Demystifying the Critical Incident Reporting Process

October 21, 2015
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.”

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

- **2010**: Launch to acute care
- **2011**: Launch to long-term care
  - MOHLTC ON reporting
- **2012**: Enhancements to collect chemotherapy information
- **2013**: Launch of batch upload functionality
- **2014**: Reporting tool upgrades
- **2015**: Expansion to radiotherapy
Medication Incident Reporting to NSIR

Incident Occurs → Facility Internal Process → Initial Submission to NSIR → Final Submission to NSIR
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

Who Were Involved in Incident  Select all that apply

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NSIR Incident Submission Processing

1. Incident is Final and Sent to NSIR
2. System Edit Checks
3. Identifier Review (*Second Reviewer)
4. Released for Analysis
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”

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

1. Critical Incident Reported to NSIR
2. ISMP Canada Review by Candace Epworth
3. ISMP Canada Review by Team
Critical Incident Reporting Process

1. Critical Incident Reported to NSIR
2. ISMP Canada Review by Candace Epworth
3. ISMP Canada Review by Team
4. Dissemination of Ontario Critical Incident Learning
   - Opioid Stewardship
   - Patient Brochures
   - Bulletins
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.
Changing to a Culture of Safety

Person Approach

vs.

Systems Approach
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

“You weren’t listening. I said, ‘Don’t fall.’”
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
"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

<table>
<thead>
<tr>
<th></th>
<th>Example Order: 60 Regular Insulin Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handwritten Orders</td>
<td></td>
</tr>
<tr>
<td>Problematic Abbreviations</td>
<td>Result: 10-fold dosing error &amp; patient harm</td>
</tr>
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<td></td>
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### Many Factors Lead to System Errors

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Many Factors Lead to System Errors

- Hand
- Problematic Abbreviations
- Confirmation
- Bias
- Environmental Factors
- Multiple Distractions

Result: 10-fold dosing error & patient harm

The power of the human mind

Now read
## Many Factors Lead to System Errors

<table>
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<th>Handwritten Orders</th>
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<td></td>
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Many Factors Lead to System Errors

Figure 1. Link analysis for RN #1

Result: 10-fold dosing error and patient harm
Many Factors Lead to System Errors

<table>
<thead>
<tr>
<th>Poor Handwriting</th>
<th>60 Regular Insulin Now</th>
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Incident Reporting
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
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
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

<table>
<thead>
<tr>
<th>Description of Incident</th>
<th>Fictional Case</th>
</tr>
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<tbody>
<tr>
<td><strong>Describe medication error with as much detail as possible</strong></td>
<td>Patient ordered Hydromorphone 2mg po q4h prn. Nurse gave 2mg IV push. Patient found unresponsive, unable to resuscitate.</td>
</tr>
<tr>
<td><strong>Contributing factors:</strong></td>
<td>distractions/frequent interruptions, attention issues-failure to remember, performance factors-unspecified, drug product confusion, work around-shortcut, delay in action.</td>
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**Example of Good Reporting**

<table>
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</thead>
<tbody>
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<td>Describe medication error with as much detail as possible</td>
<td>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.</td>
</tr>
<tr>
<td>Contributing factors</td>
<td>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.</td>
</tr>
</tbody>
</table>
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

Critical Incident Reported to NSIR

ISMP Canada Review by Candace Epworth

ISMP Canada Review by Team

Dissemination of Ontario Critical Incident Learning

Opioid Stewardship

Patient Brochures

Bulletins
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

Hierarchical Leverage

- **High Leverage (MOST EFFECTIVE)**
  - Forcing functions and constraints (e.g., removal of a product from use)
  - Automation or computerization (e.g., automated patient-specific dispensing)

- **Medium Leverage (MODERATELY EFFECTIVE)**
  - Simplification and standardization (e.g., standardized paper or electronic order sets)

- **Low Leverage (LEAST EFFECTIVE)**
  - Reminders, checklists, double checks (e.g., independent double checks for high-alert medications)
  - Education and information (e.g., education sessions on high-alert medications)
  - Rules and policies (e.g., policies to prohibit borrowing doses from other areas)

Suggested action items:
- Circulate bulletin to frontline 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

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

Issue 4
April 2013
Critical Incident Reporting Process

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Opioid Stewardship

Opioid medications are used to treat pain. Opioids are also known as narcotics. In recent years, the use of opioids has increased. Along with this increased use of opioids there has also been a corresponding and alarming increase in opioid-related harms. ISMP Canada is the leading medication safety organization in Canada. Through our ongoing analysis and research, including death when they are prescribed, used or administered incorrectly or in error.

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

WATCH and learn:

VIDEO: Consumers Can Help Prevent Harm from Opioid Use!
Critical Incident Reporting Process

Critical Incident Reported to NSIR

ISMP Canada Review by Candace Epworth

ISMP Canada Review by Team

Dissemination of Ontario Critical Incident Learning

- Opioid Stewardship
- Patient Brochures
- Bulletins
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

Pain Management Not Effective Safe Balance Dangerous Side Effects

How is pain assessed?

• Pain scales (e.g., 0 to 10) 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.

Examples of Opioids

<table>
<thead>
<tr>
<th>GENERIC NAME</th>
<th>BRAND NAMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Tylenol #1,2,3; Atosol 8,15,30</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Duragesic</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Dilaudid, Hydromorph Contin</td>
</tr>
<tr>
<td>Morphine</td>
<td>Statex, MS Contin, M-Eslon</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Percocet, OxyContin, OxyNEO</td>
</tr>
<tr>
<td>Tramadol</td>
<td>Tramacet, Ultram, Zytram XL</td>
</tr>
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HYDROmorphe remains a high-alert drug

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

**Background**
- HYDROmorphe 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 HYDROmorphe 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 HYDROmorphe.
- Although the facility did not maintain high-concentration HYDROmorphe as floor stock, it was not uncommon for nurses to borrow HYDROmorphe from patient-specific stock.
- The patient was found without vital signs shortly after administration of the HYDROmorphe.

**Learning from Analysis**
- Consistent with other reported HYDROmorphe administration errors, the availability of a high-concentration HYDROmorphe product played a significant role in the incident.¹
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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
Ontario Hospital Critical Incidents Related to Medications or IV Fluids Analysis Report

January to December 2014
# Critical Incidents

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>27</td>
</tr>
<tr>
<td>2013</td>
<td>29</td>
</tr>
<tr>
<td>2012</td>
<td>29*</td>
</tr>
</tbody>
</table>

*Proportional contribution from Year 2012
# Critical Incidents by Degree of Harm

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
<th>Severe harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>2013</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>2012</td>
<td>8*</td>
<td>21*</td>
</tr>
</tbody>
</table>

*Proportional contribution from Year 2012
In 2014, at what stage in the medication use process was a critical incident most likely to occur?

- Prescribing
- Transcribing
- Preparation/Dispensing
- Administration
- Monitoring
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
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
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
In 2014, what class of drug was more likely to be involved in a critical incident?

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

- Anti-neoplastic ➔ 4
- 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
2. Type your question in the chat box

3. Email your question to webinars@ISMP-canada.org
ISMP Canada’s Other Self Assessment Programs

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—FACILITATING SAFE MEDICATIONS AT TRANSITIONS TOOLKIT**

Developed by ISMP Canada with support from the Ontario Ministry of Health and Long Term Care

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<table>
<thead>
<tr>
<th>Hospital to Home—Medication-Focused Transitions Checklist</th>
</tr>
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<tbody>
<tr>
<td>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.</td>
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### Create the Best Possible Medication Discharge Plan (BPMDP)

- Compare a patient's discharge medication history, current medication profile and discharge prescriptions. Note any discrepancies or discontinuities.
- Ensure prescriptions are legible and complete (e.g., name, dose, quantity, frequency, and route) 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 a name of medication, what it is used for, and how to take it.
- Identify if the medication is 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 reinstalled).
- Obtain refill instructions, future or medication efficacy or toxicity.

### Chat with patient/caregiver to improve understanding of their medications

- Gather medication information (including tools e.g., medication calendars, infographic or worksheets for training purposes).
- Engage with patient to introduce yourself and your role, keeping an open dialogue.
- Review prescriptions and patient-friendly medication discharge list.
- Course patient using the Best Possible Medication Discharge Plan (BPMDP) patient interview guide.
- Provide patients regarding new medications (indication, side effects, drug interactions) using teach-back method.
- Show a sample to be filled in at pharmacy verifying dates, completeness, and eligibility for delivery.
- Validate that patient can perform specific monitoring (e.g., pulse check, blood pressure monitoring, go to lab — 1981).
- 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

- Review home location's current medication list (e.g., patient’s medication list).
- Link with community pharmacist regarding patient's discharge by 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.
- Refer to patients 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 CLIC and provide them the patient medication list, if home medication management is support is needed.

### Complete the transition

- Give finalised prescriptions and a patient medication discharge list to the patient.
- Document patient interaction and place copies of non-prescription medications in discharge medication list on chart.
- Be available to respond to questions from patients, caregivers, and community partners, and to follow-up on outstanding issues.

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Available at [www.ISMP-canada.org/ocil](http://www.ISMP-canada.org/ocil)

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Visit www.ISMP-canada.org and click on at the bottom of the home page
Thank you for attending

Additional questions?
email info@ISMP-canada.org
We all have a role in preventing harm from medication incidents.

Visit:
ISMP-canada.org
SafeMedicationUse.ca
Knowledgeisthebestmedicine.ca