Improving quality in patient safety

Ontario
CRITICAL Incident Learning

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## 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 quality and safety committees with suggestion that they consider using the new and/or updated resources to promote quality improvement activities related to medication management and to support accreditation preparation processes.
- Access the webinar on this topic at: www.ismp-canada.org/ocil

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# Resources to Sustain Incident Learning

Sharing of learning from critical incidents reported to the Ontario Critical Incident Learning (OCIL) program through the National System for Incident Reporting (NSIR) constitutes a vital component of healthcare quality improvement. Selected incidents reported and analyzed through the OCIL program are shared in safety bulletins. To aid in knowledge transfer and sustain learning from incident analyses, insight from these incidents has been incorporated into a variety of resources to assist healthcare providers and organizations in implementing system safeguards. These resources are designed to support continuous quality improvement and may also assist hospitals as they prepare for accreditation processes.

With support from the Ontario Ministry of Health and Long-Term Care, two new resources were recently developed by ISMP Canada: a toolkit to support the safe transition of patients and their medications out of acute care and a checklist to assess the safety of labels for epidural medications. In addition, the Hospital Medication Safety Self-Assessment (MSSA) has been updated to include learning from critical incidents reported through the OCIL program.

### Hospital to Home – Facilitating Safe Medications at Transitions Toolkit – NEW

The goal of the new "Hospital to Home" toolkit is to enhance patient safety by reducing the occurrence of medication discrepancies (e.g., omissions, duplications) that could lead to errors upon transition from hospital to home, particularly for patients with complex or high-risk medication regimens. An aggregate analysis of medication incidents in home care showed that a significant number of reported incidents occurred after discharge from hospital.[1] Additionally, research has shown that readmission rates are higher among patients with medication discrepancies after discharge from hospital than among those for whom no discrepancies are identified (14.3% vs. 6.1%).[2]

The new toolkit includes evidence supporting the benefits of pharmacist involvement in the discharge process for patients with complex or high-risk medication regimens and recommendations for linking with community partners to ensure supports are in place to complete transitions safely. The toolkit also includes a checklist that can be incorporated into day-to-day practice by front-line healthcare providers. The checklist consists of the following 4 broad activities, each of which has several sub-steps:

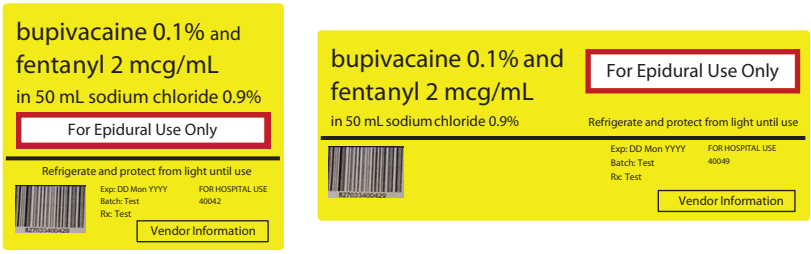
1. Create a Best Possible Medication Discharge Plan for the patient;
2. Chat with the patient and/or a caregiver to improve their understanding of the patient's medications;
3. Connect with community partners to ensure that supports are in place; and
4. Complete the transition.

### Epidural Label Safety Checklist – NEW

With the release of Dr. Jake Thiessen's review of the oncology under dosing incident in 2013;[3] increased attention has been given to medication labelling within and beyond the oncology setting. One focus of this attention has been the labelling of medications administered by the epidural route, including local anesthetics and opioids. A major risk with epidural products is that, because they are supplied in minibags or parenteral syringes, they physically resemble products intended for intravenous infusion. However, fatal consequences may result if anesthetics intended for epidural administration are inadvertently given by the intravenous route. A key recommendation in the checklist is to present the anesthetic agent first on the label, as it is the most physiologically active component and the most likely to cause harm if the medication is administered incorrectly.[4]

The Epidural Label Safety Checklist was designed with 3 goals in mind: 1) to heighten awareness of the characteristics of a safe label for medications intended for administration by the epidural route; 2) to assist hospitals, specialty pharmacies, drug preparation premises, and manufacturers to evaluate the content and design of labels for epidural products; and, 3) to provide a baseline for organizational efforts to enhance the safety of epidural medication use. The checklist consists of 14 items in 4 sections, covering label content, label design, position of the label on the bag or syringe, and other general safety considerations for epidural products.

**Figure 1:** Examples of possible label designs for epidural syringes*




**These labels are provided as illustrative examples only and should not be considered for implementation without review of applicable labelling regulations/guidelines and testing by end-users.*

Upon submission of results, participants are able to immediately view their own results and compare them with the aggregate response. With repeated assessments, participants will also be able to track their progress over time.

## Hospital Medication Safety Self-Assessment – UPDATED

The 2015 Hospital Medication Safety Self-Assessment (MSSA), (Canadian Version III), incorporates new learning from the OCIL program, as well as learning from other incidents reported to ISMP Canada and adapted content from the 2011 MSSA for Hospitals developed by ISMP (US).[5] Hospitals completing previous versions of the MSSA for Hospitals have found it to be an effective way to proactively evaluate their respective medication-use systems,[6] to help maintain momentum for quality improvement activities related to medication management, and to enhance awareness of safety issues in the medication-use system.

The self-assessment is divided into 10 elements that most strongly influence the safety of medication use in hospitals. Many items from the Hospital MSSA have been adopted or adapted for inclusion in Accreditation Canada's Medication Management Standards and Required Organizational Practices, and the Hospital MSSA is referenced within the standards as a tool for regular evaluation of the medication-use system. The Accreditation Canada Medication Management Standards suggest the Hospital MSSA as a tool for regular evaluation of the medication-use system. By completing the MSSA for Hospitals, individual institutions can track improvements from previous years and compare their own data with responses of other comparable facilities.

## Accessing the new resources:

These new resources are available on the OCIL page of the ISMP Canada website: www.ismp-canada.org/ocil . The "Hospital to Home" transitions toolkit is available complimentary to all practitioners. The Epidural Label Safety Checklist and the upcoming Hospital MSSA are available at no charge to Ontario hospitals.

References for this bulletin are available at: www.ismp-canada.org/download/ocil/ISMPCONCIL2015-13_IncidentLearning_References.pdf

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**Medication Safety bulletins contribute to Global Patient Safety Alerts**



## Collaborating parties of the Ontario Critical Incident Reporting program

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