Canadian Medication Safety Network

More May Not be Better
Supporting Patients, Caregivers and Health Care Providers with Multiple Medications

Summary of Webinar Participant Feedback

November 26, 2025

Institute for Safe Medication Practices Canada

ismp CANADA

The Institute for Safe Medication Practices Canada (ISMP Canada) is a national, independent, and not-for-profit organization that purposefully partners with organizations, practitioners, consumers, and caregivers to advance medication safety in all healthcare settings. Our team of experts analyze reports of medication errors from across the country and provide resources, education, and consulting services to improve medication safety.

We analyze reports of medication errors and other issues so we can learn about the risks related to medications and collaboratively develop strategies to address them. We share lessons learned, including compelling actionable, evidence-informed recommendations that organizations, practitioners, consumers, and caregivers can use to reduce the risks related to medications. We partner to implement, sustain, and evaluate medication safety improvements in practice.

Additional information about ISMP Canada, and its products and services, is available at www.ismpcanada.ca

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A Key Partner in the Canadian Medication Incident Reporting and Prevention System
Un partenaire clé du Système canadien de déclaration et de prévention des incidents médicamenteux

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Executive Summary

The Canadian Medication Safety Network was created by the Institute for Safe Medication Practices Canada (ISMP Canada) to:

- Create a community to exchange medication safety information between healthcare providers and consumers,
- Obtain information and advice from participants on specific topics and then to have dialogue and learn together,
- Provide participants with valuable Canadian medication safety information,
- Use the information/advice from participants to more effectively develop and implement strategies for reducing preventable harm from medications.

The network engages with participants and the broader public in a variety of ways, such as interactive webinars, social media, and through dissemination and feedback of ISMP Canada materials. This report focuses on the findings from a webinar that was held on November 26, 2025, from 12 – 1 PM EST. There were 53 attendees from across Canada and internationally (the United Kingdom, Bermuda, United Arab Emirates and New Zealand) plus 11 ISMP Canada staff and students and 1 invited guest.

The topic of the webinar was "More May Not Be Better - Supporting Patients, Caregivers and Health Care Providers with Multiple Medications". This topic has been widely requested by participants as a topic for discussion since the inception of the webinar series. In addition, Canada's Drug Agency provided funding to ISMP Canada this year for the development of the tool and toolkit, *5 Questions to Ask About my Multiple Medications*. This webinar provided an opportunity to share the resources intended for and co-designed by patients and caregivers. As many participants are health care providers, a tool and toolkit for providers called 5 Tips to Manage Polypharmacy (created by deprescribing.org) was also shared. The agenda included: Opening remarks, 2 speakers, breakout room discussions and closing remarks.

Attendees participated enthusiastically and there was a positive response to the flow and the content of the webinar, based on a survey that was sent afterwards (see a summary of the results in Appendix 1).

One of the main goals of the webinar was to obtain information about issues, risks and strategies in medication safety from health care providers and people with lived experience and this was achieved. A facilitator and note taker in each breakout room captured the ideas and information that were shared. The feedback has been compiled in this report for public distribution and use by ISMP Canada to advance medication safety across the country.

The link to the recording of the webinar can be found here: https://youtu.be/2MZyZ9x_pZY

Links to each resource are available:

5 Questions to Ask About My Multiple Medications

Tool – in English and in French

Toolkit – in English and in French

5 Tips to Manage Polypharmacy

Tool – in English and in French

Toolkit – in English and in French

1. Purpose and Scope of the Network

One of the goals of the Canadian Medication Safety Network is to provide opportunities for participants to engage in a community to exchange information and ideas. People that interact with medications are invited to come together and learn from each other (including healthcare professionals and people with lived experience).

Developing a webinar with a format to carry this out was an important step in furthering the network activities. Five webinars have been hosted since the inception of the network in 2024.

2. Methodology

For this webinar, a decision was made to extend the invitation more widely than just network members. An e-mail invitation for this webinar was sent to approximately 1100 network participants, 6000 recipients of consumers on ISMP Canada's email list, and it was published on social media. Registrants were asked to complete a Zoom registration form that included a request to select one of 3 topic options under the theme of *More May Not Be Better – Supporting Patients, Caregivers and Health Care Providers with Multiple Medications.* Based on their selection, participants were assigned to that small group discussion (breakout room) during the webinar.

1. Patient Experiences with Multiple Medications
2. Provider Experiences with Multiple Medications (Polypharmacy)
3. Open Dialogue: Emerging Issues (discussion open to all medication safety topics based on the initiative of the participants).

When the webinar began, introductory information was provided, and several polls were launched for voluntary and anonymous completion by participants.

The polls asked the following questions and selected response rates are also provided.

- What is your primary role in health care? N=34
    - Pharmacy Team Member 38%
    - Prescriber 6%
    - Person with Lived Experience 12%
    - Quality Improvement or Patient Safety Professional 21%
    - Other Experts 24%
- Have you or someone you know experienced an issue with the safety of medications?
    - Yes: 94% No: 6%
- Is this your first network webinar? No 38% Yes 62%

Speakers

Jonathan Lam, MSc, Director, Canada's Drug Agency

Jonathan joined the webinar to share information about Canada's Drug Agency (CDA) and the work that they do. He gave background information on their appropriate use strategy and some of the work that has been done to further this strategy.

Alice Watt, Senior Medication Safety Specialist, ISMP Canada

Alice presented the background of the work to create the patient resources. This included the story of the Judith Maxwell, a patient who collaborated on the original 5 Questions to Ask and who experienced preventable effects of taking multiple medications. Alice shared the methodology of the development of the tool and toolkit. She also introduced the companion tool and toolkit for health care providers, 5 Tips to Manage Polypharmacy.

Jonathan and Alice's full presentations can be viewed in the recording found here: https://youtu.be/2MZyZ9x_pZY

The next stage of the webinar was small group sessions where participants spent 30 minutes sharing their perspective. They chose their preferred topic when they registered for the webinar.

Small Group Discussion Topics

1. Patient Experiences with Multiple Medications
2. Provider Experiences with Multiple Medications (Polypharmacy)
3. Open Dialogue: Emerging Issues (discussion open to all medication safety topics based on the initiative of the participants).

Approximately 5 participants were in each facilitated breakout room, and feedback recorded (through written notes) by an ISMP Canada staff member. Facilitators and note takers were prepared for this role by receiving targeted facilitation documents as well as their previous experience in these roles during the prior network webinars. Also, each room had prompt questions developed for the facilitators to help support the conversation. Breakout rooms were not digitally recorded so the notetaker's role was critical to ensure the main points were captured.

Once the breakout rooms were finished, all members returned to the large group and facilitators shared one gem of information from their discussion with all participants.

At the end of the webinar, another poll was launched:

What would you like to share or learn about at the next webinar? Choose your top 3. (n=27)

- Medication safety during times of medication shortages 48%
- Sharing and learning from reported incidents 59%
- Advocacy 101: What does it look like and how do you do it? 30%

- Labelling and Packaging Issues 37%
- Other?: Look Alike/Sound Alike Medications, High Alert Medications, Opioid Safety for a total of 52%

Finally, a post webinar survey link was shared, and members were asked to complete it. Results of the survey are in Appendix 1.

3. Findings and Next Steps

Findings

The notes from each small group discussion were analyzed and themes identified then formalized. They are listed below according to the topic of the discussion.

Patient Experiences with Multiple Medications (3 breakout rooms with the same discussion prompts)

<u>Are these patient resources helpful, and would you use these resources? (Referring to 5 Questions tool and toolkit)</u>

Respondents agreed that the tools are useful. Quotes and observations included:

- "...I will definitely be using the 5 questions."
- A registered nurse agreed and said she would use it with her patients.
- A participant said there is a need in their country for something like this to start a conversation about medications and their safety.
- "This tool is clear for patients to use and practitioners to support."
- There was encouragement to share the tool widely on social media and news outlets
- Participants agreed that the patient resource can also be helpful to health care providers to guide conversations
- "It is helpful for cancer patients"
- "Appreciate the simplicity of the tool"
- "Consider an additional tool to help with notetaking"
- "Pharmacy or physician should print this off for their patients every 6 months or before their appointment"

Key Insight: The tool is useful for both patients and health care providers. People who manage chronic conditions would benefit from using the tool.

What is working well and what could be improved when it comes to your experience with multiple medications?

- There is a lot of information and misinformation available, and it's important for people to understand what they're using and why, and its appropriateness.
- It would be helpful to publish the Best Possible Medication History (BPMH) on the electronic health record (EHR) so that all health care providers can see why a patient is taking a particular medication,
- More sharing of information is needed between providers.
- One concern is the loss of doctors across the country for the care of patients with complex health conditions. When being transferred from one doctor to the next, there is a breakdown in why they're using their medications, and if it's effective. Sometimes the patient has to be a strong advocate, and there isn't anything to help with these transitions. A thorough medication review would help that transition.

Key Insight: There is much information to know about, and misinformation can be a problem. A thorough BPMH is a key tool to support medication safety, especially during transitions of care. The 5 Questions tool can be helpful during transitions of care and medication changes.

What can health care teams do differently to ensure patients feel informed, empowered, and safe when taking multiple medications?

- Patient education from pharmacists could be improved, and more time could be spent with patients. Printouts from the pharmacy are not engaging patients. An example is the opioid safety sheet.
- There is a need to engage patients as partners more effectively and for them to play a bigger role in their health team as an active participant. This can only be done by developing a relationship with them.
- There was a concern shared that bigger/chain pharmacies are not taking as much time with patients as smaller pharmacies are.

Key Insight: Patient/provider relationships are key in improving safety and managing medications.

Prescriber Experiences with Multiple Medications (2 breakout sessions with the same discussion prompts)

Key Discussion Points:

Polypharmacy, Medication Safety & Deprescribing (both the 5 Questions to Ask About my Multiple Medications & the 5 Tips to Manage Polypharmacy are being discussed in these breakout rooms)

Provider Experiences & System Challenges

- Medication Reviews: Often done by pharmacists or nurses; prescribers are less involved.
- Fragmented Care: Having multiple specialists can lead to poor communication, incomplete patient profiles, and make it challenging to follow-up.
- Drug Interaction Risks: Monographs and electronic medication record (EMR) alerts have limitations; newer drugs may lack studied interactions; AI tools are still preliminary and may not be reliable.
- EMR & Pop-up Fatigue: Excessive alerts reduce effectiveness; duplicate medications remain a concern.
- Indication Documentation: There was a discussion about making the documentation of the indication for each medication mandatory for all prescriptions.
- Polypharmacy Burden: Compounding medications may reduce pill burden but does not eliminate polypharmacy. The use of multiple active pharmaceutical ingredients in one compound is still polypharmacy.

Key Aspects to Support Deprescribing

- Patient and prescriber buy-In is essential for success.
- Organizing medication reviews: Sort medications into categories (e.g., cardiac, gastrointestinal, psychiatric, pain, supplements, etc.) to identify duplications.
- Time and planning: Deprescribing takes months; clear tapering and potential stopping plans needed from the start (including expected duration, reduction strategy).
- Post-discharge reassessment: Hospital discharges often add medications to the patient's list; follow-up is needed to avoid unnecessary continuation.
- Addressing fear: Patients and providers may fear stopping medications (possible concerns such as symptom recurrence, negative consequences).
- Check for adverse reactions and pill burden: Helps guide risk-benefit discussions and identify deprescribing opportunities.
- Knowledge gaps: A participant observes limited awareness of tapering protocols and latest evidence in their interactions.

Key Insights: To strengthen medication safety, we need to increase education on deprescribing strategies and high-alert medications, improve communication among care teams, and enhance EMR systems for usability while maintaining critical alerts. Additionally, encouraging documentation of indications and deprescribing plans, along with fostering collaborative research and knowledge sharing, will support more effective and patient-centered care.

Open Dialogue (2 breakout rooms)

What are the biggest challenges with polypharmacy?

- Prescribing cascades – treating side effects with more medications.
- Lack of person-centred care due to following system guidelines. How can we adjust guidelines to fit patients' goals?
- The medical approach tends not to be preventative or proactive, it is reactive. Furthermore, patients often wait until problems occur rather than taking a proactive approach.
- There are communication gaps and medication reconciliation is not done regularly.
- An important example was shared: "*Sometimes, a patient has been on a regular medication for a long time and during their acute care/hospital stay, the medication is not available in hospital formulary and patient's family hasn't brought it from home so the hospital is forced to add more medications and change regimens that creates a disconnect again between patient regimen in and out of hospital."*
- Primary care provider shortages can cause barriers to safe care.

A few other key themes emerged:

Advocacy and Care partners: Patients should be encouraged to have caregivers help them advocate and providers should encourage this engagement.

Tools, Resources and the 5 Questions: The public needs to know where to find the information. Tools should be integrated into electronic health records.

Primary Care: Teams have an important role to play in medication safety. Community pharmacists know their patients but lack time and resources to comprehensively assess medications and give patient/caregiver education. The 5 Questions to Ask and deprescribing tools should become routine and normalized in primary care.

Accessing Information: Not all patient/caregivers can search for information effectively and don't know where to begin. Mederror.ca provides a good start. Canadian and province specific information can be difficult to find. ISMP Canada resources are a trusted source of information.

Key Insights:

Polypharmacy is often exacerbated by prescribing cascades, where additional medications are introduced to manage side effects rather than reassessing the original therapy.

Communication gaps and inconsistent medication reconciliation further compound these challenges, particularly during care transitions such as hospital admissions.

After the Webinar

A survey was sent to all participants and results are summarized in Appendix 1.

A follow up email will be sent to all Network registrants, including a link to this summary report.

In addition, applicable resources suggested at the webinar will be added to the website page at https://ismpcanada.ca/resource/canadian-medication-safety-network/.

These resources will include the following.

- The Zoom recording of the main presentation.
- A copy of this report.

Next Steps

Based on the feedback in the breakout rooms, the polls during the webinar and the post webinar survey, the following actions will be implemented by ISMP Canada.

1. Continue to use the webinar format, including the use of the facilitated small group sessions in breakout rooms.
2. Schedule the next webinar.
3. Based on participant feedback, the theme and breakout room subthemes for the next webinar will be decided.
4. Explore new ways to engage with consumers to have greater engagement at the webinar.

Conclusion

The recent Canadian Medication Safety Network webinar successfully met its objectives. Looking ahead, the network's greatest strength will lie in its ability to foster ongoing conversations between consumers and health care providers, ensuring their voices are heard and their priorities understood. ISMP Canada remains committed to listening and incorporating these insights into the development of future products and services. Through this collaborative approach, participants will play a vital role in shaping the future of medication safety across Canada.

Participants expressed support for the tools presented in this webinar. Overall, patients, caregivers and providers recognize the challenges of managing multiple medications and appreciate the usability of these tools.

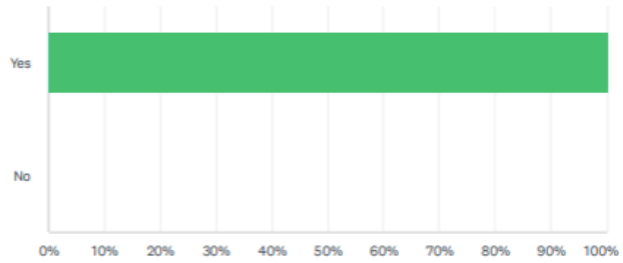
Appendix 1: Post Webinar Survey Results

A short survey was given to all attendees the end of the webinar, and they were asked to complete it with their feedback. A total of 8 people (15% of attendees) completed the survey, results are below.

Question 1

Q1 Did you like the flow of the webinar? (e.g., opening presentation, speaker, breakout rooms, wrap up)

Answered: 8 Skipped: 0



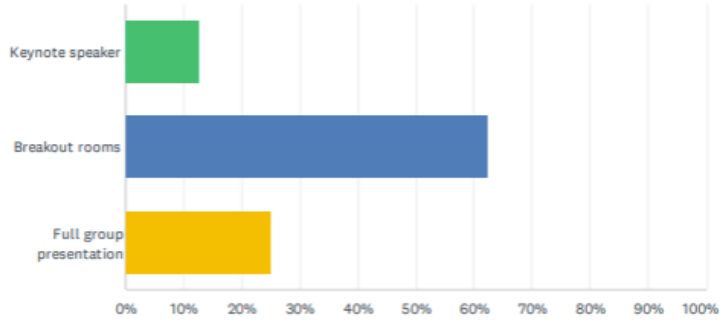
ANSWER CHOICES	RESPONSES	
Yes	100.00%	8
No	0.00%	0
TOTAL		8

#	PLEASE TELL US MORE.	DATE
1	It was concise and easy to understand	11/26/2025 1:06 PM

Question 2

Q2 Tell us your preferred section of the webinar.

Answered: 8 Skipped: 0



ANSWER CHOICES	RESPONSES	
Keynote speaker	12.50%	1
Breakout rooms	62.50%	5
Full group presentation	25.00%	2
TOTAL		8

#	COMMENT	DATE
1	I feel the breakout rooms make for more engagement and people speaking up	11/26/2025 1:13 PM
2	Breakout group allows for small group participation	11/26/2025 1:07 PM
3	The breakout room was amazing but the keynote speakers helped keep the conversation focused	11/26/2025 1:06 PM
4	There were many breakout rooms, not sure if its too hard to make bigger groups to hear more ideas from more participants	11/26/2025 1:03 PM

Question 3

Please indicate your level of agreement by checking the appropriate column.

	STRONGLY AGREE	AGREE	NEUTRAL	DISGREE	STRONGLY DISAGREE	TOTAL
The quality of the content was relevant to my interests.	50.00% 4	50.00% 4	0.00% 0	0.00% 0	0.00% 0	8
The keynote speaker was engaging.	50.00% 4	50.00% 4	0.00% 0	0.00% 0	0.00% 0	8
The time in the breakout rooms was well used.	62.50% 5	37.50% 3	0.00% 0	0.00% 0	0.00% 0	8
The conversation in the breakout room was meaningful.	50.00% 4	50.00% 4	0.00% 0	0.00% 0	0.00% 0	8

#	COMMENTS	DATE
1	I found that listening to the experience of professionals in the breakout room was helpful for me to help advocate for the patient I represent	11/26/2025 1:06 PM

Question 4:

Q4 What topics would you like to see addressed in future webinars?

Answered: 1 Skipped: 7

#	RESPONSES	DATE
1	Losing your prescriber, and transitioning care for complex patients.	11/26/2025 1:06 PM

Question 5:

Q5 Any other suggestions?

Answered: 1 Skipped: 7

#	RESPONSES	DATE
1	One area that we struggle with when helping chronic pain patients is the difference between smaller community-owned pharmacies versus Big Box pharmacies. When prescribing becomes more complex we need all pharmacies to meet a basic level of safety that is higher than it currently is. I would be very interested in discussions around how we might accomplish this.	11/26/2025 1:06 PM