Initiative Update Webinar

March 23rd, 2022

Strengthening Medication Safety in Long-Term Care

ismp CANADA

Land Acknowledgement

We acknowledge we are hosted on the lands of the Mississaugas of the Anishinaabe, the Haudenosaunee Confederacy and the Wendat. We also recognize the enduring presence of all First Nations, Métis and the Inuit peoples.[1] We are grateful to live, work and play on this land and we want to contribute to the implementation of the Truth and Reconciliation Commission's eight health recommendations.

Nous tenons à souligner que nous sommes accueillis sur le territoire traditional des Mississaugas, des Anichinabés, des Haudenosaunees et des Wendats. Nous voulons également reconnaître la pérennité de la presence des Premières Nations, des Métis et des Inuits. Nous sommes reconnaissants de vivre, de travailler et de jouer sur ce territoire et nous voulons contribuer à la mise en œuvre des huit recommandations de la Commission de verité et de reconciliation en matière de santé.

Find your land acknowledgement at https://native-land.ca/

1. https://www.tdsb.on.ca/Community/Indigenous-Education/Resources/Land-Acknowledgement

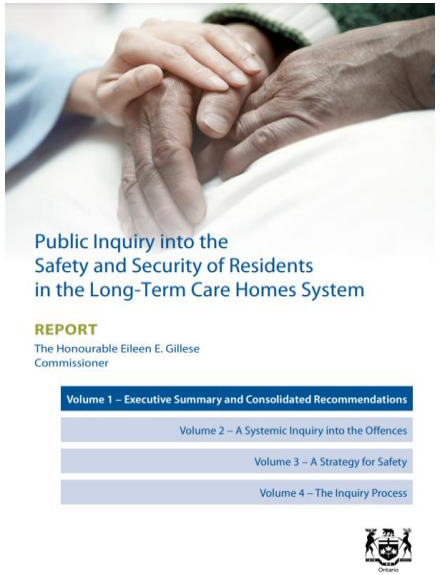
Agenda

Welcome and Introduction to Initiative

Overview of Champion Home Activities

- **Baseline Medication Safety Assessment**
  - Early learnings/takeaways
  - MSSA-LTC Action Plan – Maricar Dulay (Fairview Lodge
- **Incident Analysis**
  - Incident Analysis for Long-Term Care Workshops
  - Incident Analysis Process – Alice Jyu (Bendale Acres)
- **Quality Improvement Process**
- **Resources** – Model Policies, Med Safety Signal
- **MSSA-LTC re-survey**
- **Opportunities for all Homes**
- **What's next?**

An Initiative to Support the Long-Term Care Sector



http://longtermcareinquiry.ca/wp-content/uploads/LTCI_Final_Report_Volume1_e.pdf

The 3-year initiative is funded by the Ontario Ministry of Long-Term Care

This work will include addressing Justice Gillese's specific recommendations with respect to detecting potential medication incidents that would otherwise go unnoticed

Views expressed are the views of ISMP Canada and do not necessarily reflect those of the Province

4 Key Areas of Collaboration and Support

Medication safety education and model practices

Teaching and coaching in ***quality improvement***

Workshops and facilitation in ***medication incident analysis***

Updated tools/indicators for ***measuring and evaluating*** medication safety

ISMP Canada LTC Team

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Chief Executive Officer

Melissa Sheldrick, BA Soc, MSc Ed,
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Alice Watt, RPh, BScPhm
Medication Safety Specialist

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Medical Director

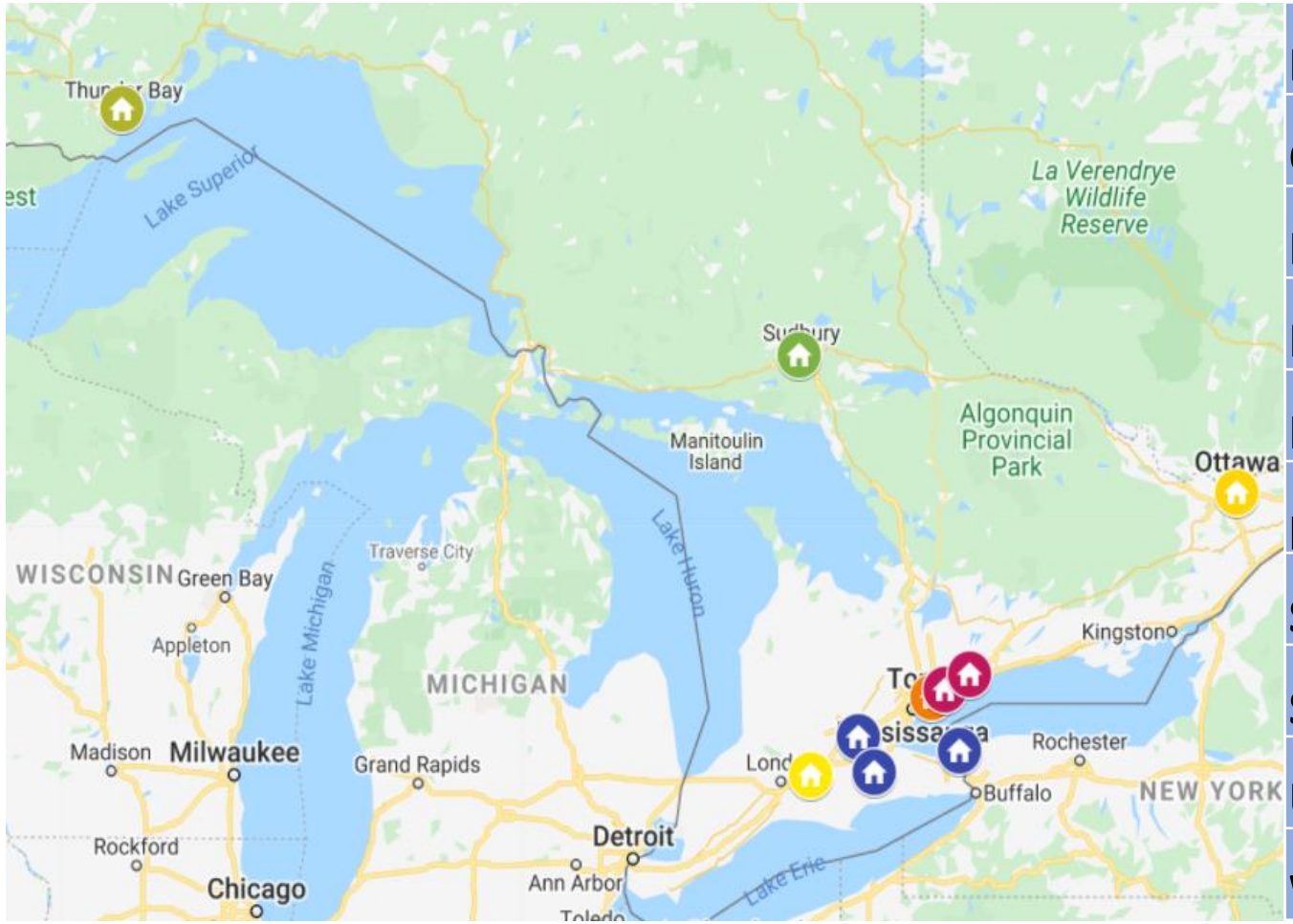
Anurag Pandey, MASc,
Quality Improvement Consultant

Shirley Drever, RPh, BScPhm
Project Manager

Sylvia Hyland, RPh, BScPhm, MHSc
Vice President

Public Launch of the 10 Champion Homes on November 24

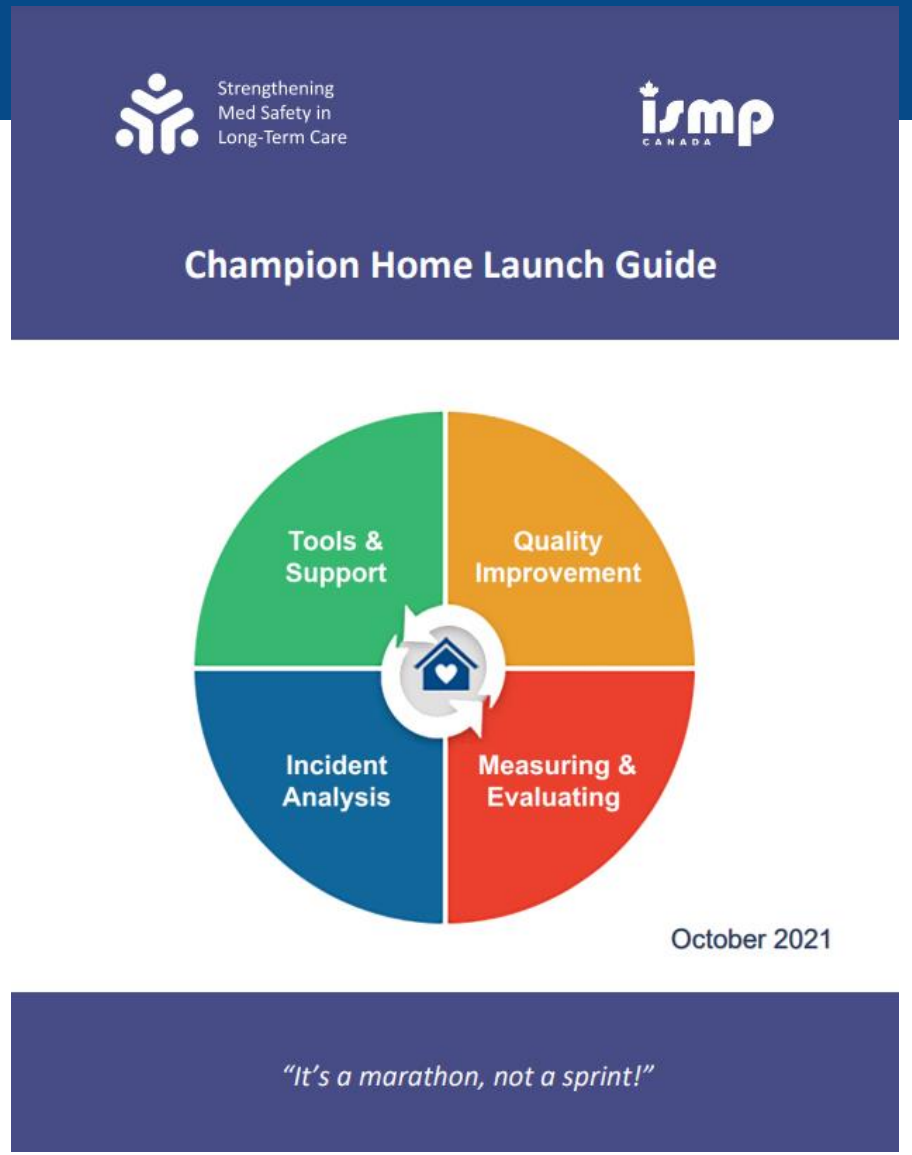
10 Champion Homes



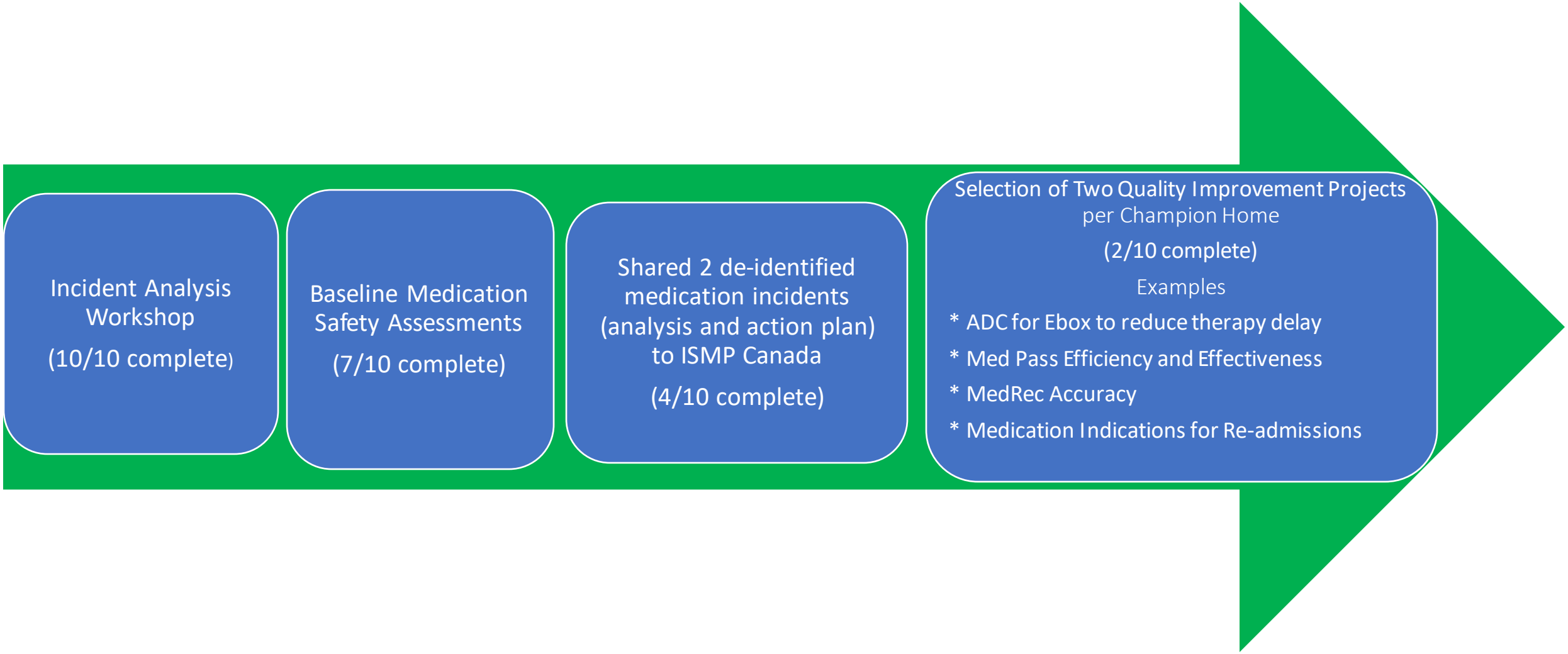
- Bendale Acres Long-Term Care Scarborough
- Cedarvale Terrace Toronto
- Extendicare York Sudbury
- Fairview Lodge Whitby
- Iroquois Lodge Ohsweken
- peopleCare Hilltop Manor Cambridge
- Southbridge Pinewood Thunder Bay
- St. Patrick's Home of Ottawa
- Upper Canada Lodge Niagara-on-the-Lake
- Woodingford Lodge Ingersoll

Update

- ISMP Canada Faculty now working with representatives of Champion Home to support a structured approach to improving med safety in their homes
- Champion Home Launch Guide outlines the key activities (ismpcanada.ca)
- Key focus now:
  - Baseline Med Safety Assessment at each Home (including MSSA-LTC)
  - Increasing med safety reporting and learning in Ontario (over 200 LTC staff members have participated in Incident Analysis for LTC workshops since launch of initiative)
- Budget and deliverables proceeding as planned



Overview of Champion Homes



Baseline Medication Safety Assessment

Four Components:

Resident and Family Engagement

Med Safety Related Indicators

MedRec Quality Audit

MSSA-LTC

Resident and Family Engagement

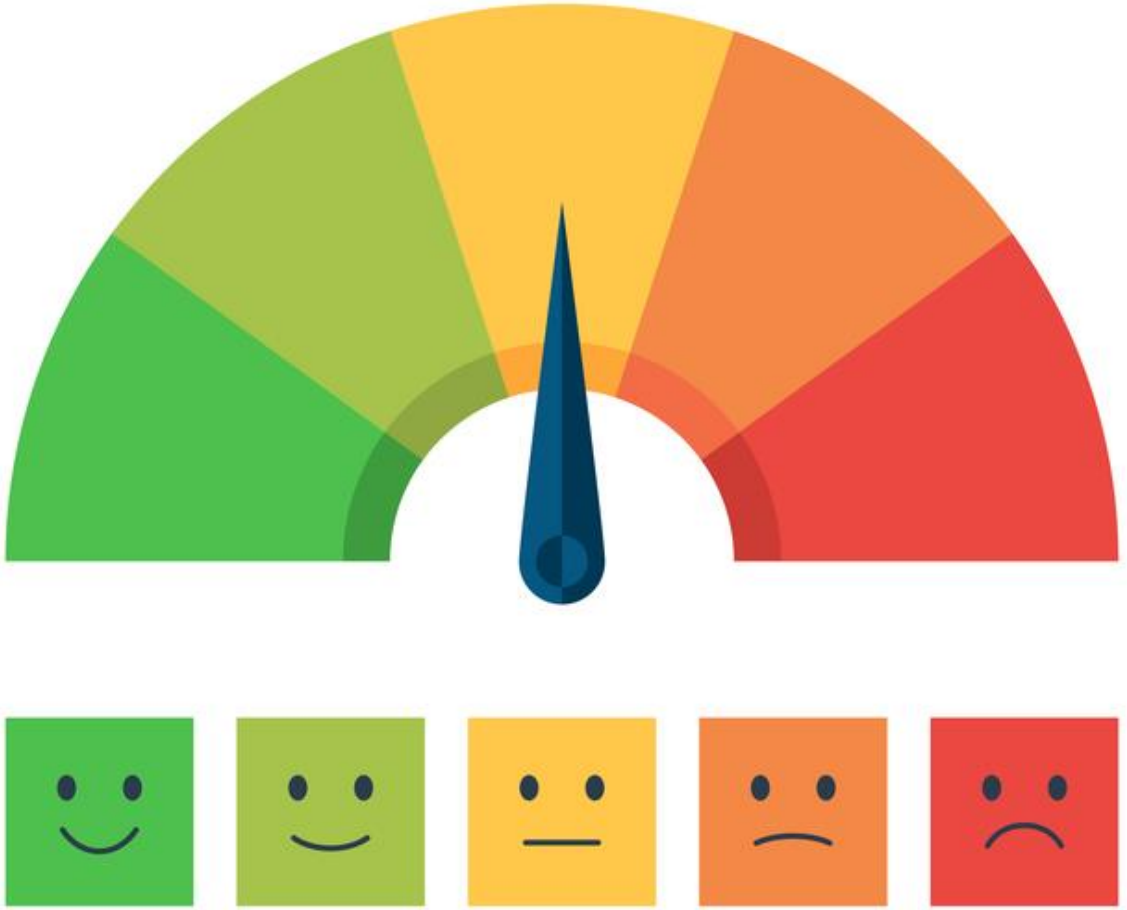
Baseline Assessment Tools

- ✓ iAP2 Spectrum
- ✓ MSSA Questions
- ✓ Survey Questions

"I would like to be on the committee that decides how they are going to reduce errors so that I can add the resident's voice..."

Devora, resident in Ontario LTC

Indicator Update



MedRec Audit

- Challenges in documentation:
  - resident engagement in the BPMH process
  - rationale for medication holds or discontinuations
- Tools available to complete and audit the BPMH/MedRec process
- Upcoming MedRec and BPMH training

Thursday, May 19th
10 am – 5 pm
If interested in attending, please email:
alice.watt@ismp-canada.ca

"I feel like this was a good opportunity to get some experience with performing BPMH's and get feedback from others"

- LTC provider

MSSA-LTC

- Completion of the MSSA-LTC was a helpful starting point for Champion Homes to identify opportunities for improvement
  - Feedback on the updated version has been positive
  - There are many successes to celebrate in medication management in LTC
- A consistent theme was the opportunity to increase resident and family engagement
- One of the Champion Homes developed a template to document findings which is being used by others

Fairview Lodge Update

Maricar Dulay

Medication Safety Self-Assessment Fairview Lodge

- Completing MSSA annually
- MSSA- LTC Version III (2019)- participated in the validation testing.
- Completed updated version on June 25, 2021
- In consideration of individual strength and expertise, we established a team who can effectively contribute to the assessment.

Our team includes:

Director of Care
Resident Care Coordinators
Medical Director
Nurse Practitioner
Consultant Pharmacist
Registered Nurse
Registered Practical Nurse

- Tasks: Facilitator, Note Taker, Hard Copy scorer and Electronic scorer. Everyone took turn in reading the Core Characteristics.

MSSA Action Plan

Action Plan MSSA Assessment 2021

Canadian Version III

MSSA Assessment Date: June 25, 2021 **SCORE: 84%**

Core Distinguishing Characteristics	MSSA Score	Comments	Plan	Responsible Parties/Completion
1.1 The medication safety committee includes resident and/or family caregiver representatives.	**Not Implemented 0/4**	Resident and/or family caregiver representatives are not part of the MMC-Interdisciplinary	Continue with the committee's terms of reference.	
1.6 When a resident experience a medication incident, the resident and/or their family caregivers are given an opportunity to share their perspective as part of the information gathering step of an incident analysis and are invited to provide input into possible preventive actions.	**Sometimes 2/4**	Resident, if capable, and/or the SDM is informed of the medication incident and has an opportunity to share their perspective. They are not part of the incident analysis and investigation of the incident.	Continue with the home's protocol.	
2.1 The medication administration record contains current resident photographs to assist staff in identifying residents for medication administration.	**Always 4/4 (75%-100%)**	We met this Core Characteristics however we want to maintain. Keeping the photographs up to date	All resident has an updated photograph in the PCC profile. Updated annually during care conferences and as needed.	Reception Clerk is collaborating with the recreation department to complete the task. Ongoing due to the increased number of new admissions.
2.3 *In paper systems* (e.g., prescriber order sheets, Medication Administration Records, including back-up paper processes for electronic system downtime), medication allergies/ sensitivities/ intolerances and other details, such as swallowing difficulties or the need to crush medications, are accurately listed and clearly visible on all pages as a visible reminder to those prescribing and administering medications.	**Often 3/4**	Swallowing difficulties or the need to crush medications, is not in the physician's digi-order sheet.	Registered staff to complete the information in the physician's digi-order sheet including the "Medication Crushed" sticker.	"Medication Crushed" green-coloured stickers provided in the units to apply on the physician's digi-order paper. **Completed July 9, 2021** Email sent to inform all registered staff. **July 13, 2021**

Action Plan:

Action Plan form developed to help analyze the level of implementation of individual core characteristics efficiently/thoroughly. We entered the identified vulnerabilities and opportunities for improvement.

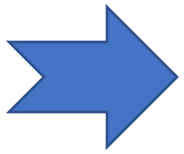
Column 1= Full statement of the Core Characteristics to refer to and fully understand the assessment item.
Column 2= Score- 4/4 does not mean 100% it's 75%-100%. Think about why not 100%?
Column 3= Comments- Summary and outcome of the discussion during the assessment.
Column 4= Plan- Action plan to implement strategies to improve medication safety in the Home.
Column 5= Responsible parties and completion date. Who will implement and when?

Once we established the recommended strategies, we implemented and evaluated the outcome.

We were able to accomplish the plan, given the cadence of the pandemic by not losing sight of what is important. We made time to follow-up and practiced more flexibility with our timetable. Delegating and balancing tasks was advantageous.

Fairview Lodge is committed to improve medication safety in our Home. It is embedded in our daily practice to ensure that our residents are provided with exemplary care.

Incident Analysis – it's a journey



Monthly Incident Analysis For LTC Virtual Workshops
9:00 am to 3:00 pm
Next dates: April 21st, May 12th, June 9th

March 2022
"Excellent workshop - Great work by facilitators and presenters!"

Jan 2022
"Enhance just safety culture"

Debbie Santos, VP Clinical Excellence CareRx

Feb 2022
"Apply a standardized methodology in analyzing med incidents and to come up on action plans "

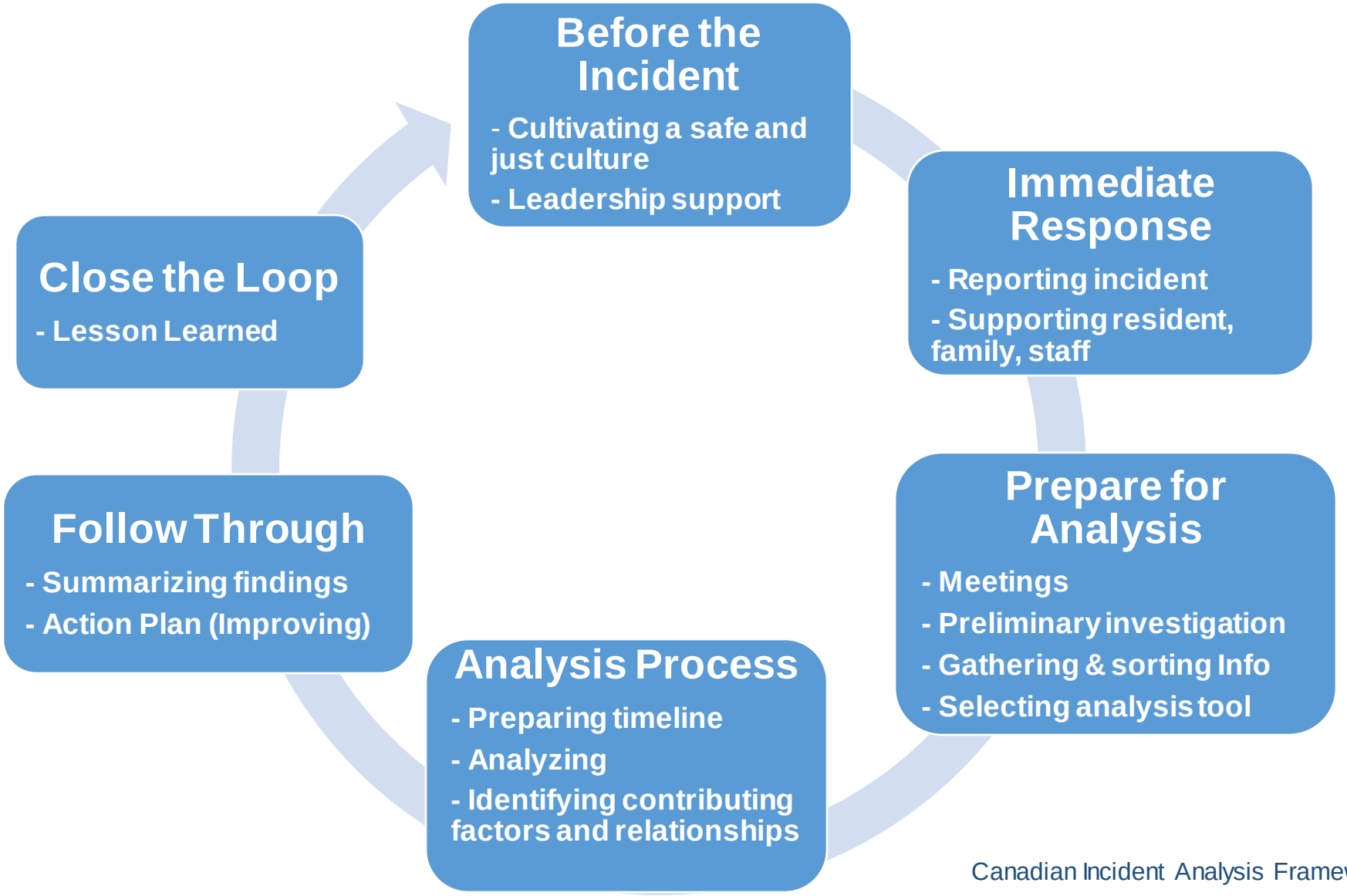
Participant feedback from previous Workshops

February 2022
"I will use the resources and templates for medication incident analysis and share with the team"

Incident Analysis Process in Practice

- Over 200 participants have completed the Incident Analysis for Long-term Care Workshop
- **97%** of registrants report **that they will use the contents of the workshop in their homes**
- **Alice Jyu from Bendale Acres** will now share the application of this process in her home

The Incident Management Continuum



Canadian Incident Analysis Framework, p. 26

System Levels Approach to Incident Management

Gathering and Sorting Information: Prepare Timeline

Timeline for Med Incident #1 – Amoxicillin vs Amoxi-Clav

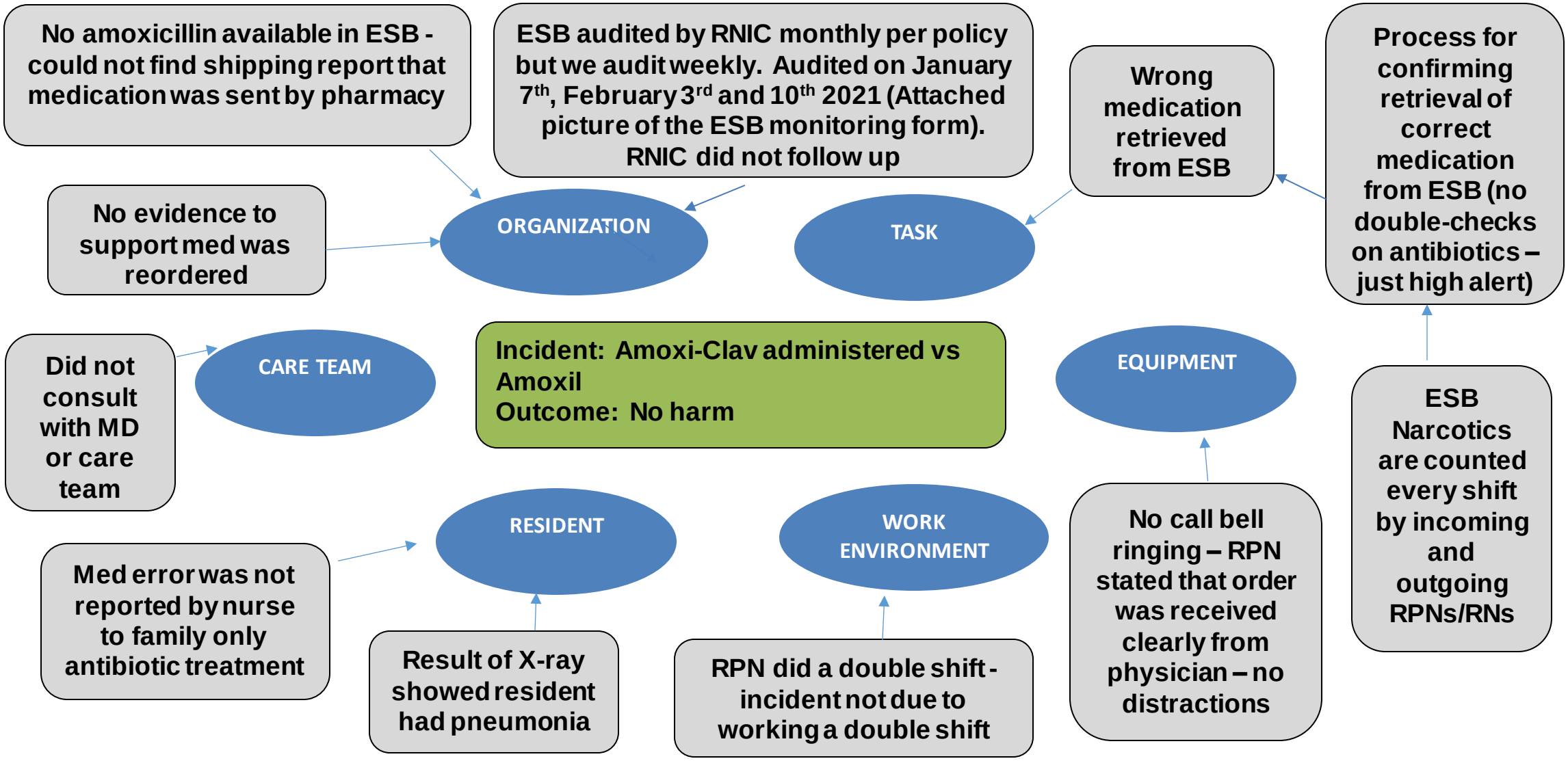
Time	Information Item	Information Source
(Sunday)	**Resident displayed symptoms of pneumonia** – received x-ray report of pneumonia, symptoms started on Wednesday, SOB and desaturation, poor appetite	RPN#1 + incident report
	RPN made call to MD	RPN#1 + incident report
	RPN spoke with MD and an **order for Amoxicillin: give 1g tid x 5 days received by phone**	RPN#1 + incident report
	Documented in chart on a digital prescriber's order form – med, strength, directions, timeline, route, clinical indication, telephone order, name of the prescriber, time and date by RPN who received the order (see attached digital order)	RPN#1 + incident report
	RPN went to the 2nd floor emergency medication supply- emergency starter box (ESB) in the home	RPN#1 + incident report

Timeline for Med Incident #1 – Amoxicillin vs Amoxi-Clav

	There was **no Amoxicillin 250 mg or 500mg in the ESB**. AmoxiClav 500 mg was retrieved from the ESB. There were 2 strengths of AmoxiClav in the ESB (500mg/125mg and 875/125mg). The **AmoxiClav 500mg/125mg was taken and 2 tablets were given as initial dose** given in the evening. Only one dose of 2 tablets of AmoxiClav was given. RPN#1 thought that because of the same strength (500mg) the AmoxiClav would be the same as the Amoxicillin 500mg as an alternative. (See pictures of Amoxicillin 250 mg, AmoxiClav 500mg/125mg and 875/125mg).	RPN#1 + incident report
	As per eMAR - Amoxicillin 500 mg Give 1000mg po TID for indicated diagnoses for 5 days (see attached)	RPN#1 + incident report
Monday	**Med error was detected by doing second nursing check** on digital order with the medication.	Chart & RN#1
	MD was notified of wrong drug medication error, stopped Amoxicillin order and started Amoxi-Clav 500mg/125mg po 1 tab tid for 5 days (see digital order)	RN#1 + Incident report
	Next of kin notified of antibiotic for pneumonia, but not med error.	RN#1 + Incident report
17 days later	**Nurse manager reviewed incident report**	Incident report
	No harm incident	

Analyzing

Constellation Diagram - Identify contributing factors



Summarize Findings

Describe the Incident:

INCIDENT: Resident was given wrong medication (Antibiotic) than what was ordered

OUTCOME: No harm

IDENTIFY POTENTIAL CONTRIBUTING FACTORS: Similar medication name

DEFINE INTER-RELATIONSHIPS: Medication order and process to re-order ESB was not followed, staff took the wrong medication with similar names and failed to consult with MD/care team, family was not notified of med error

IDENTIFY THE FINDINGS: **1)** second check was not completed by next shift, **2)** no evidence of Amoxicillin 250mg was re-ordered or received, **3)** when ESB monitoring form was audited, no follow up was done, **4)** RPN did not notify MD or consult with pharmacy/team regarding Amoxicillin vs Amoxi-Clav, **5)** RPN denied working double shift as a contributing factor, **6)** family was notified of antibiotic treatment but not med error

CONFIRM THE FINDINGS WITH THE TEAM: Yes

ACTION PLAN – Improving

Summary Statement:

1.The lack of availability of Amoxicillin in the Emergency Medication supply increased the likelihood of another medication being selected and administered to the resident causing harm.

2. The similarity in name and lack of clear differentiation between amoxicillin and Amoxi-Clav labelling increased the likelihood of the wrong medication being selected and administered leading to resident harm.

Good catch: The second check within the next shift caught the error

Recommendations/ Actions (What are you planning to do?)	Specific (Is the action clear and precise?)	Measurable (How will it be confirmed that the action was implemented? How will it be determined if it was effective?)	Achievable (Is the action attainable with resources and support by a defined date? What more is needed to achieve the goal?)	Relevant (Does the action actually address the issue? Will the incident be less likely to occur if the action is implemented?)	Time-bound (What is the timeframe for implementation?)	Rank Hierarchy of Effectiveness (high, medium, low)	Priority	Accountability (Who, or what department is accountable for the implementation?)
ESB medications are re-ordered after each use	Yes	Number of missing ESB medications	Yes	Yes	Immediately	Medium	3	RN/RPN/RNIC/Clinical Nurse
Follow up on gaps identified after each weekly ESB audit	Yes	Number of gaps	Yes	Yes	Immediately	Medium	4	RNIC
Second check to be done by the next shift	Yes	Decrease in wrong medication administered vs med order	Yes	Yes	Immediately	Medium	2	RN/RPN/Clinical Nurses/Nurse Manager
Implementation of Automated Dispensing Cupboard (ADC)	Yes	Automated electronic tracking	Yes	Yes	ADC April, 2022	High	1	Head Office
Flag similar named meds in Ebox with bright coloured tag	Yes	Yes	Yes	Yes - serves as a reminder	Immediately	Low	6	RN/RPN
Inform POA/family on all	Yes	# of incident reports	Yes	Yes	Immediately	Low	5	RN/RPN/CN/NM

Lesson Learned

- Need team collaboration to do a deeper analysis of incidents – looking at contributing factors and what can be done right away
- Timely follow up to gathering information as much as we can as soon as an incident happens
- Physicians need to become more involved in the analysis of medication incidents
- Physicians need to document the whole order rather than sometimes omitting other doses (i.e. AmoxiClav 500mg/125mg)
- Nurses should also repeat the order (if telephone order) to confirm with the physician
- Incident Analysis Approach – a great process & analysis tools
- Ongoing training in-services on how to conduct proper incident analysis and must be shared broadly
- Suggestion to revamp the Resident Incident Report to include the feedback/suggestions from physicians
- Self-reflection section for staff to identify learnings to ensure resident safety
- Transparency to families on med incidents - policy needs to be followed by all staff in notification of wrong medication given and what was done to correct it

Quality Improvement (QI) – E-Learning

AVAILABLE TO EVERYONE AT: [Long-Term Care | ISMP Canada (ismp-canada.org)]

Quality Improvement Project Flow

Model Policies Update

The first 5 Model Policies for testing are available on the ISMP Canada website for interested LTC homes to test and provide feedback:

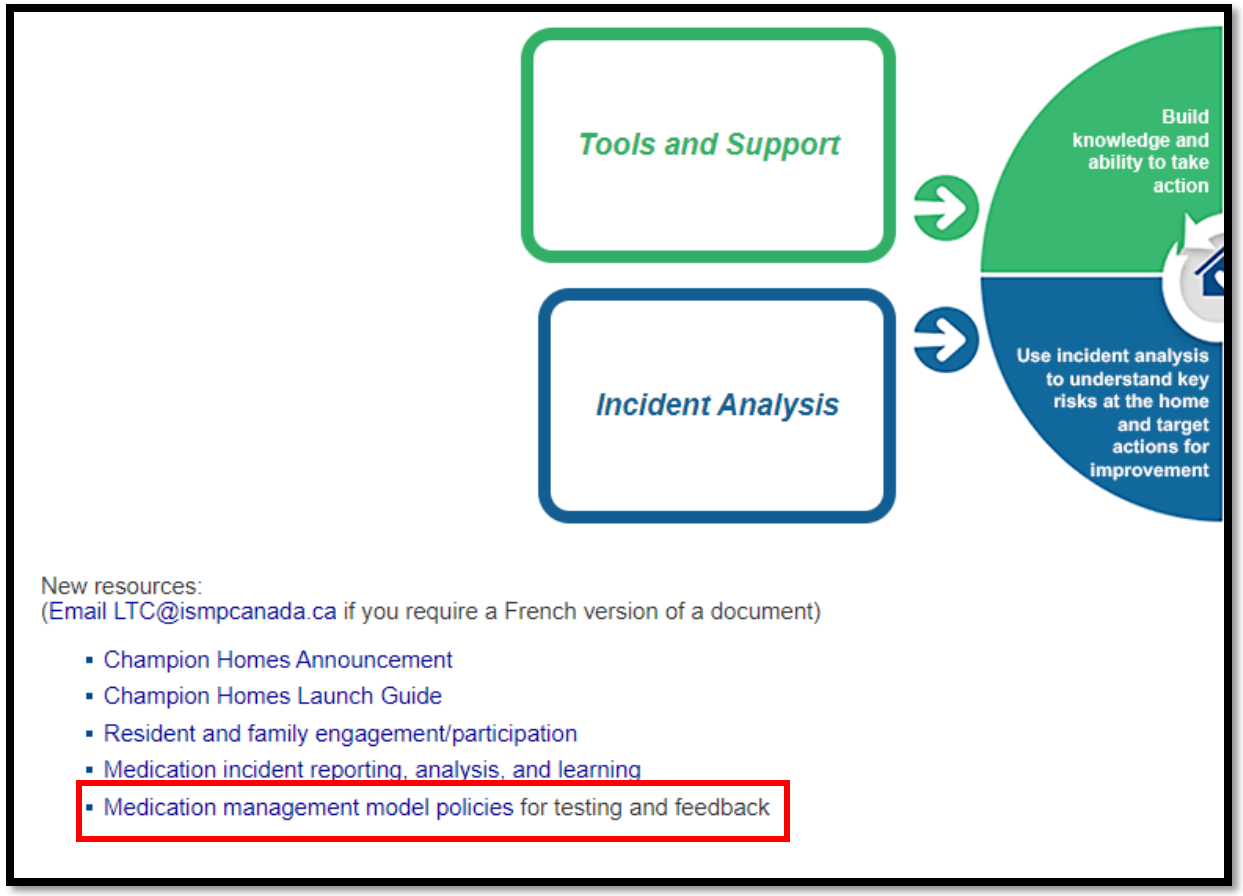
Long-Term Care | ISMP Canada ismp-canada.org

Medication Reconciliation
High Alert Medications
Monitoring for Preventable Harm from Medications
Quarterly Medication Assessments
Emergency Medication Supply

Coming soon:

Drug Destruction and Disposal
Medication Storage
Automated Dispensing Cabinets
Incident Reporting and Learning

Model Policies for Testing



Medication Management Model Policies for Testing and Feedback

ISMP Canada is pleased to provide the following Model Policies for testing and feedback to LTC Homes in Ontario.

Model Policy Feedback

- Model Policy 1 for Testing: Medication Reconciliation (MedRec)
- Model Policy 2 for Testing: High-Alert Medications
- Model Policy 3 for Testing: Monitoring for Preventable Harm from Medications
- Model Policy 4 for Testing: Quarterly Medication Assessments
- Model Policy 5 for Testing: Emergency Medication Supply
- Model Policy 6 for Testing: Drug Destruction and Disposal - To come
- Model Policy 7 for Testing: Medication Storage - To come
- Model Policy 8 for Testing: Automated Dispensing Cabinets - To come
- Model Policy 9 for Testing: Incident Reporting and Analysis - To come

Please provide your feedback at:
https://www.surveymonkey.com/r/LTCModelPolicy

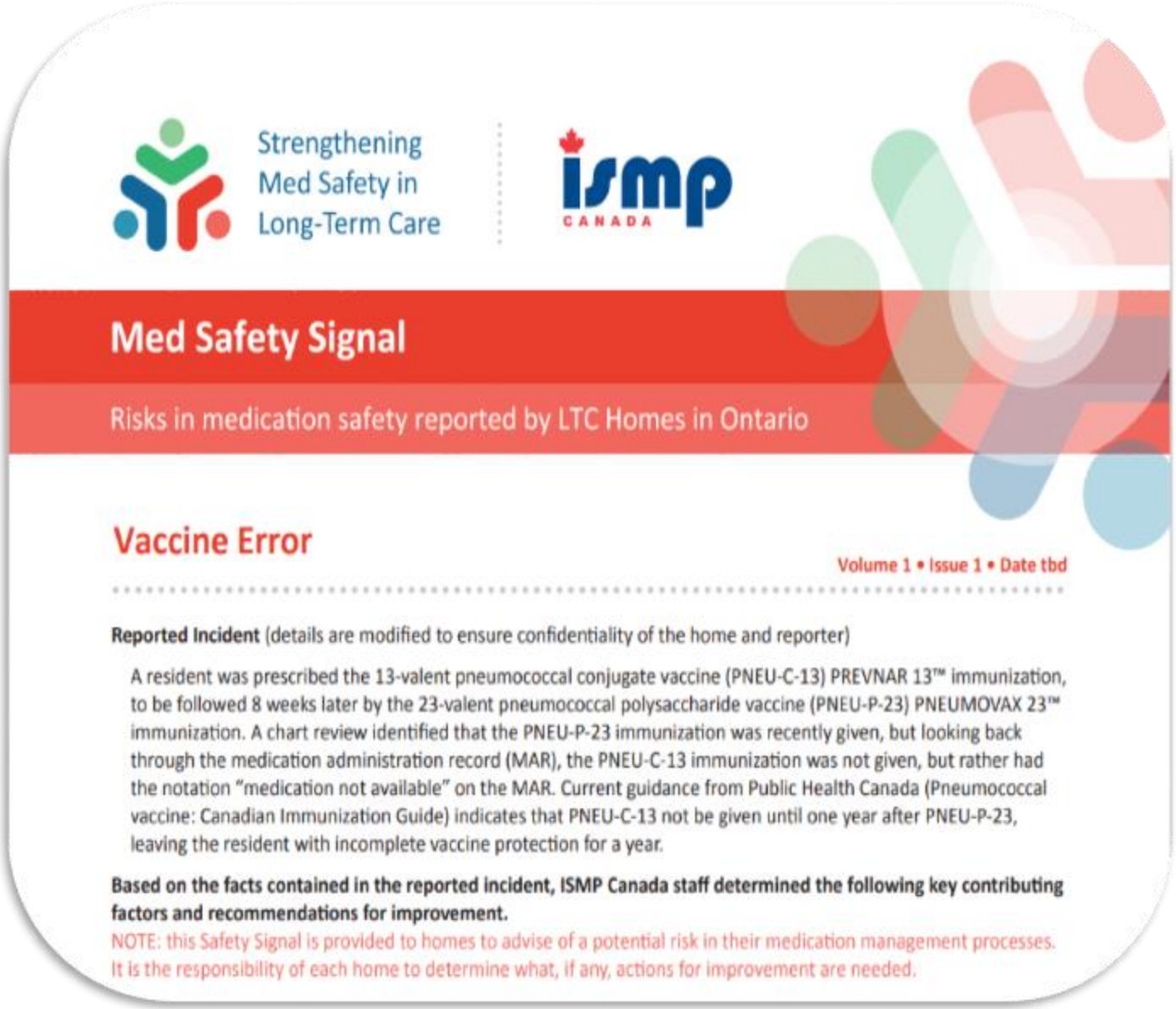
Med Safety Signal

Distribution February 9th via:

- **ISMP Canada email distribution list**
- **Social media**

Sign up for the Signal on ismpcanada.ca

- **Thank you to all the Champion Homes that provided feedback**



Strengthening Med Safety in Long-Term Care

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Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

Vaccine Error

Volume 1 • Issue 1 • Date tbd

Reported Incident (details are modified to ensure confidentiality of the home and reporter)

A resident was prescribed the 13-valent pneumococcal conjugate vaccine (PNEU-C-13) PREVNAR 13™ immunization, to be followed 8 weeks later by the 23-valent pneumococcal polysaccharide vaccine (PNEU-P-23) PNEUMOVAX 23™ immunization. A chart review identified that the PNEU-P-23 immunization was recently given, but looking back through the medication administration record (MAR), the PNEU-C-13 immunization was not given, but rather had the notation "medication not available" on the MAR. Current guidance from Public Health Canada (Pneumococcal vaccine: Canadian Immunization Guide) indicates that PNEU-C-13 not be given until one year after PNEU-P-23, leaving the resident with incomplete vaccine protection for a year.

Based on the facts contained in the reported incident, ISMP Canada staff determined the following key contributing factors and recommendations for improvement.

NOTE: this Safety Signal is provided to homes to advise of a potential risk in their medication management processes. It is the responsibility of each home to determine what, if any, actions for improvement are needed.

MSSA – Resurvey Planning

- The MSSA-LTC is a key measurement tool for the initiative
  - It will be open for resurvey submission starting **June 1st, 2022**
- Please wait **at least 12 months** before finalizing and submitting your resurvey
  - E.g., If your first survey was submitted on July 15, 2021, plan to submit your resurvey sometime after July 16, 2022
- Minor wording changes are planned to a few items to improve clarity
  - E.g., some items related to use of Automated Dispensing Cabinets were more broadly interpreted by some Homes

Opportunities for all homes

- **Access and use various tools available on the website and provide feedback**
- **Model polices**
- **Resident and family engagement tools**
- **MedRec Quality audit**
- **Indicators (Launch Guide)**
- **Workshops -Incident Analysis, BPMH and MedRec, Multi-Incident Analysis Workshops**
- **QI modules**

What's Coming Next...

- MedRec module
- Concise Incident Analysis Workbook
- Advanced Quality Improvement Workshops
- Additional Model **policies**
- Additional Med **Safety signals**

Thank you for participating

Any Questions or
Comments?
Use Chat box

For follow-up
LTC@ismpcanada.ca