Canadian Medication Safety Network

Consumers and Providers Sharing and Learning About Medication Safety Together

Webinar 1 Report

February 2024

Institute for Safe Medication Practices 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

Purposeful Partnerships

Focus & Impact

Data Driven

Institute for Safe Medication Practices Canada
4711 Yonge Street
Suite 706
Toronto ON
M2N 6K8

Telephone: 416-733-3131 or toll free 1-866-544-7672
Fax: 416-733-1146
www.ismpcanada.ca
info@ismpcanada.ca

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

Contents

Executive Summary

The Canadian Medication Safety Network was created to support the achievement of ISMP Canada's Strategic Plan 2022 – 2026. The goals of the network are to:

- To create a community to exchange medication safety information between healthcare providers and consumers.
- To obtain information and advice from participants on specific topics and then to have dialogue and learn together.
- To provide participants with valuable Canadian medication safety information.
- To use (by ISMP Canada) the information/advice from participants to more effectively develop and implement strategies for reducing preventable harm from medications.

The network will be developed in a variety of ways such as interactive webinars, social media engagement and through dissemination and feedback of ISMP Canada materials. This report focuses on the findings from the first webinar which was held on February 7, 2024, from 12 – 1 PM EST. There were 129 attendees including 21 ISMP Canada staff.

The agenda of the webinar included: Opening remarks, keynote speaker, breakout rooms 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.

One of the main goals is 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.

As one of the main goals is to listen to the needs and ideas of the network participants, there was also a specific focus on learning what topics were important to integrate into future webinars. Creating a culture of medication safety was the top choice for webinar participants based on the post webinar survey responses.

1. Background and Understanding of Project

One of the goals of the Canadian Medication Safety Network is to provide opportunities for members to gather in one community to exchange information and ideas. Developing a webinar with a format to carry this out was an important step in furthering the network activities. This webinar was the first and there is a plan to f conduct more.

2. Purpose and Scope

To provide an exchange forum where people who interact with medications can come together and learn from each other (including health care professionals and people with lived experience).

3. Methodology

An e-mail invitation for the first network webinar was sent to the approximately 600 network registrants. They were asked to complete a Zoom registration form that included a request to select one of 5 topic options that they wanted to discuss within a small group (breakout room) during the webinar.

1. Enhancing Communication for Medication Safety: Exploring Challenges and Solutions
2. Medication Safety: Addressing Errors and Advancing Improvement Strategies
3. Designing a Consumer-Focused Website: Structure and Content Considerations
4. Evaluating the ISMP Canada Website: Providing Feedback on Structure and Content
5. Open Dialogue Rooms: Informal Sharing of Feedback on Medication Safety Initiatives

When the webinar began, an opening presentation was shared that included information about ISMP Canada, the goals of the webinar, and participant polls. The polls asked the following questions and some responses have also been provided below.

- What is your primary role in health care?
    - Pharmacy Team Member 44%
    - Nurse 16%
    - Person with Lived Experience 12%
    - Quality Improvement or Patient Safety Professional 24%
    - Other Experts 4%
- Have you or someone you know experienced an issue with the safety of medications? 90% Yes, 10% No
- What matters to you about this webinar?
    - Hearing diverse perspectives 74%
    - Learning more about medication safety 83%
    - Meeting people in my field 47%
    - Learning about everyone's role in medication safety 65%
    - Receiving resources6 4%
- What was one word that makes you think of medication safety? This data was collected and was used to create a word cloud (See Appendix A for the word cloud)

Dr. Leigh Chapman, Chief Nursing Officer of Canada gave a keynote address to the webinar attendees. Her knowledge and expertise helped set the stage for meaningful dialogue between participants about medication safety and the impacts that consumers and health care providers experience. She spoke

about the importance of lived experience from patients and families to help inform and support system strategies to reduce preventable harm from medications. She discussed the acute challenges nurses face in ensuring safe medication administration, drawing on her experience in critical care where even minor errors in dosage calculations could have serious consequences.

The next stage of the webinar was the small group sessions where participants spent 20 minutes sharing their perspective (they chose their preferred topic when they registered for the webinar):

- Enhancing Communication for Medication Safety: Exploring Challenges and Solutions
- Medication Safety: Addressing Errors and Advancing Improvement Strategies
- Designing a Consumer-Focused Website: Structure and Content Considerations
- Evaluating the ISMP Canada Website: Providing Feedback on Structure and Content
- Open Dialogue Rooms: Informal Sharing of Feedback on Medication Safety Initiatives

Each breakout room was facilitated, and feedback recorded (through written notes) by an ISMP Canada staff member and/or a purposeful partner representative that volunteered for this role. Facilitators and note takers were prepared for this role by attending a prep session to ensure they were able to use the Zoom platform easily, and a support document was created to give them tips to successfully facilitate the small group discussions. Also, each room had prompt questions developed to help support conversation. Breakout rooms were not digitally recorded so the note taker'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 2 facilitators shared one gem of information from their discussion. Then, a new LinkedIn group for participants was introduced and another poll was launched:

What would you like to share or learn about at the next webinar? Choose your top 3. Below are the answers, ranked in order from most interested to least interested.

- Creating a culture of medication safety (65% ranked as #1)
- Overprescribing of medications (e.g., opioids, antibiotics) (40% ranked as #2)
- Medication and healthcare provider shortages (39% ranked as #3)
- Prevention of harm from known information (e.g., allergies or interactions) (36% ranked as #4)
- Polypharmacy (32% ranked as #5)

Finally, a post webinar survey link was shared, and members were asked to complete it. Results of the survey are in Appendix 2

4. Findings and Recommendations

Findings

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

Enhancing Communication for Medication Safety

- Medication errors stem from communication lapses at critical points, emphasizing the need for enhanced channels and clear information dissemination.
- Patient engagement and increased health literacy are vital to improve communication. Health care providers must encourage questions and tailor information. There is a need for improved packaging and labeling for error prevention.
- Engaging patients and caregivers to be active members of their health care team adds a layer of safety as do innovative solutions such as web apps, involving patient/citizen partners in research projects, and establishing a clear feedback loop. Transparency and collaboration between siloed information sources is essential to improve communication and prevent adverse drug events.

Medication Safety: Addressing Errors and Advancing Improvement Strategies

Health care professional shortages and process workarounds are contributing factors to medication errors. Increased dialogue with patients and caregivers is an important strategy to prevent errors.

- Collaboration between healthcare providers and patients is essential for mitigating risks during transitions of care.
- Patient involvement in discussions and treating them as partners in care, helps break down barriers and enhance medication safety.
- Establishing and advancing systems for medication error reporting and broader sharing of information is vital for learning from mistakes and preventing future errors.

Technology plays a dual role in medication safety, serving both as a tool for error reduction and a potential source of new errors.

- Solutions like electronic charting and barcode scanning are discussed as methods for reducing errors.
- Technology is also recognized as a potential source of new errors, highlighting the importance of careful implementation and monitoring.

Psychological Safety: Empower the public to feel safe and speak up, keeping in mind that they may not know exactly what questions to ask. A culture of overall safety and learning is key.

    - Help patients/families to know what to monitor and what to do if something goes wrong, encourage learning from errors.
    - Use a multi-prong approach to connect with, engage, and advance public engagement (including media, social media and public forums)
    - Advance “Medication Safety Literacy”

Designing a Consumer-Focused Website: Structure and Content Considerations

Awareness gaps exist among consumers and healthcare professionals regarding medication safety reporting and information dissemination, emphasizing the need for improved education and targeted advertising.

Diverse communication preferences necessitate varied approaches, from newsletters to videos, to effectively convey medication safety information and procedures.

Collaboration and resource sharing, including creating content for external organizations, can enhance communication efforts and address turnover-related challenges in healthcare leadership.

Open Dialogue Room: Informal Sharing of Feedback on Medication Safety Initiatives

Standardized education and training modules are crucial for frontline healthcare workers to address practice deficiencies and ensure up-to-date knowledge on medication safety.

- A basic medication safety module can help retrain staff and promote consistent practices across the country.
- Lack of standardized education contributes to medication errors during transitions of care, indicating a need for national level standards

Establishing national and provincial systems for medication reconciliation and logging patient medication records can help prevent medication discrepancies and duplications, especially for patients transitioning between healthcare settings.

- Discrepancies in medication safety information highlight the need for standardized guidelines and information from organizations like ISMP Canada
- Consistent medication records and reconciliation processes are essential for promoting appropriate medication use and minimizing errors.

Collaborative efforts between policy makers, clinical teams, and indigenous communities are essential for culturally appropriate medication safety initiatives and education.

- Guidelines and trainings tailored for frontline workers can help ensure culturally appropriate care for indigenous communities and improve medication safety outcomes.

Evaluating the ISMP Canada Website: Providing Feedback on Structure and Content

Note: this breakout room did not occur due to lack of participants.

Common Themes from All Breakout Rooms

Communication gaps are a major contributing factor to medication errors.

There is a need for greater medication safety (health) literacy, awareness, education, and national/provincial standardization of tools.

Technology is an important tool in medication safety but cannot be relied upon independently.

Patient/provider dialogue and engagement are important factors in preventing harm from medication.

Safety culture is essential in health care.

After the Webinar

After the webinar was completed, there was a debrief meeting held with breakout room facilitators, note takers and IT support. The purpose of the meeting was to hear about their experiences during the small group sessions including their level of preparation to be a facilitator/note taker, how supported they felt throughout the process, the discussion prompts that were provided, and any feedback on how to improve the experience for them and webinar attendees' next time. Participants said they felt well prepared after the prep session as well as after reviewing the facilitator guide that was created and distributed ahead of time.

A follow up email will be sent to all Network registrants and applicable resources will be added to the website page on ismpcanada.ca.

These resources will include the following.:

- The Zoom recording of the main presentation: https://www.youtube.com/watch?v=NXvUl20pLSo
- A copy of this report
- Any relevant infographics designed to summarize key facts about the webinar and applicable findings.

Recommendations

Based on the feedback in the breakout rooms, the polls during the webinar and the post webinar survey, the following are recommendations for action 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 for Wednesday May 8, 2024, at 12 – 1 ET. Follow a similar format to the first webinar however extend the time in small group discussions (30 minutes).
3. Explore the creation of tools suggested by the participants, e.g., standardized medication safety education tools and provide updates as applicable.
4. Examine the potential for collaboration between ISMP Canada and specific consumer groups such as those in Indigenous communities and health care providers who work in these communities.
5. Incorporate a variety of formats to convey information on the new consumer website.

5. Conclusion

The inaugural Canadian Medication Safety Network webinar was successful in its goals and set a great precedent for future events. The true value of this network will be to continue to facilitate dialogue with consumers and health care providers about their needs and interests. ISMP Canada will continue to listen to these voices and integrate the findings into new products and services. Through this process, network participants will help shape the future of medication safety across the country.

Appendix 1:

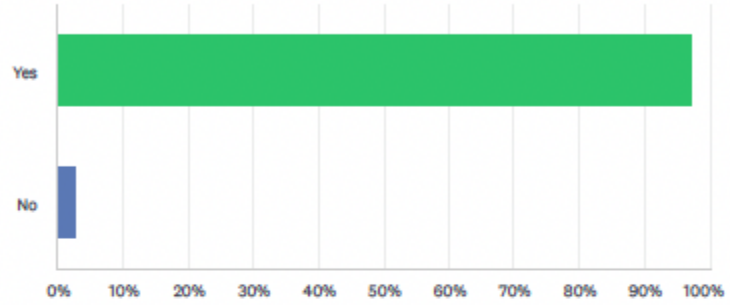
This word cloud was created with the input of webinar participants. They were asked, **"What is one word that makes you think about medication safety?"** A word cloud is formed when participants add one word at a time. The more times the word is mentioned (usually by different people), the larger the word gets. In this word cloud, the most common words used are *patient(s), errors, collaboration, communication, harm, accountability and improvement.*

Appendix 2:

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 37 people (34% of attendees) completed the survey, results are below.

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

Answered: 37 Skipped: 0

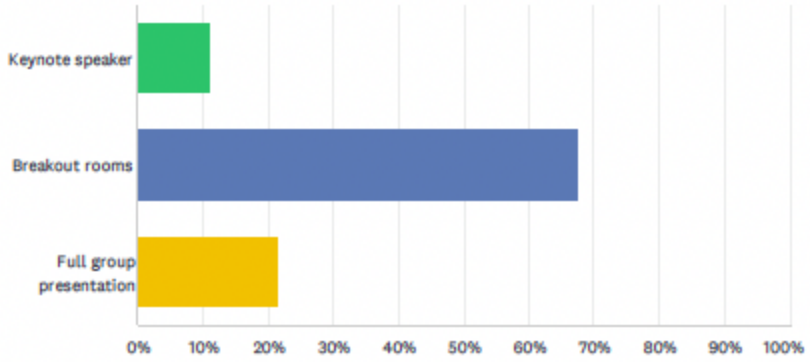


ANSWER CHOICES	RESPONSES	
Yes	97.30%	36
No	2.70%	1
TOTAL		37

#	PLEASE TELL US MORE.	DATE
1	Listening to Leigh and learning about that position was great. The intro could have been quicker.	2/7/2024 1:20 PM
2	need more time in the Breakout rooms	2/7/2024 1:07 PM
3	You really managed to pack a lot of great discussion in without it feeling too rushed. Fantastic session.	2/7/2024 1:06 PM
4	Love having a breakout. Would like to.have a list of attendees if people are comfortable. This will support provincial sharing (generative learning)	2/7/2024 1:02 PM
5	My breakout room wasn't relevant to me at this time	2/7/2024 1:00 PM
6	Sorry, was busy and didn't get signed in in good time.	2/7/2024 1:00 PM

Q2 Tell us your preferred section of the webinar.

Answered: 37 Skipped: 0



ANSWER CHOICES	RESPONSES	
Keynote speaker	10.81%	4
Breakout rooms	67.57%	25
Full group presentation	21.62%	8
TOTAL		37

#	COMMENT	DATE
1	all was very good so hard to say	2/7/2024 7:52 PM
2	Breakout room was good conversation. Would have loved to brainstorm/consider current resources of ways to improve. what are other Health Authorities doing? etc.	2/7/2024 1:20 PM
3	More in depth and real-life specific scenarios, problems and suggestions.	2/7/2024 1:03 PM
4	It was a great combination	2/7/2024 1:02 PM
5	I wish I didn't have to choose only one	2/7/2024 1:01 PM
6	Sorry got signed in late. Will watch the recording.	2/7/2024 1:00 PM

Q3 Please indicate your level of agreement by checking the appropriate column.

Answered: 37 Skipped: 0

	STRONGLY AGREE	AGREE	NEUTRAL	DISGREE	STRONGLY DISAGREE	TOTAL
The quality of the content was relevant to my interests.	51.35% 19	35.14% 13	13.51% 5	0.00% 0	0.00% 0	37
The keynote speaker was engaging.	40.54% 15	35.14% 13	24.32% 9	0.00% 0	0.00% 0	37
The time in the breakout rooms was well used.	51.35% 19	37.84% 14	10.81% 4	0.00% 0	0.00% 0	37
The conversation in the breakout room was meaningful.	59.46% 22	27.03% 10	10.81% 4	2.70% 1	0.00% 0	37

#	COMMENTS	DATE
1	The time in the breakout room was a bit too long.	2/7/2024 1:20 PM
2	I was in a very quiet group and there wasn't much conversation.	2/7/2024 1:02 PM
3	Only suggestion is to request people promoting their products/ websites that it is discouraged	2/7/2024 1:01 PM
4	More time in breakout rooms would be great!	2/7/2024 1:00 PM

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

Answered: 24 Skipped: 13

#	RESPONSES	DATE
1	how to use medications safely; how to be a medicaition advocate as a caregiver for a LTC patient; how to use the system to report on the medication continum ie safe use, side effects, errors, contraindications, overdoses, deaths, serious events; how to report as a patient or caregiver; education for regualr patients/POA/caregivers to participate and be listened to as part of the system	2/7/2024 7:52 PM
2	what was discovered during these breakout sessions and the next steps.	2/7/2024 4:23 PM
3	How to advocate for medication safety as a healthcare worker. nurse, pharmacist level etc. How can we empower frontline workers to be part of ensuring safe medication administration?	2/7/2024 1:20 PM
4	Clear steps to take when things go wrong, so nothing is hidden in the system and a change from status quo is not optional.	2/7/2024 1:07 PM
5	Ways to support cultivation of safety culture in healthcare	2/7/2024 1:06 PM
6	-creating a culture of safety in the pharmacy reducing medication errors -patient and hcp med safety/error prevention tools and resources to share more broadly	2/7/2024 1:05 PM
7	polypharmacy, overprescribing, teaching providers how to engage with patients/families and the importance thereof.	2/7/2024 1:04 PM
8	Building safety culture.	2/7/2024 1:03 PM
9	polypharmacy	2/7/2024 1:03 PM
10	Medication Safety and Technology Fostering Safety Culture Share at organizations review their incident reporting data? Share organizations med safety structure	2/7/2024 1:03 PM
11	Cancer care med errors and processes	2/7/2024 1:02 PM
12	The ones identified in the poll	2/7/2024 1:02 PM
13	Spotlights on certain strategies other organizations have put in place to address medication safety issues. I think there is a lot we can learn from each other.	2/7/2024 1:02 PM
14	Medication safety initiatives and mitigation strategies that have been successful.	2/7/2024 1:01 PM
15	Automated dispensing cabinets and barcoding safety challenges	2/7/2024 1:01 PM
16	Operationalization of Just culture beyond a policy statement	2/7/2024 1:01 PM
17	Explanation of how ISMP works and its use to health professionals	2/7/2024 1:00 PM
18	Population-specific ie. Pediatrics, Geriatrics, critical care	2/7/2024 1:00 PM
19	How to educate patients about their medication	2/7/2024 1:00 PM
20	Development of a national hazardous medication list	2/7/2024 1:00 PM
21	As discussion moves forward it would be helpful to learn about evidenced based strategies to reduce errors, based on practice setting.	2/7/2024 1:00 PM
22	polypharmacy	2/7/2024 1:00 PM
23	These were great topics	2/7/2024 12:59 PM
24	Medication safety initiatives across the country	2/7/2024 12:59 PM

Q5 Any other suggestions?

Answered: 11 Skipped: 26

#	RESPONSES	DATE
1	present the medication safety as a continum ie safe use, side effects, contraindications, near miss, errors. Communication and education is the key to preventing death and life changing occurences.	2/7/2024 7:52 PM
2	Thanks for planning and hosting this and I hope it continues. Appreciate your efforts at ISMP	2/7/2024 1:20 PM
3	Allow some one with a story to submit it to a safe place that will be addressed, not locally, at the top level so changes can actually happen in the system. Not just where it happened but for the overall necessity of safety for all patients in Canada. I am an advocate for those without a voice and I love to sing strong for advocacy for those who can't. Where can I send my Case Story which is fully presented in writing and changes that have to happen in order for it to never happen again to anyone?	2/7/2024 1:07 PM
4	Exciting initiative!	2/7/2024 1:05 PM
5	creating a medication safety culture	2/7/2024 1:04 PM
6	Increase time please!	2/7/2024 1:03 PM
7	How to inform about an ER adverse drug event -- to the patient experiencing it and then back to the prescriber who prescribed the medication without alienating the prescriber.	2/7/2024 1:03 PM
8	I would not consider some of the future topics in the poll to be part of Medication Safety: Polypharmacy - this is more of a clinical issue Shortage of providers/healthcare workers - not within my scope of work; nor interest Cost of medications - while intersting is not within my scope of medication safety work	2/7/2024 1:03 PM
9	Great job today - very helpful and looking forward to more webinars. Thank you all.	2/7/2024 1:01 PM
10	Great organization and content!	2/7/2024 1:00 PM
11	safety with changing health care needs and staff shortages	2/7/2024 1:00 PM