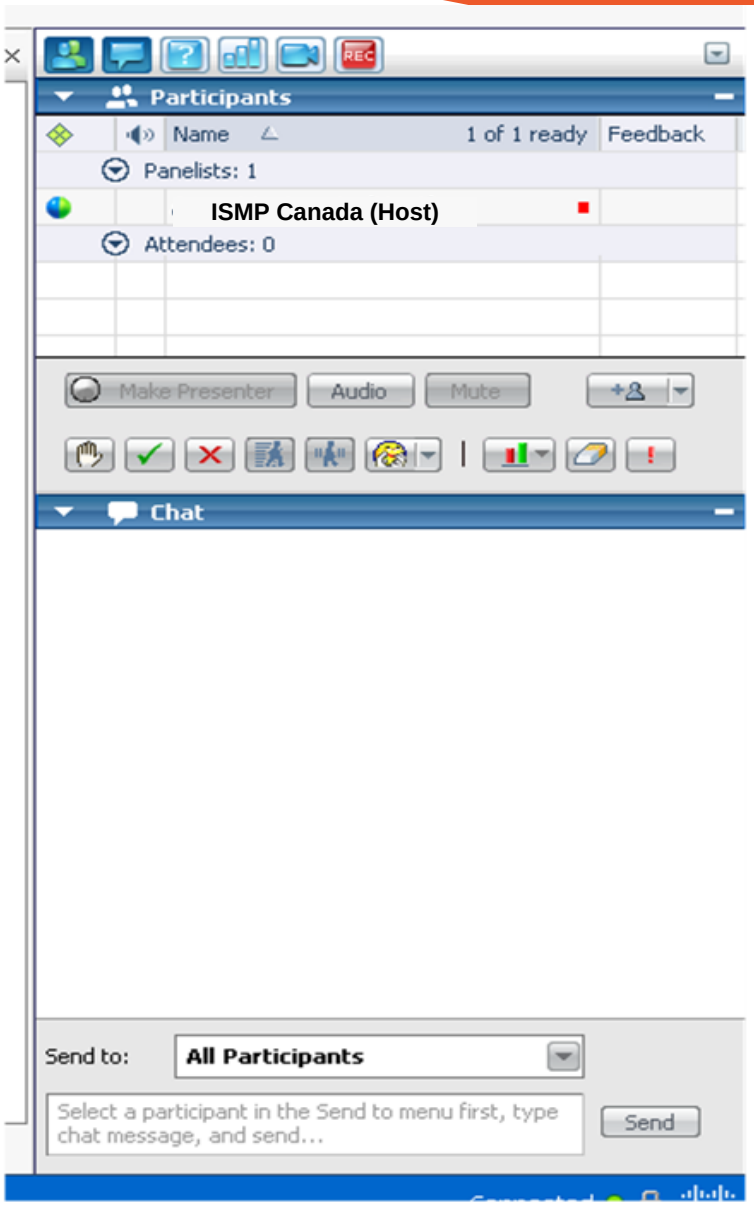
Candace Epworth RN, BScN, PANC(C)
Medication Safety Specialist
ISMP Canada



2. Type your question in the chat box

3. Email your question to webinars@ISMP-canada.org

Please Complete our Poll



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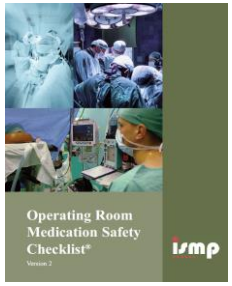
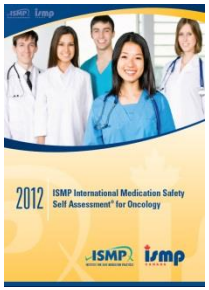
ISMP Canada's Other Self Assessment Programs



HYDROmorphone Safety Self-Assessment®



Hospital Self-Assessment® for Anticoagulant Safety

All Medication Safety Self-Assessments® available at www.ISMP-canada.org/mssa

*with support from the Ontario Ministry of Health and Long-Term Care and HQO

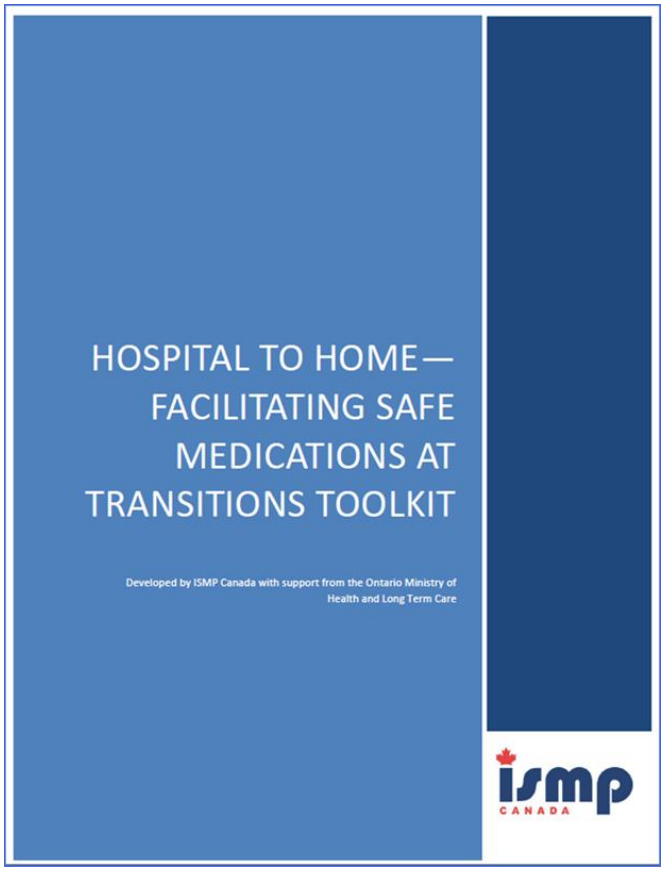
How to Access These Resources

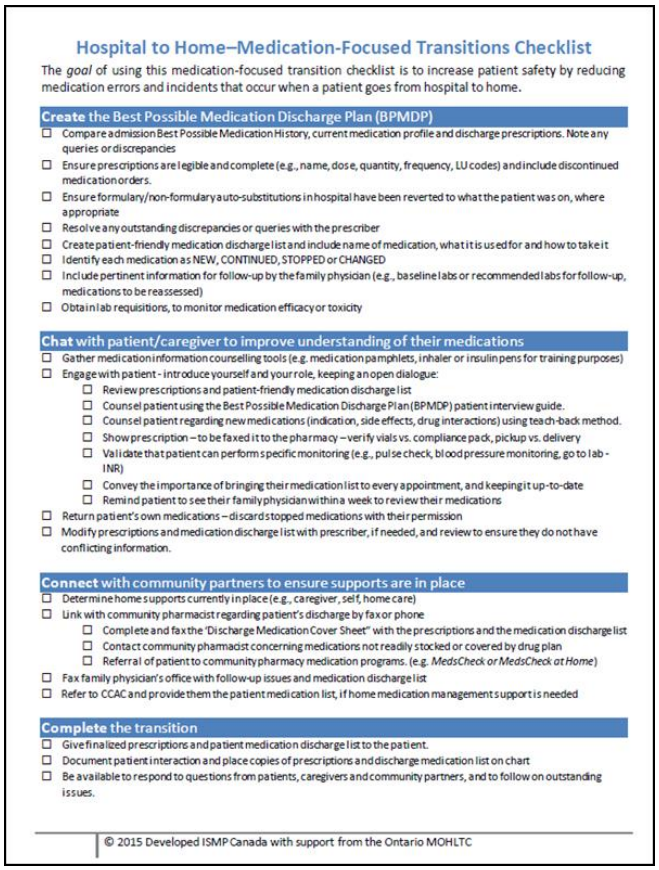
Medication Safety Self-Assessments®	• www.ISMP-canada.org/mssa
Hospital to Home Checklist and Toolkit	• www.ISMP-canada.org/ocil
Epidural Label Safety Checklist	• www.ISMP-canada.org/mssa

Complimentary

Questions? email info@ISMP-canada.org

Complimentary Across Canada





Hospital to Home–Medication-Focused Transitions Checklist

The *goal* of using this medication-focused transition checklist is to increase patient safety by reducing medication errors and incidents that occur when a patient goes from hospital to home.

Create the Best Possible Medication Discharge Plan (BPMDP)

- ☐ Compare admission Best Possible Medication History, current medication profile and discharge prescriptions. Note any queries or discrepancies
- ☐ Ensure prescriptions are legible and complete (e.g., name, dose, quantity, frequency, LU codes) and include discontinued medication orders.
- ☐ Ensure formulary/non-formulary auto-substitutions in hospital have been reverted to what the patient was on, where appropriate
- ☐ Resolve any outstanding discrepancies or queries with the prescriber
- ☐ Create patient-friendly medication discharge list and include name of medication, what it is used for and how to take it
- ☐ Identify each medication as NEW, CONTINUED, STOPPED or CHANGED
- ☐ Include pertinent information for follow-up by the family physician (e.g., baseline labs or recommended labs for follow-up, medications to be reassessed)
- ☐ Obtain lab requisitions, to monitor medication efficacy or toxicity

Chat with patient/caregiver to improve understanding of their medications

- ☐ Gather medication information counselling tools (e.g. medication pamphlets, inhaler or insulin pens for training purposes)
- ☐ Engage with patient - introduce yourself and your role, keeping an open dialogue:
  - ☐ Review prescriptions and patient-friendly medication discharge list
  - ☐ Counsel patient using the Best Possible Medication Discharge Plan (BPMDP) patient interview guide.
  - ☐ Counsel patient regarding new medications (indication, side effects, drug interactions) using teach-back method.
  - ☐ Show prescription – to be faxed it to the pharmacy – verify vials vs. compliance pack, pickup vs. delivery
  - ☐ Validate that patient can perform specific monitoring (e.g., pulse check, blood pressure monitoring, go to lab - INR)
  - ☐ Convey the importance of bringing their medication list to every appointment, and keeping it up-to-date
  - ☐ Remind patient to see their family physician within a week to review their medications
- ☐ Return patient's own medications – discard stopped medications with their permission
- ☐ Modify prescriptions and medication discharge list with prescriber, if needed, and review to ensure they do not have conflicting information.

Connect with community partners to ensure supports are in place

- ☐ Determine home supports currently in place (e.g., caregiver, self, home care)
- ☐ Link with community pharmacist regarding patient's discharge by fax or phone
  - ☐ Complete and fax the 'Discharge Medication Cover Sheet" with the prescriptions and the medication discharge list
  - ☐ Contact community pharmacist concerning medications not readily stocked or covered by drug plan
  - ☐ Referral of patient to community pharmacy medication programs. (e.g. *MedsCheck or MedsCheck at Home*)
- ☐ Fax family physician's office with follow-up issues and medication discharge list
- ☐ Refer to CCAC and provide them the patient medication list, if home medication management support is needed

Complete the transition

- ☐ Give finalized prescriptions and patient medication discharge list to the patient.
- ☐ Document patient interaction and place copies of prescriptions and discharge medication list on chart
- ☐ Be available to respond to questions from patients, caregivers and community partners, and to follow on outstanding issues.

Available at www.ISMP-canada.org/ocil

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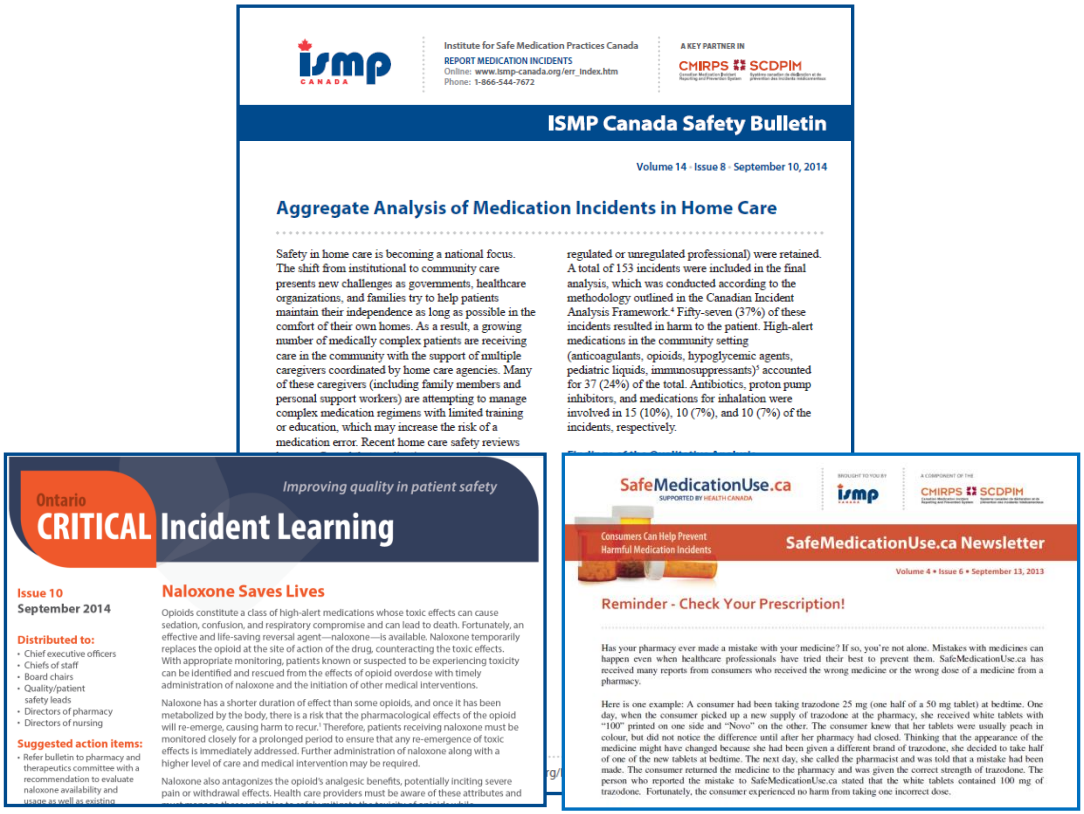

ISMP CANADA

Institute for Safe Medication Practices Canada
REPORT MEDICATION INCIDENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

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ISMP Canada Safety Bulletin

Volume 14 · Issue 8 · September 10, 2014

Aggregate Analysis of Medication Incidents in Home Care

Safety in home care is becoming a national focus. The shift from institutional to community care presents new challenges as governments, healthcare organizations, and families try to help patients maintain their independence as long as possible in the comfort of their own homes. As a result, a growing number of medically complex patients are receiving care in the community with the support of multiple caregivers coordinated by home care agencies. Many of these caregivers (including family members and personal support workers) are attempting to manage complex medication regimens with limited training or education, which may increase the risk of a medication error. Recent home care safety reviews

regulated or unregulated professional) were retained. A total of 153 incidents were included in the final analysis, which was conducted according to the methodology outlined in the Canadian Incident Analysis Framework.[4] Fifty-seven (37%) of these incidents resulted in harm to the patient. High-alert medications in the community setting (anticoagulants, opioids, hypoglycemic agents, pediatric liquids, immunosuppressants)[5] accounted for 37 (24%) of the total. Antibiotics, proton pump inhibitors, and medications for inhalation were involved in 15 (10%), 10 (7%), and 10 (7%) of the incidents, respectively.

Ontario CRITICAL Incident Learning

Improving quality in patient safety

Issue 10
September 2014

Distributed to:
- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy
- Directors of nursing

Suggested action items:
- Refer bulletin to pharmacy and therapeutics committee with a recommendation to evaluate naloxone availability and usage as well as existing

Naloxone Saves Lives

Opioids constitute a class of high-alert medications whose toxic effects can cause sedation, confusion, and respiratory compromise and can lead to death. Fortunately, an effective and life-saving reversal agent—naloxone—is available. Naloxone temporarily replaces the opioid at the site of action of the drug, counteracting the toxic effects. With appropriate monitoring, patients known or suspected to be experiencing toxicity can be identified and rescued from the effects of opioid overdose with timely administration of naloxone and the initiation of other medical interventions.

Naloxone has a shorter duration of effect than some opioids, and once it has been metabolized by the body, there is a risk that the pharmacological effects of the opioid will re-emerge, causing harm to recur.[1] Therefore, patients receiving naloxone must be monitored closely for a prolonged period to ensure that any re-emergence of toxic effects is immediately addressed. Further administration of naloxone along with a higher level of care and medical intervention may be required.

Naloxone also antagonizes the opioid's analgesic benefits, potentially inciting severe pain or withdrawal effects. Health care providers must be aware of these attributes and

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Consumers Can Help Prevent Harmful Medication Incidents

SafeMedicationUse.ca Newsletter

Volume 4 • Issue 6 • September 13, 2013

Reminder - Check Your Prescription!

Has your pharmacy ever made a mistake with your medicine? If so, you're not alone. Mistakes with medicines can happen even when healthcare professionals have tried their best to prevent them. SafeMedicationUse.ca has received many reports from consumers who received the wrong medicine or the wrong dose of a medicine from a pharmacy.

Here is one example: A consumer had been taking trazodone 25 mg (one half of a 50 mg tablet) at bedtime. One day, when the consumer picked up a new supply of trazodone at the pharmacy, she received white tablets with "100" printed on one side and "Novo" on the other. The consumer knew that her tablets were usually peach in colour, but did not notice the difference until after her pharmacy had closed. Thinking that the appearance of the medicine might have changed because she had been given a different brand of trazodone, she decided to take half of one of the new tablets at bedtime. The next day, she called the pharmacist and was told that a mistake had been made. The consumer returned the medicine to the pharmacy and was given the correct strength of trazodone. The person who reported the mistake to SafeMedicationUse.ca stated that the white tablets contained 100 mg of trazodone. Fortunately, the consumer experienced no harm from taking one incorrect dose.

Visit www.ISMP-canada.org and click on Stay Informed at the bottom of the home page

Improving quality in patient safety

Ontario CRITICAL Incident Learning

Thank you for attending

Additional questions?
email info@ISMP-canada.org

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We all have a role in preventing harm from medication incidents.

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