4th Qatar Patient Safety Week (QPSW)

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Healthcare Quality & Patient Safety Department
Ministry of Public Health
A Global Perspective on Medication Safety: from evidence to action

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Conflict of Interest

I have no conflict of interest or disclosure in relation to this presentation
Objectives

• Highlight the global impact of unsafe medication safety practices and medication errors

• Describe the WHO *Medication Without Harm - Global Patient Safety Challenge on Medication Safety*

• Provide an update on Medication Reconciliation and other strategies/tools for taking action to improve med safety across the continuum

• Highlight the importance of patient and family engagement in medication safety and share a number of examples
Unsafe medication practices and medication errors are a leading cause of avoidable harm

Globally, the cost associated with medication errors has been estimated at $42 billion (US) annually

Why now?

• Medication related harm has been documented for 60 years and continues to cause harm amongst patients

• Patients are harmed because:
  • Medication naming, packaging, and labelling causes confusion
  • Errors are made in prescribing and administering medications
  • The patient is often not engaged, not informed and not empowered
Five Specific Objectives of the Global Challenge

*Facilitate a strengthening of systems and practices that can initiate corrective actions*

1. **ASSESS** the scope and nature of avoidable harm and strengthen the monitoring systems to detect and track this harm
Five Specific Objectives of the Global Challenge

Facilitate a strengthening of systems and practices that can initiate corrective actions

2. CREATE a framework for action aimed at patients, health professionals and Member States to facilitate improvements
Five Specific Objectives of the Global Challenge

*Facilitate a strengthening of systems and practices that can initiate corrective actions*

3. DEVELOP guidance, materials, technologies and tools to support the setting up of safer medication use systems
Five Specific Objectives of the Global Challenge

*Facilitate a strengthening of systems and practices that can initiate corrective actions*

4. ENGAGE key stakeholders partners and industry to raise awareness of the problem and actively pursue improvement efforts
Five Specific Objectives of the Global Challenge

Facilitate a strengthening of systems and practices that can initiate corrective actions

5. EMPOWER patients, families and their carers to become actively involved and engaged in treatment or care decisions, ask questions, spot errors and effectively manage their medications.
Third Global Patient Safety Challenge: 
Medication without Harm

Goal –
• to reduce severe, avoidable medication-related harm by 50% within 5 years.
Third Global Patient Safety Challenge: 
**Medication without Harm**

- Since April 2016, countries have been assisting the WHO to prepare
- Five WHO Working Groups have been established:
  - Patients and Public,
  - Health Care Professionals,
  - Medicines,
  - Systems and Practices, and
  - Monitoring and Evaluation.
- **ISMP Canada, the Canadian Patient Safety Institute, and Patients for Patient Safety Canada are contributors to several Working Groups.**
Focus on

1. High risk medication/ High risk situations
2. Polypharmacy
3. Transitions of Care

Resources:
http://www.who.int/patientsafety/medication-safety/en/
Medication Reconciliation - MedRec

• At hospital admission, up to 67% of patients’ prescription medication histories have one or more errors


• Using MedRec to ensure accuracy of medications at transitions of care
Medication Management
Medication management is defined as patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams.

Clinical Medication Review
Addresses issues relating to the patient’s use of medication in the context of their clinical condition in order to improve health outcomes.

Medication Reconciliation
A formal process in which healthcare providers work together with patients to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.

Best Possible Medication History
A complete and accurate list of all the medications a patient is taking created using at least 2 sources of information including a client and/or family interview.

1. Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012.
2. www.health.gov.bc.ca/pharmcare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
4. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011

Adapted from Fraser Health, Providence Health Care, Provincial Health Services Authority, Vancouver Coastal Health

ISMP Canada / CPSI Mar 2017 Medication Reconciliation in Acute Care Getting Started Kit
National Medication Reconciliation Strategy

CO-LED BY ISMP CANADA AND CPSI

Available from www.ismp-canada.org/medrec

Acute Care: Complete at all care transitions for >50% of beds
Long Term Care, Complex Continuing Care: Complete at all care transitions
Home Care/Ambulatory: Complete across entire program or targeted patient group

(All based on self-report)

The data is reflective of all of the organizations recommended for interviews.
Medication Reconciliation During Transitions of Care as a Patient Safety Strategy: Systematic Review

JL Kwan, L. Lo, M. Sampson, KG Shojaia


Medication Reconciliation During Transitions of Care as a Patient Safety Strategy
A Systematic Review

Janice L. Kwan, MD*; Lisha Lo, MPH*; Margaret Sampson, MJUS, PhD; and Kaveh G. Shojaia, MD

Medication reconciliation identifies and resolves unintentional discrepancies between patients' medication lists across transitions in care. The purpose of this review is to summarize evidence about the effectiveness of hospital-based medication reconciliation interventions. Searches encompassed MEDLINE through November 2012 and EMBASE and the Cochrane Central Register of Controlled Trials through July 2012. Eligible studies evaluated the effects of hospital-based medication reconciliation on unintentional discrepancies with non-trivial risks for harm to patients or 30-day postdischarge emergency department visits and readmission. Two reviewers evaluated study eligibility, abstracted data, and assessed study quality.

Eighteen studies evaluating 20 interventions met the selection criteria. Pharmacists performed medication reconciliation in 17 of the 20 interventions. Most unintentional discrepancies identified had no clinical significance. Medication reconciliation alone probably does not reduce postdischarge hospital utilization but may do so when bundled with interventions aimed at improving care transitions.
Summary Points

• Med Rec is *widely recommended* to avoid unintentional discrepancies between patients’ medications across transitions in care
• Clinically significant *unintentional discrepancies* affect only a few patients
• Med Rec alone probably does not reduce post-discharge hospital utilization within 30 days but may do so when *bundled* with other interventions that improve discharge coordination
• *Pharmacists* play a major role in most successful interventions
• Commonly used criteria for selecting *high-risk patients* do not consistently improve the effect of med rec
11 Critical Elements of a Med Rec Bundle May Influence Post Discharge Hospital Visits

1. Systematic BPMH process on admission
2. Integrated admission to discharge reconciliation processes
3. Discharge delineation of med changes since admission
4. Pharmacist involvement in reconciliation from admission to discharge
5. An electronic platform to support interprofessional reconciliation
6. Formal discharge reconciliation with pharmacist-provider collaboration
7. Patient education prior to discharge (counselling)
8. Post-discharge communication with the patient
9. Discharge communication with outpatient providers
10. High risk group focus
11. Pharmaceutical care (Med Management)
Using a Bundle of Clinical Pharmacy Services

Figure 5: Bundle of Clinical Pharmacy Services Used in the Intervention Arm

Medication reconciliation on admission → Pharmaceutical care plan → Active participation in interprofessional patient care rounds → Patient education → Medication reconciliation at discharge → Bundle

MyMedRec app

Medication Record Book

iPhone
Android
Blackberry

Partnering with Patients and Families

• Values their insights and experience
• Empowers them to take an active role in their care
• Instead of asking what’s the matter with you, asking ‘What Matters to you?’

“Patients are the extra sets of eyes and ears that should be integrated into the safety processes of all health care organizations”

*Engaging Patients in Patient Safety - a Canadian Guide CPSI 2017*
Use TeachBack Method -
Confirm patient understanding

“Tell me what you’ve understood.”
“I want to make sure I explained your medicine clearly. Can you tell me how you will take your medicine?”

Reference/Resource: www.teachbacktraining.org
Health Literacy: Hidden Barriers and Practical Strategies.
Emily Musing, Executive Director, Pharmacy, Clinical Risk and Quality and Patient Safety Officer at UHN, (Photo: UHN)

Yin Ling Wong, Emily Musing’s father, with his grandchildren Marisa and Max, had to keep track of 20 medications daily. (Photo: Courtesy of Emily Musing)
Five Questions to Ask: Collaborative Process

• Completed environmental scan
• Working group consisted of patients, nurses, doctors and pharmacists developed a draft
• Feedback obtained from patients, clinicians, advisory panel and external stakeholder groups
• Checklist revised using the model for improvement and PDSA cycles and based on feedback received and tested
5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS when you see your doctor, nurse, or pharmacist.

1. CHANGES?
Have any medications been added, stopped or changed, and why?

2. CONTINUE?
What medications do I need to keep taking, and why?

3. PROPER USE?
How do I take my medications, and for how long?

4. MONITOR?
How will I know if my medication is working, and what side effects do I watch for?

5. FOLLOW-UP?
Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:
- drug allergies
- vitamins and minerals
- herbal/natural products
- all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

Visit safemedicationuse.ca for more information.

https://www.ismp-canada.org/medrec/5questions.htm
It’s about starting a conversation

5 Questions to Ask About Your Medication can help “…initiate a 2 way communication and encourages everyone to be more involved with their personal health care – take more accountability and responsibility”

5 questions survey respondent
It’s about starting a conversation

عند الحديث عن أدويةك

1. التغييرات التي حدثت؟
2. الاستمرارية؟
3. الاستخدام الصحيح؟
4. المراقبة؟
5. المتتابعة؟

استشر الطبيب أو المحترف الصحي أو المقدم المقدم لإشراف أدوية أو أدوية تناولها.

لمزيد من المعلومات زوروا:
safemedicationuse.ca
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https://www.ismp-canada.org/medrec/5questions.htm#l=tab2
Patients can take a snapshot of the 5 questions to ask
Additional Strategies/Tools
Opioids for pain after surgery: Your questions answered

1. Changes?
You have been prescribed an opioid.
Opioids reduce pain but will not take away all your pain. Ask your prescriber about other methods of reducing pain including using ice, stretching, physiotherapy, or non-opioid drugs like acetaminophen or Ibuprofen. Know your pain control plan and work closely with your prescriber if your pain does not improve.

2. Continue?
Opioids are usually required for less than 1 week after surgery.
As you continue to recover from your surgery, your pain should get better day by day. As you get better, you will need less opioids. Consult your healthcare provider about how and when to reduce your dose.

3. Proper Use?
Use the lowest possible dose for the shortest possible time.
Overdose and addiction can occur with opioids. Avoid alcohol and sleeping pills (e.g. benzodiazepines like Klonopin) while taking opioids. Do not drive while taking opioids.

4. Monitor?
Side effects include: sedation, constipation, nausea and dizziness.
Contact your healthcare provider if you have severe dizziness or inability to stay awake.

5. Follow-Up?
Ask your prescriber when your pain should get better.
If your pain is not improving as expected, talk to your healthcare provider.

PREVENT MEDICATION ACCIDENTS

1. Store medications out of sight and reach of:

- CHILDREN & TEENS
- VISITORS
- PETS

2. Place unused medications in a bag and bring to a pharmacy.

3. For locations that accept returns:

- 1.844.535.8889
- HEALTHSTEWARD.CA

Ask a healthcare provider if you have questions.

Consumer Reporting of Medication Incidents

https://www.safemedicationuse.ca/report/privacy.html
Hospital Reporting of Medication Incidents

National System For Incident Reporting (NSIR)

CIHI’s National System for Incident Reporting (NSIR) is a web-based application used by Canadian health care facilities to securely and anonymously share, analyze and discuss medication/IV fluid incidents. Its data and analyses inform quality improvement activities at local, regional, provincial, territorial and national levels to foster improvements in health care delivery.

Pharmacy Reporting of Medication Incidents

https://secure.ismp-canada.org/CPHIR/Reporting/login.php
Knowledge Mobilization Tool (ISMP Canada)

https://secure.ismp-canada.org/KMT/
From Evidence to Action...

https://www.ismp-canada.org/education/
References


  • http://www.who.int/patientsafety/medication-safety/en/
Thank you

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Slides will be available online following the conference