Supporting Medication System Safety
and Preparing for Accreditation

Applying New Tools for Home and Community Care and Acute Care

June 23, 2015

Presented with support from Ontario

Objectives

At the end of this session, participants will understand:

- The importance of regular evaluation of medication system safety
- How ISMP Canada's customized Medication Safety Self-Assessment® programs can be used to provide comprehensive interdisciplinary medication system review and prepare for Accreditation Canada surveys
- How customized medication safety checklists can be used to focus and support improvement efforts.

Alignment with Accreditation Canada Standards and ROPs

- ISMP Canada and Accreditation have very complementary mandates
  - Many ISMP Canada recommendations have been incorporated into Accreditation ROPs and standards
- This webinar will provide some illustrative examples of how new ISMP Canada tools and resources support organizations to prepare for Accreditation
- Consult Accreditation Canada for details on the Qmentum program and tests for compliance

About ISMP Canada

Incorporated in 2000 for the purpose of analysis of medication incidents, sharing the learning, and making recommendations for medication system safeguards.

Independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings.

Our goal is the creation of safe and reliable **systems** for managing medications.

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Advancing safe medication use

The Institute for Safe Medication Practices Canada is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada works 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. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

CMIRPS
Supported by Health Canada

Community Pharmacy PROGRAMS

SafeMedicationUse.ca *for consumers*

Reporting and Prevention Systems

REPORT a Medication Incident

Medication Incident and Near Miss Reporting Programs for:

- Practitioners
- General Public (SafeMedicationUse.ca)

Ontario MOHLTC Supported Initiatives

Ontario Critical Incident Learning

- Hospital-Acquired Hyponatremia - Resources for Safety
- Safe Use of Insulin Interventions
- Safe Use of Insulin Pen e-Learning Module
- Safer Medication Use in Older Persons

Multi-Stakeholder Projects

Opioid Stewardship

Drug Shortage Safety

Medication Reconciliation

Canadian Incident Analysis Framework

Upcoming ISMP Canada Events

Workshops	Wednesday, June 10, 2015	Resolving Drug-Drug Interactions: *A Guide for Community Pharmacies to Reduce Potential Hospitalizations* - Toronto, ON - **All Sessions are FULL**
	June 11-12, 2015	Medication Safety for Pharmacy Practice: *Incident Analysis and Prospective Risk Assessment* - Toronto, ON
	Thursday, June 18, 2015	Resolving Drug-Drug Interactions: *A Guide for Community Pharmacies to Reduce*

SafeMedicationUse.ca

SUPPORTED BY HEALTH CANADA

Help Prevent Harmful Medication Incidents

A component of the Canadian Medication Incident Reporting and Prevention System (**CMIRPS**).

Preventing harm from medication incidents is a responsibility of health professionals. **Consumers like you** can also play a vital role.

Reporting Medication Incidents benefits all Canadians.

REPORT NOW

- About SafeMedicationUse.ca
- About Medication Incidents
- Why Report?
- Resolving Concerns About the Safety of Your Care
- Frequently Asked Questions (FAQs)
- Your privacy

Sign up to receive the latest Alerts and Newsletters:

Your Email SIGN UP

Tell Us How We're Doing:

TAKE THE SURVEY

Pilot funding provided by Health Canada

Latest News and Resources

SHARE

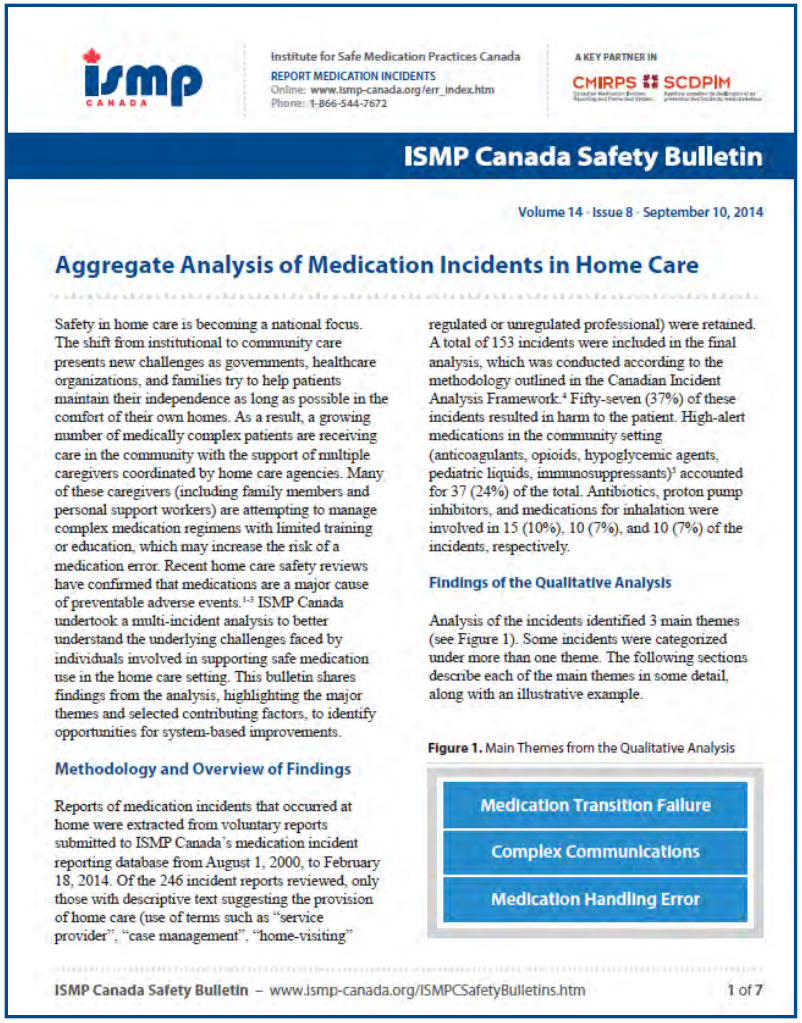
- Caution: Not All Medicines Are Taken Every Day 2015-03-31
- Beware: Medicine Names May Sound Alike, but the Medicines May Be Very Different! 2015-03-18
- Same Brand Name, Different Ingredient 2015-02-12
- Confusion with a Baby's Dose of Medicine 2015-01-14
- Reminder: Pay Attention to the Appearance of Your Medicines 2014-12-02
- Health Canada Advisory - Unlicensed Home-Use HIV Test Kits via amazon.ca
- Health Canada Advisory - Health Canada reminds Canadians not to use unauthorized health products
- Know When Your Medicine Should Be Stopped! 2014-11-04
- SafeMedicationUse.ca's Jennifer Turple talks about medication safety and drug interactions on CBC (interview starts at the 22nd minute)
- One Simple Solution for Medication Safety – Doc Mike Evans Video now available!
- Additional information on Mylan Pharmaceuticals nitroglycerin spray recall

Data access and analysis is the foundation of ISMP Canada's work

Medication incidents submitted to ISMP Canada are analyzed

Incident reports received through:

Outputs from Incidents Submitted



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

A KEY PARTNER IN CMIRPS SCDPIM

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 have confirmed that medications are a major cause of preventable adverse events.[1-3] ISMP Canada undertook a multi-incident analysis to better understand the underlying challenges faced by individuals involved in supporting safe medication use in the home care setting. This bulletin shares findings from the analysis, highlighting the major themes and selected contributing factors, to identify opportunities for system-based improvements.

Methodology and Overview of Findings

Reports of medication incidents that occurred at home were extracted from voluntary reports submitted to ISMP Canada's medication incident reporting database from August 1, 2000, to February 18, 2014. Of the 246 incident reports reviewed, only those with descriptive text suggesting the provision of home care (use of terms such as "service provider", "case management", "home-visiting" 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.

Findings of the Qualitative Analysis

Analysis of the incidents identified 3 main themes (see Figure 1). Some incidents were categorized under more than one theme. The following sections describe each of the main themes in some detail, along with an illustrative example.

Figure 1. Main Themes from the Qualitative Analysis

- Medication Transition Failure
- Complex Communications
- Medication Handling Error

SafeMedicationUse.ca
SUPPORTED BY HEALTH CANADA

BROUGHT TO YOU BY ISMP CANADA

A COMPONENT OF THE CMIRPS SCDPIM

Consumers Can Help Prevent Harmful Medication Incidents

SafeMedicationUse.ca Newsletter

Volume 4 • Issue 7 • October 29, 2013

Good Communication Can Help Prevent Harmful Mistakes with Medicines!

Everyone experiences communication problems at one time or another. Maybe you've missed a meeting because you weren't told that the location had been changed. Or perhaps you've bought the wrong size or brand of an item at the supermarket because you didn't get enough information from the person who asked you to pick it up. Most communication mistakes cause nothing more than an inconvenience. But when it comes to medicines, a lapse in communication could lead to a mistake that could in turn cause serious harm.

Here is an example of an incident involving a communication breakdown that was reported to SafeMedicationUse.ca. A consumer was taking a medicine called ramipril to control high blood pressure. This medicine comes in several different strengths. The consumer had been taking two of the 10 mg capsules every day, for a total daily dose of 20 mg. However, the doctor thought the consumer was taking two of the 2.5 mg capsules, for a total daily dose of 5 mg. The consumer's blood pressure was still a bit too high, and the doctor instructed her to increase the dose to 3 or 4 capsules a day.[1] Using the 2.5 mg capsules, the total daily dose would have been 7.5 mg to 10 mg. However, because the consumer used the 10 mg capsules she had on hand, she took 4 times the amount of ramipril that the doctor had intended! Eventually, a family member realized what had happened. The family had some difficulties sorting out the mix-up with the doctor's office and the pharmacy, but fortunately no harm was reported.

Figure 1 - Example of a Prescription Label *

LOCAL PHARMACY
123 MAIN STREET
CITY, PROVINCE
555-123-4567
RX: 9876543 REF:3 DR. V. FRIENDLY
PATIENT, NAME
TAKE 2 CAPSULES ONCE DAILY
ABC-RAMIPRIL 10 MG
RAMIPRIL 10 MG
30 CAPSULES
ABC
01234556
KEEP OUT OF REACH OF CHILDREN
Generic Name & Strength
Brand Name & Strength
Total amount in each dose = Number of capsules (2) x Strength (10 mg) = 20 mg

*Example only, not all prescription medicine labels will appear exactly as shown

SafeMedicationUse.ca has the following suggestions for preventing communication problems with your medicines:

- Keep a list of all your medicines and how to take them. Be sure to update your list whenever there is a change in any of your medicines. Always show the list to healthcare providers when you receive care.
- Know **the strength per unit** of each medicine you are taking or using, the **total amount to be taken for each dose** and how many times a day you take it. **The dose and strength are often expressed in grams, milligrams, micrograms, or units (see Figure 1).** It is important to know this information for all forms of your medicines (for example, patches, liquids, creams, drops, injections, and inhalers, as well as tablets and capsules). Document this information on your list of medicines.

Ontario CRITICAL Incident Learning

Improving quality in patient safety

Ontario Critical Incident Learning

Improving quality in patient safety

SHARE

Home | Collaboration

To advance the patient safety agenda, in August 2011 the Ontario Ministry of Health and Long-Term Care issued a directive that hospitals must report critical incidents involving medications and intravenous fluids to the Canadian Institute for Health Information National System for Incident Reporting (NSIR). A critical incident is an "unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment".

ISMP Canada has been identified as the lead organization for analysis of the reported incidents. A multidisciplinary team reviews each submitted critical incident report to ensure effective identification of the contributing factors. In addition, ISMP Canada will periodically conduct aggregate analysis of reported incidents to provide a more in-depth assessment of events involving a particular medication or care setting. On the basis of these analyses, ISMP Canada will develop and disseminate outcome-directed recommendations, with an emphasis on high-leverage actions that take into account human factors engineering principles and the need to design systems with integrated safeguards.

Bulletins:

- Fluid Management - Iss.12/2015
- Multiple IV Infusions: Risks and Recommendations - Iss.11/2014
- Naloxone Saves Lives - Iss.10/2014
- Sharing Insulin Pens is a High-Risk Practice - Iss.9/2014
- Safe Pain Control in the Emergency Department - Iss.8/2014
- Smart Pumps Need Smart Systems - Iss.7/2014
- Monitoring Processes Contribute to Safe Use of Warfarin - Iss.6/2013
- Promoting the Safe Use of Insulin in Hospitals - Iss.5/2013
- Designing Effective Recommendations - Iss.4/2013
- Quality Medication Reconciliation Processes Are Critical - Iss.3/2013
- HYDROmorphone remains a high-alert drug - Iss.2/2013
- Mandatory Reporting—Can We Do Better? - Iss.1/2012

Analysis Report:

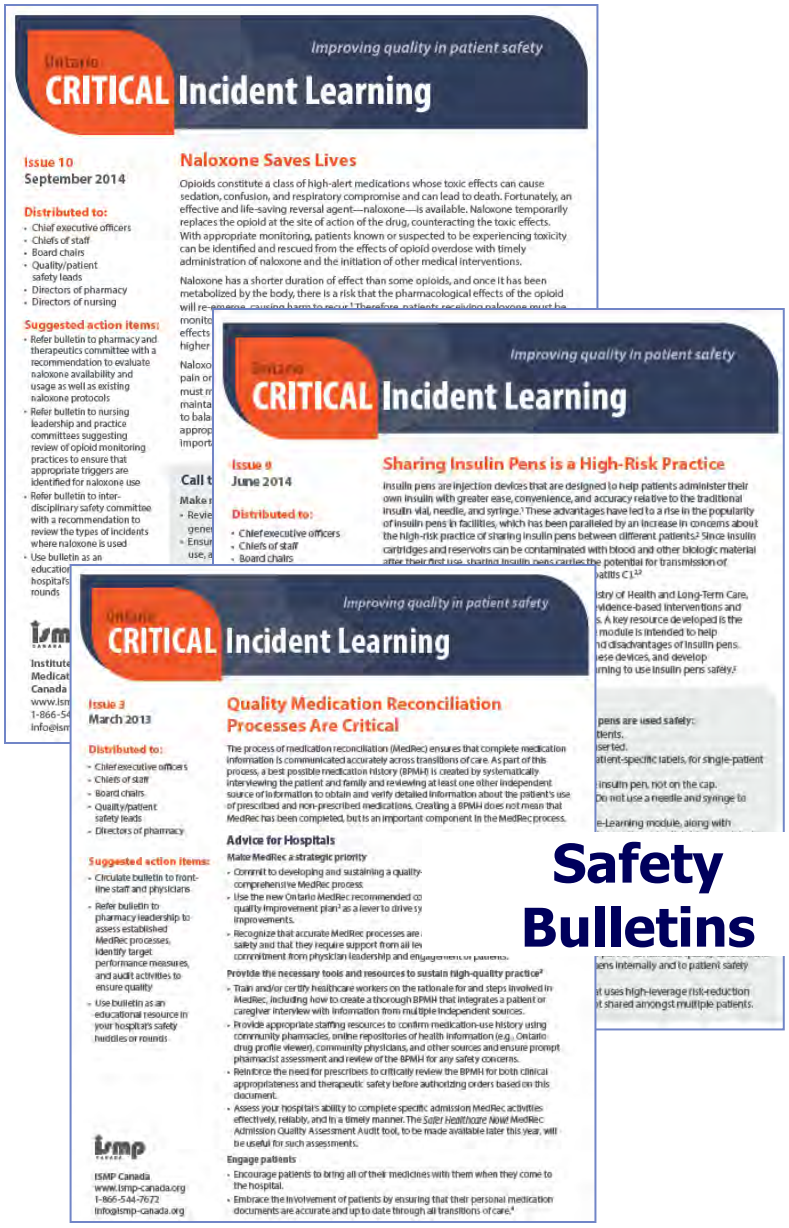
- Ontario Hospital Critical Incidents Related to Medications or IV Fluids Analysis Report - 2014
- Ontario Hospital Critical Incidents Related to Medications or IV Fluids Analysis Report - 2013

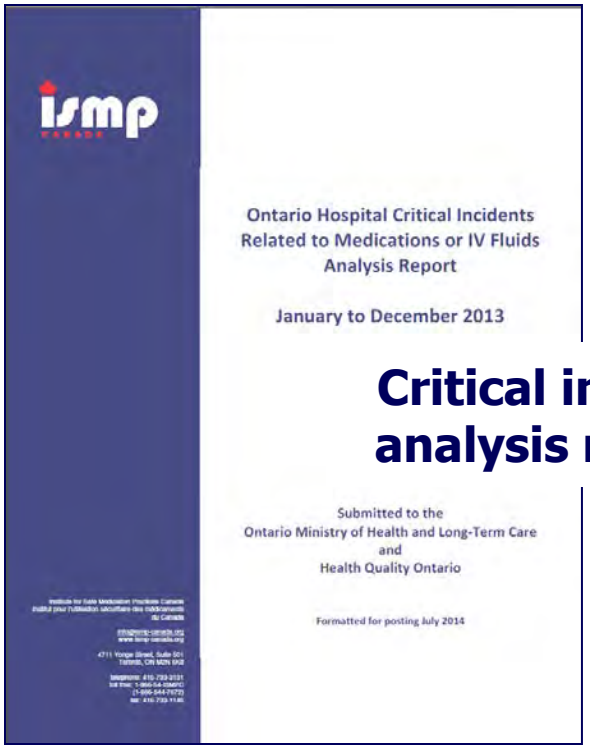
Webinars:

- Supporting Medication System Safety and Preparing for your Accreditation Survey: Applying New Tools for Home and Community Care and Acute Care - 2015/06/23
- Medication Safety Learning from Ontario Coroners' Cases - Focus on Opioids - 2013/03/06
- Hospital Related Deaths: The Role of the Coroner's Office in Enhancing Patient Safety - 2013/01/31

Knowledge Translation Projects:

- Insulin Use Interventions/Safeguards





Critical incident analysis reports

Knowledge translation projects – e.g., Insulin Use Interventions; see: http://www.ismp-canada.org/insulin/

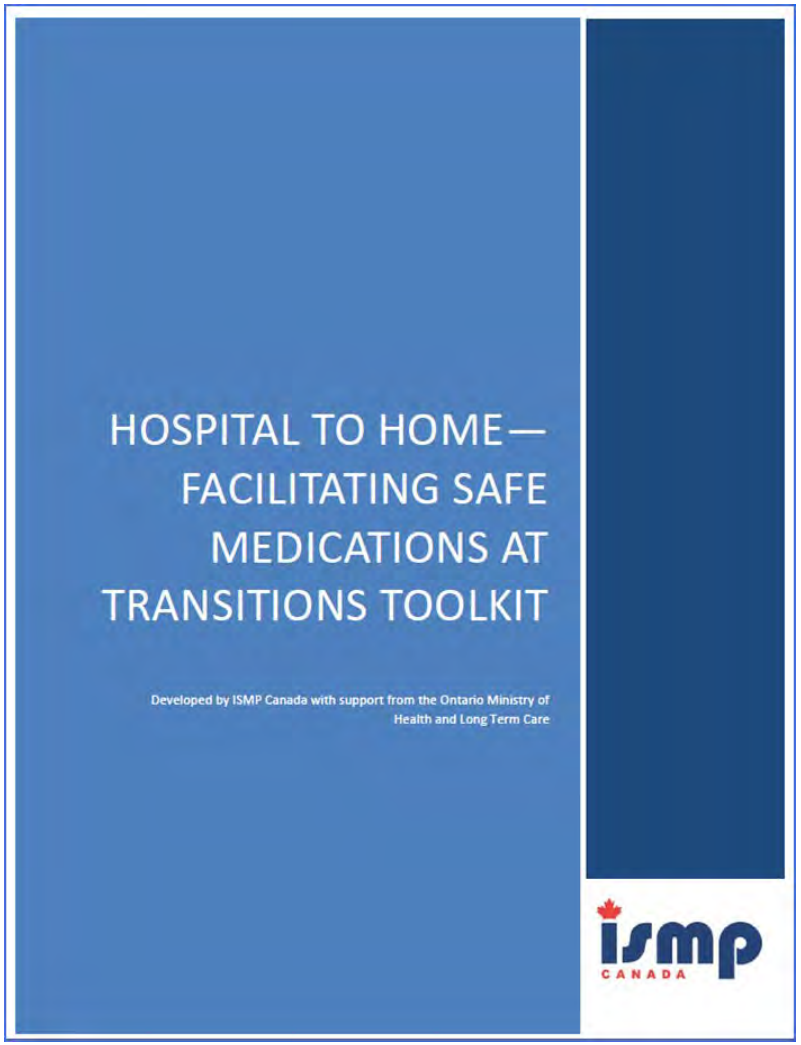
New Resources

For Home and Community Care:

- Home Care Organizations Medication Safety Self-Assessment®
- Home and Community Care Personal Support Worker Organizations Medication Safety Self-Assessment®

For Acute Care:

- Hospital to Home – Facilitating Safe Medications at Transitions Toolkit
- Epidural Label Safety Checklist
- Updated Hospital Medication Safety Self-Assessment®

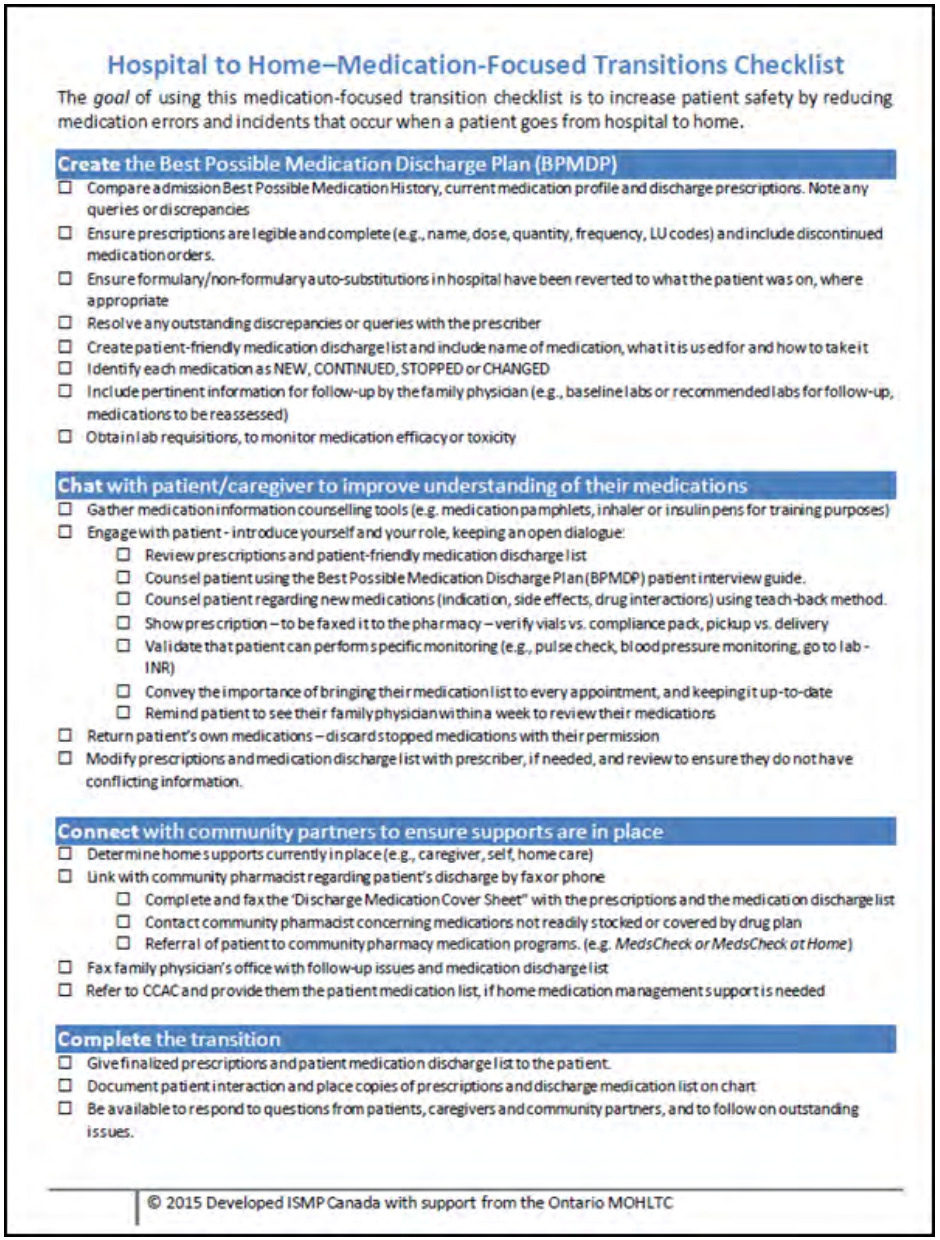


New Hospital to Home Facilitating Safe Medication Transitions Toolkit

Lisa Sever
Medication Safety Specialist
ISMP Canada, and
Medication Safety Lead at
Home Care Rx

Contents of the Toolkit

- Patient story
- How this will benefit the patient experience
- Rationale for developing a toolkit and checklist
- Identify your target population
- Define key players- roles and responsibilities
- Home support for medication follow-up
- Pharmacists – a good return on investment
- Change ideas, overcoming barriers



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.

And the Checklist….

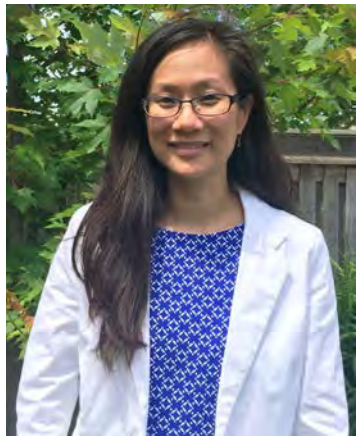
Interventions to reduce medication errors when a patient goes from hospital to home

Comment from a pilot site

"It is one of the most rewarding parts of my job, improving the patient's understanding of their medications and to help them feel more confident about taking their medications when they go home. It really helps improve their overall experience at the hospital if we take the time to address all of their medication questions and ensure supports are there for them if they need it.

The checklist prompts me to systematically go through each step so that the medication information we send with the patient and to their healthcare providers is accurate and complete. It's about passing the baton to ensure the patient can succeed at home."

Clinical pharmacist



Alice Watt

Clinical Pharmacist
Markham Stouffville Hospital Corporation, and
Medication Safety Specialist
ISMP Canada

Alignment with Accreditation Canada Required Organizational Practices (ROPs)

- Medication reconciliation as a strategic priority
- Medication reconciliation at care transitions
- Information transfer at care transitions

Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

ROP: Information transfer at care transitions

Tests for compliance	Assists
The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, transfer, and discharge	√
Documentation tools and communication strategies are used to standardize information transfer at care transitions.	√
During care transitions, clients and families are given information that they need to make decisions and support their own care.	√
Information shared at care transitions is documented.	√
The effectiveness of communication is evaluated and improvements are made based on feedback received.	

Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

New Medication Safety Self-Assessments® for the Home and Community Care Sectors

Lisa Sever
Medication Safety Specialist
ISMP Canada, and
Medication Safety Lead at
Home Care Rx

Medication systems are complex

- Integration of patient specific information
- Communication, sharing, interpretation, assessment and interventions related to medication information
- Handling, processing, labelling, assisting with, administering, monitoring and disposing of medications
- Responsibility, competency, collaboration and knowledge of the team / patient

Why do an MSSA?

- Indicates the organization is committed to improving medication safety
- Provides heightened awareness of safe medication practices in the home setting
- Initial assessment provides a baseline evaluation which can then be compared upon reassessment

How to conduct an MSSA

- Appoint a team leader
- Register with ISMP Canada
- Establish an interdisciplinary team, book two meetings (1-2 hrs in length)
- Team answers the questions and enters them into the secure ISMP Canada database
- Print, compare and examine report
- Choose medication safety initiatives to implement or refine in your organization

Sample Questions (Both MSSAs)

Rating Scale

A	This item is applicable, but there has been **no activity** to implement
B	This item has been **formally discussed for possible implementation, but is not implemented at this time**
C	This item has been **partially implemented, requires more internal development**
D	This item has been **partially implemented, requires more collaboration with partners**
E	This item has been **fully implemented**

	Self-Assessment Items	A	B	C	D	E
2.1	The organization has adopted a standardized definition for MEDICATION MANAGEMENT.					
2.2	There are standardized MEDICATION MANAGEMENT role definitions for each team member including patient, caregiver, staff, and unregulated and regulated providers.					
2.3	The organization has adopted criteria that identify patients in MEDICATION RISK situations. **FAQ 2.3**					

Sample Questions for PSW Organizations

The organization has a STANDARDIZED PROCESS, supported by a written policy and procedure, to create a client-specific MEDICATION CARE PLAN for monitoring the effects of medications and to follow through with appropriate interventions, when required.
The organization has a STANDARDIZED PROCESS to ensure the medication list and MEDICATION CARE PLAN are updated when changes are made and communicated to the assigned PSW.

Sample Questions for Home Care Organizations

All medication lists received from other care providers (e.g., hospital, physicians, nursing providers, pharmacists) are dated, stored in patient-specific records, and are shared with or viewable by all service providers supporting medication-related activities.

Laboratory results are stored in patient-specific records and are shared with or viewable by all service providers supporting medication-related activities.

PARENTERAL MEDICATION therapy referrals include patient weight, height, serum creatinine with date obtained and indication for use.

Norm Umali

Pharmacist

Toronto Central Community Care Access Centre

WOODGREEN

Opportunity made here.

Bruce Graham

Senior Manager Compliance and Innovation

WoodGreen Community Services

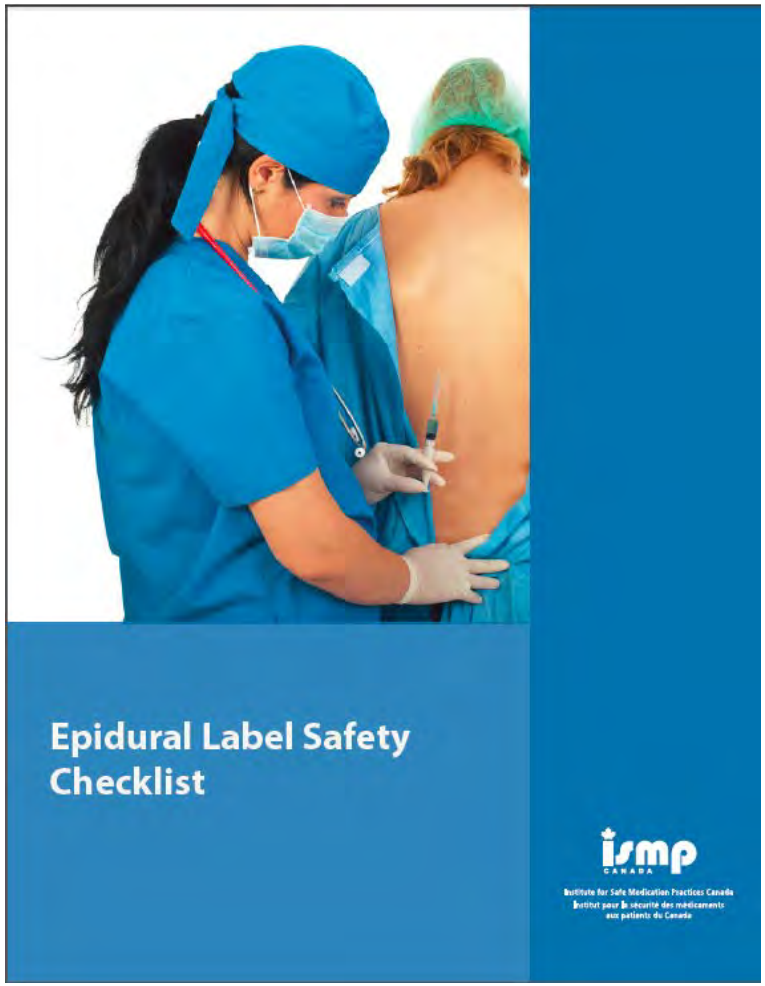
Accreditation Canada Required Organizational Practices (ROP)

- Client Safety Prospective Analysis

Tests for compliance	Assists
At least one prospective analysis has been completed within the past year.	√

Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

- Also, Medication Management standards recommend a regular comprehensive evaluation of the medication system



New Epidural Label Safety Checklist

Julie Greenall
Director of Projects and Education
ISMP Canada

Why a Checklist for Epidural Labels?

ISMP Canada Safety Bulletin

Reports of Epidural Infusion Errors

ISMP Canada Safety Bulletin

Epidural Medications Given Intravenously May Result in Death

- Increased attention to medication labelling beyond oncology (Thiessen Report, 2013*)
- Increased external compounding by specialty pharmacies, drug preparation premises, manufacturers
  - May increase variability in label information content and design vs. in-house preparation in hospitals.
- Particular risk – epidural products resemble products intended for intravenous use
  - Local anaesthetic component is cardiotoxic if given IV

*Thiessen JJ. A Review of the Oncology Under-Dosing Incident. A Report to the Ontario Minister of Health and Long-Term Care, July 12, 2013. Available from: http://www.health.gov.on.ca/en/public/programs/cancer/drugsupply/docs/report_thiessen_oncology_under-dosing.pdf

Why a Checklist for Epidural Labels?

It is **crucial to consider the intended use of the product and the needs of the end user** for each medication label

Label content and design have been identified as contributing factors to numerous medication incidents

Epidural Label Safety Checklist

Designed to:

- Heighten awareness of the characteristics of a safe label for medications intended for administration by the epidural route
- Assist organizations to evaluate label content and design for epidural products
- Provide a baseline for hospital efforts to enhance the safety of epidural medication use

Checklist Content

- 14 items in 4 sections:
  - Label content
  - Label design
  - Label position
  - Other considerations

Checklist Content

A	There has been **no activity** to implement this item for any epidural labels
B	This item has been **formally considered but not implemented** for any epidural labels
C	This item has been **partially implemented for some epidural labels** or in some areas of the organization
D	This item is **fully implemented for all epidural labels in some areas** of the organization
E	This item is **fully implemented for all epidural labels throughout** the organization
NA	**Not applicable; selected items only**

1. LABEL CONTENT

1.4	For epidural products containing both a local anaesthetic and an opioid, the anaesthetic agent is listed first on the label followed by the opioid (e.g., bupivacaine 0.1% and fentanyl 2 mcg/mL). *Choose NA if your organization does not use or prepare epidurals with more than one ingredient.*

Pilot Test Results

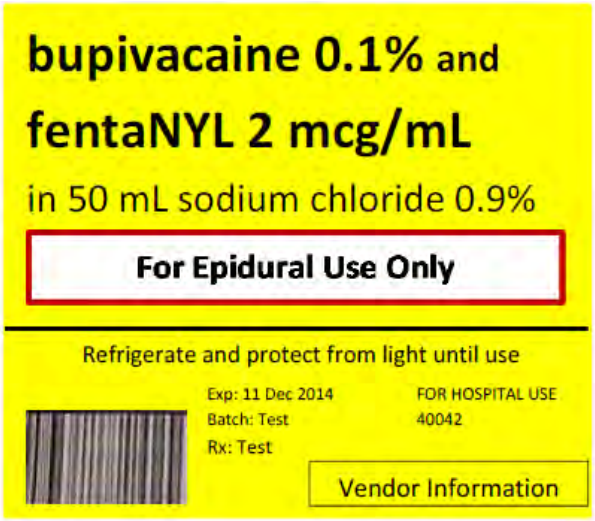
Participation:

- 142 downloads
- 47 password requests
- 12 organizations submitted data

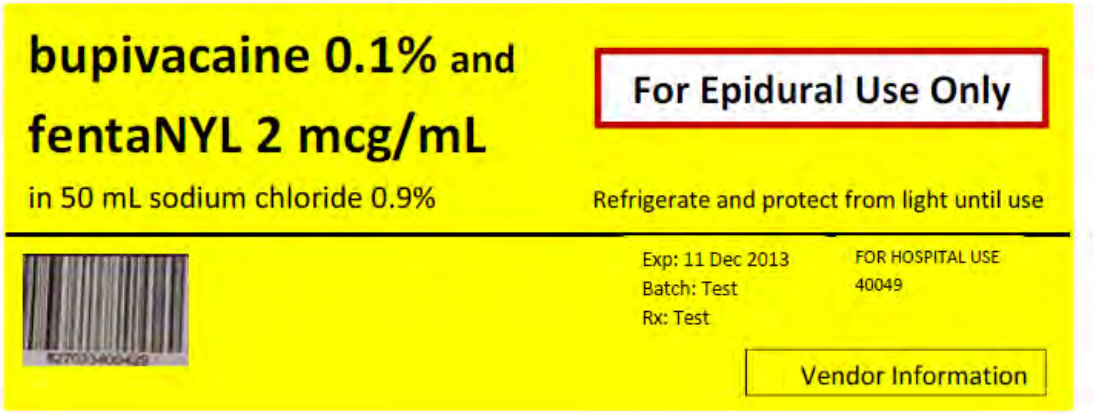
Results:

Item Number	Assessment item	% of achievable score
1.5	For epidural products containing both a local anaesthetic and an opioid, the anaesthetic agent is listed first on the label	52.1
2.2	A non-condensed, sans serif type style in the largest point size possible is used. (A minimum of 12 point is recommended.) The use of mixed case lettering may enhance readability.	66.7
2.3	Critical information is highlighted using contrasting type characteristics (e.g., **bolding**, colour)	62.5
4.2	End user (e.g., nurse, physician) testing of the legibility and readability of the label has been completed, ideally using a simulation process that replicates actual practice.	64.6

Sample Epidural Labels



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

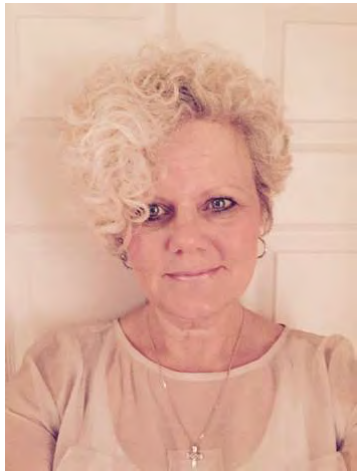


Who should use the Epidural Checklist

- Designed for organizations that prepare, dispense or administer epidural medications

- If your organization does not use epidural medications, some aspects of this checklist may be applicable to other medication label content and design
  - But you will not be able to complete the electronic data submission and assess your data against the aggregate responses

North Bay Regional Health Centre / Centre régional de santé de North Bay



Kathryn McLenaghan

Manager of Pharmacy Services,
North Bay Regional Health Centre

Accreditation Canada Required Organizational Practices (ROP)

- High-Alert Medications

Tests for compliance	Assists
The [high-alert] policy includes procedures for storage, prescribing, preparation, administration, dispensing and documentation for each high-alert medication, as appropriate.	√

Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

Updated Hospital Medication Safety Self-Assessment®

Julie Greenall
Director of Projects and Education
ISMP Canada

UPDATED HOSPITAL MSSA – VERSION III

An effective resource for proactively assessing the risk of medication-use systems and enhancing an organizational culture of safety

Updated Hospital MSSA – Version III

- Incorporates:
  - New learning from the Ontario Critical Incident Learning program
  - Learning from other incidents reported to ISMP Canada
  - Adapted content from the 2011 ISMP (US) Medication Safety Self Assessment for Hospitals
- ISMP Canada working with Accreditation Canada to assess ability to indicate alignment between MSSA and Medication Management standards to support organizations preparing for Accreditation

Selected Highlights of New Content – Learning from OCIL

- A rescue protocol has been developed for naloxone that supports rapid administration when opioid toxicity/overdose is suspected
  - There is regular review of availability of specific antidotes and reversal agents in the facility generally and in each clinical area
- Smart pump drug libraries are configured for use throughout the hospital, rather than for individual care units
- Insulin pens are labelled with pharmacy-generated, patient-specific labels, for single patient use only and labels are placed on the barrel of the insulin pen

Accreditation Canada Required Organizational Practices (ROP)

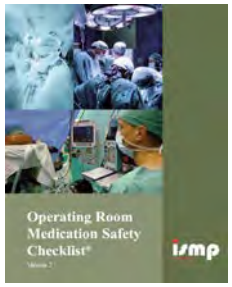
- Client Safety Prospective Analysis

Tests for compliance	Assists
At least one prospective analysis has been completed within the past year.	√

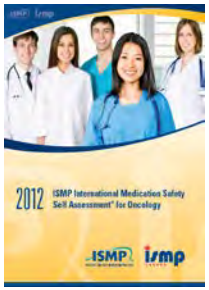
Ref: Accreditation Canada Required Organizational Practices Handbook 2015; available from: http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf

- Also, Medication Management standards recommend a regular comprehensive evaluation of the medication system

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

“The most detrimental error is failing to learn from an error.”

James Reason

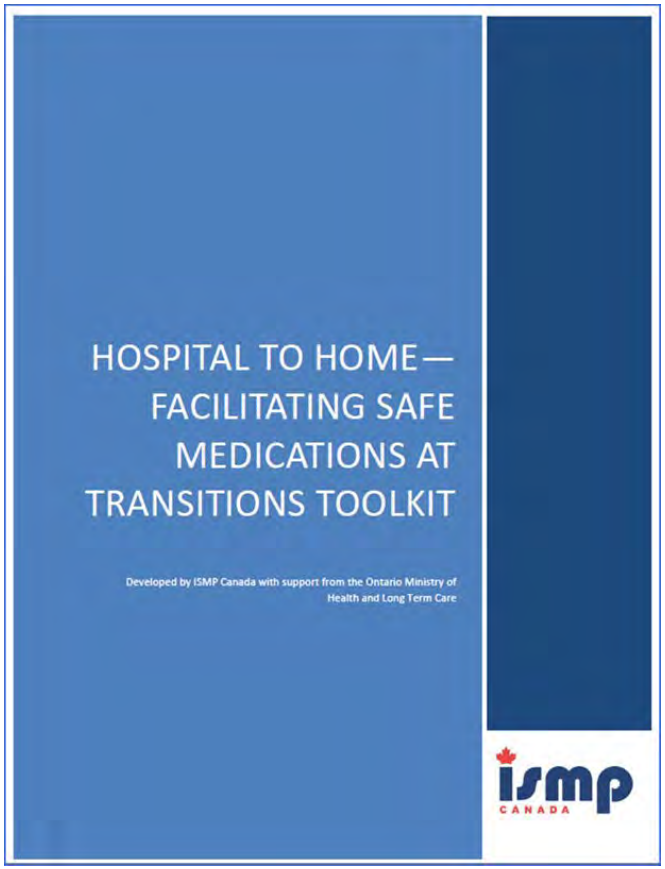
How to access these resources

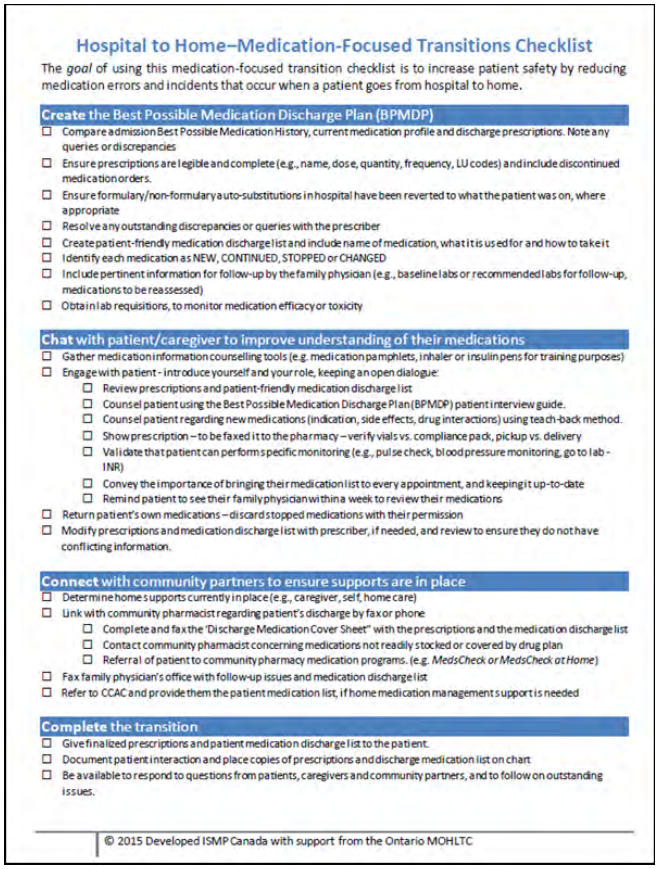
Medication Safety Self-Assessments®	• www.ismp-canada.org/mssa
Hospital to Home Checklist and Toolkit	• www.ismp-canada.org/ocil
Epidural Label Safety Checklist	• www.ismp-canada.org/mssa

Available Summer 2015

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

Ontario CRITICAL Incident Learning

Improving quality in patient safety

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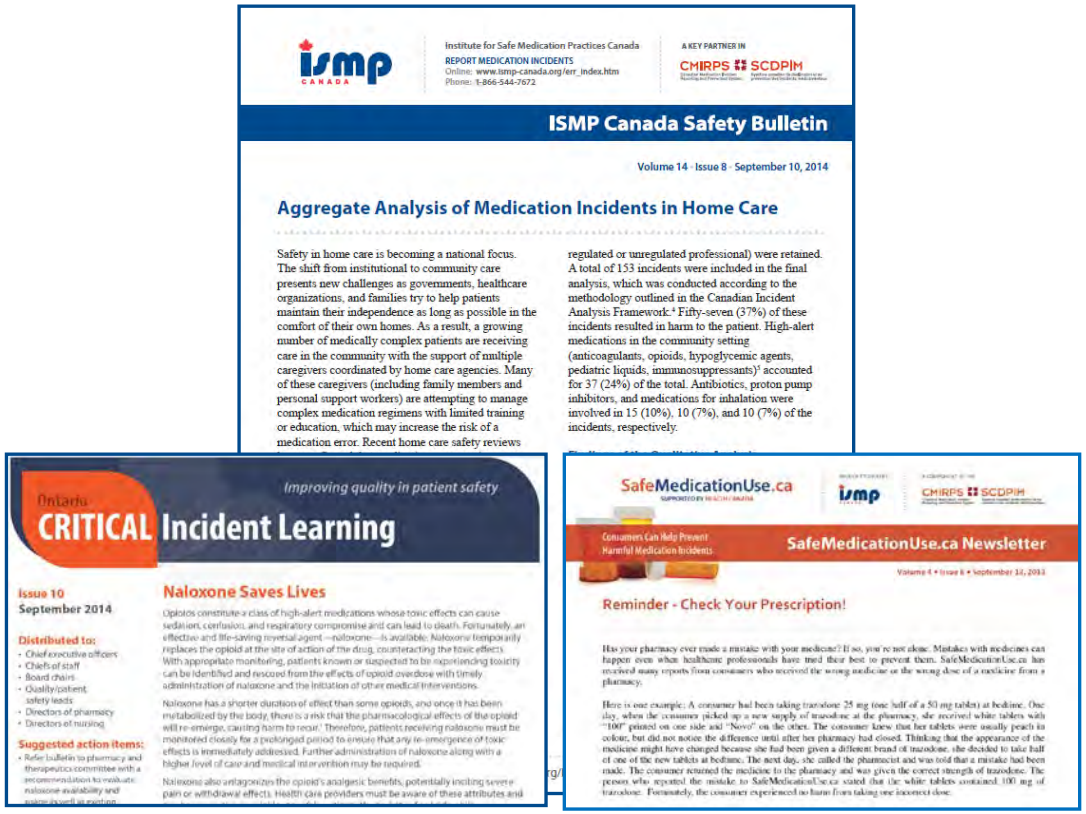


Visit www.ismp-canada.org and click on Stay Informed at the bottom of the home page

Upcoming Educational Events

October 1, 2015	**Incident Analysis Framework: Train-the-Trainer Workshop (For PSEP – Canada Trainers)** - Toronto, ON
October 22, 2015	**BPMH Training for Pharmacy Technicians** - Toronto, ON
November 5-6, 2015	**Medication Safety for Pharmacy Practice: *Incident Analysis and Prospective Risk Assessment*** - Toronto, ON

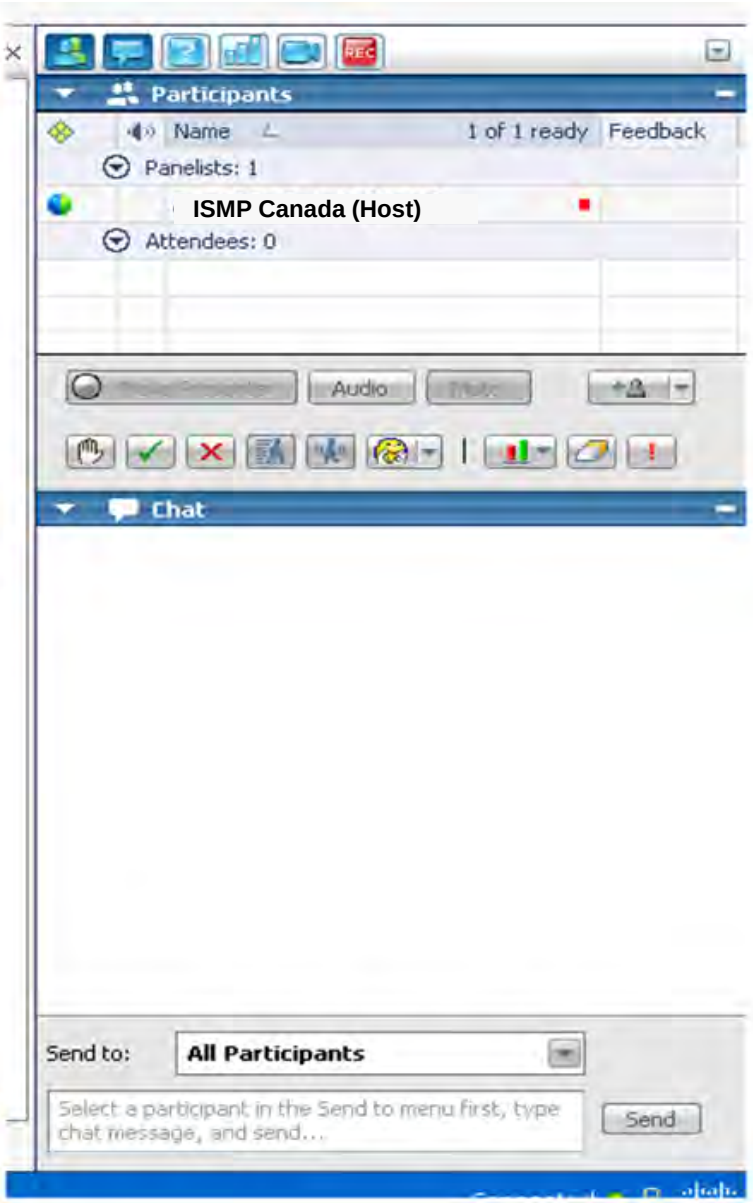
Visit www.ismp-canada.org/education

We encourage you to submit medication incidents to NSIR or ISMP Canada

www.ismp-canada.org/err_index.htm

NSIR reporting: http://www.cihi.ca/CIHI-ext-portal/pdf/internet/NSIR_INFOSHEET_2015_EN

PLEASE TAKE OUR POLL



2. Type your question in the chat box

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

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