Provincial Update Webinar

March 22nd, 2023

Strengthening Medication Safety in Long-Term Care

Zoom Webinar Platform

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Audience settings

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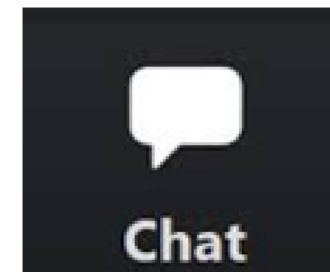

WEBINAR IS RECORDED

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

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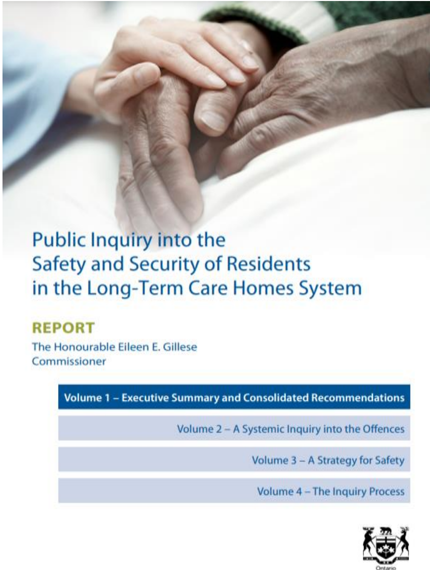
An Initiative to Support the Long-Term Care Sector



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

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AGENDA

- **Welcome**
- **Trailblazer Home Updates**

  1. Resident and Family Engagement
  - Melissa Sheldrick, Patient and Family Advisor, ISMP Canada
  - Alex Lamsen, Manager of Clinical Practice, Niagara Region

  2. Adapt and Implement a Model Policy
  - Christine Fleming, Staff Educator, Chester Village Long-term Care, Toronto

  3. Quality Improvement Initiative
  - Mary Kate Garrity, Director of Care, Sienna Living – Midland Gardens, Scarborough

  4. Medication Reconciliation
  - Elimar Guaca, Director of Resident Care, Rekai Centres – Sherbourne Place, Toronto

  5. Report, Learn and Act
  - Brittany Saini, Director of Care, Arbour Creek Care Centre, Hamilton
- **Faculty Updates**

  ✓ *Practice Tool for Insulin Destruction and Disposal*

  ✓ *Med Safety Signal #4 – Hydromorphone Dosing*

Thank you to the 10 Champion Homes and the 52 Trailblazer Homes!

The path ahead has been started and now our work together is to spread and scale the improvements to medication safety provincially!

Strengthening
Med Safety in
Long-Term Care

Trailblazer Home
Getting Started Kit!

November 2022

"It's a marathon, not a sprint!"

Trailblazer Home Cohorts

Trailblazer Home Workbook
Resident and Family Engagement in Medication Management

November 2022

Trailblazer Home Workbook
Completing a Quality Improvement Project

November 2022

"It's a marathon, not a sprint!"

Trailblazer Home Workbook
Report, Learn & Act After a Medication Incident

November 2022

"It's a marathon, not a sprint!"

Trailblazer Home Workbook
Adapt and Implement Medication Management Model Policies

November 2022

"It's a marathon, not a sprint!"

Trailblazer Home Workbook
Medication Reconciliation (MedRec)

November 2022

"It's a marathon, not a sprint!"

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Melissa Sheldrick
Patient and Family Advisor,
ISMP Canada Faculty

Resident and Family Engagement

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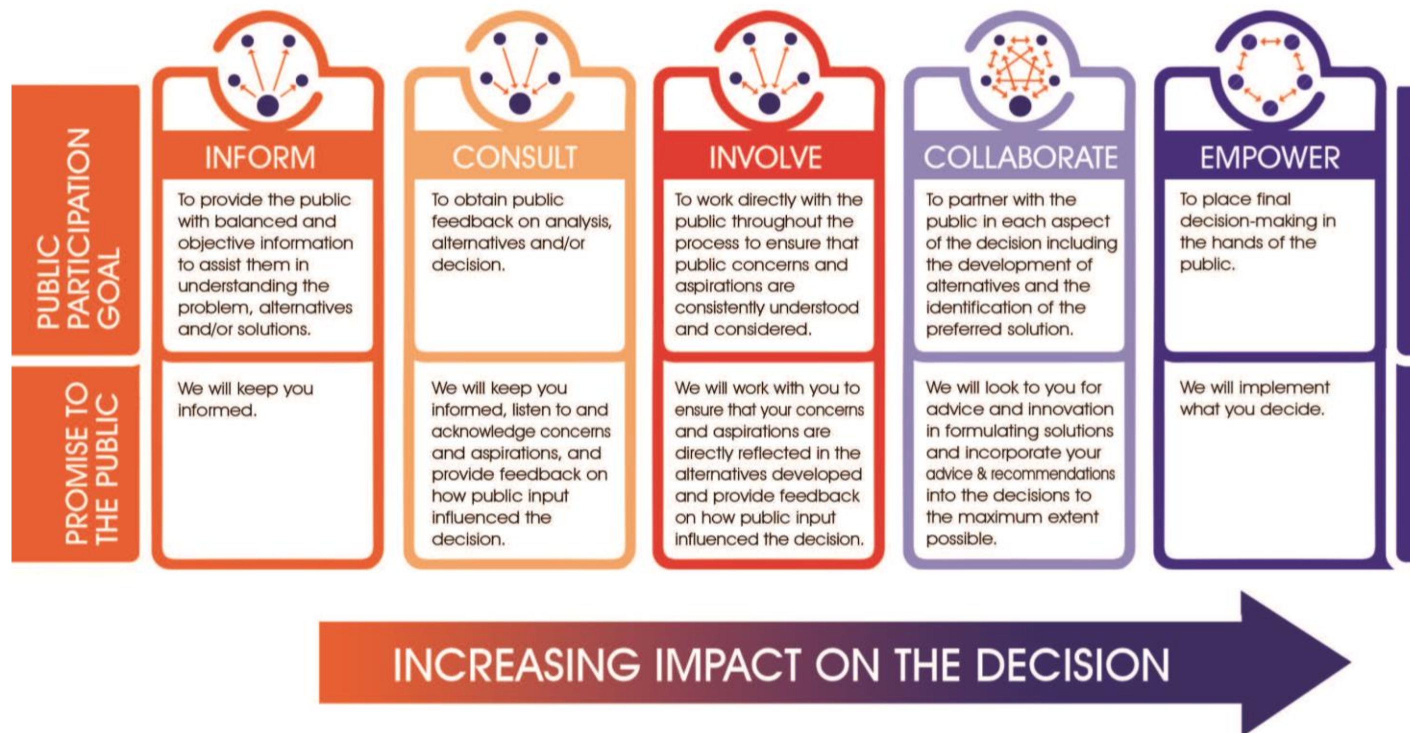

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SENIORS SERVICES

Resident and Family Engagement

Alexis Lamsen, Nurse Manager, Niagara Region

Niagara Region

Deer Park Villa

Gilmore Lodge

Linhaven

Meadows of Dorchester

Northland Pointe

Rapelje Lodge

Upper Canada Lodge

Woodlands of Sunset

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Resident and Family Engagement

Legislative requirements

Resident and Family Survey

MSSA- LTC

Seniors Services Resident and Family Engagement Review- 2022

Project Update

Niagara Region

1. Medication Incident Analysis
2. MSSA Assessments (Year 1 and 2)

1. Resident and Family Engagement
2. Quality Improvement
3. Two QI projects

Model Policy (2)
- Monitoring for Preventable Harm from Medication
- Medication Storage

SUCCESS

SENIORS SERVICES

Resident and Family Engagement

Focus: Build on the results of the Resident and Family Engagement survey from ISMP Canada and the Seniors Services Engagement Survey

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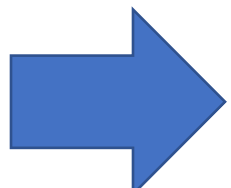
Project Update

	Inform	Consult	Involve	Collaborate	Empower
Public Participation Goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives and/or solution.	To obtain public feedback on analysis, alternatives and/or decision.	To walk directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public	We will keep you informed	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how the public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice & recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Inform	Timeline	Activities	Person Responsible	Consult	Timeline	Activities	Person Responsible	Notes
Information Provided to resident and family regarding the project	October 2021	Email send to residents and families	UCL Office Lead	Survey sent to families and residents	December 2021	Survey developed and sent	Project lead QI advisor	
		Maintain up-to-date email list of residents/families		Survey reviewed by the project lead	January 2022	Review	Project lead	
Information Board for residents and families regarding the project	December 2021	Information board set up	☐ UCL Team ☐ Project Lead	Survey to be reviewed by the team July 2022	July 2022	Discussion and develop action plan	Team	
Medication Management Brochure	June 2022	Brochure for Medication Management	☐ Project Lead ☐ Communications-HQ	Revise medication management safety meeting TOR	April 2022	Developed TOR for the medication management safety	Project lead QI advisor	Next Month Aug 2022
Medication Information in TV	July 2022	Project different medications: information and possible side effects in the TV	Team	Review and Revised Consent to Treatment and medication Policy	June 2022	Review and revise policy	Project lead	
			☐	Resident Council Meeting	June 20022			
			☐	Quality Meeting	June 2022			

Involve	Timeline	Activities	Person Responsible	Collaborate	Timeline	Activities	Person Responsible	Notes
Develop script when obtaining consent	June 2022	Script when obtaining consent	Project lead	What Matters To You - script encourages the resident or SDM/family to ask questions	June 2022	Script when obtaining consent	Project Lead	
Include resident/family in medication safety meetings and PAC	Ongoing	Send invitation	Team	Work with the nursing staff/pharmacy/resident/SDM in MSSA	Ongoing	MSSA	Project Lead/ DRC	Resident involvement
				Annual Care Conference - Add question- ***Do you have any questions about your medications?***	August 2022	Consult with RFSW	Project Lead	Included during care conference



Informed Decision Making

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Informed Decision Making

SENIOR SERVICES

RESIDENT ENGAGEMENT MEDICATION SCRIPT

Ensure you are talking to the correct resident and acknowledge the chief complaint (i.e. pain).

"Hi (name of the resident), my name is (nurse) and I will be taking care of you today. I understand you are having significant (type/location) pain, is that correct?"

Introduce the medication you will be using for the pain.

"The medication we will be using to help control your pain is (type of medicine)."

Explain how long the medication will take to work and how long it will work.

"This medication will take about (timeframe) to start working and should help to control your pain for (timeframe)."

Explain to the resident how the medication will work (check the Pepid portal or ask your pharmacist). Discuss possible side effects.

"This medication will help to control your pain by (describe effects). There are possible side effects to this medication, including (describe side effects). We will be monitoring you very closely. Our priority is to control your pain and will continue to check in on how you are feeling. If this medication does not control your pain, we can talk about other alternatives that may help."

Answer all the resident's questions and address any concerns. Thank the resident for their time and ensure they understand the plan.

"Thank you for your time, I am confident this medication will help to control your pain. Please let me know if you have any additional questions or concerns. I hope you start feeling better soon."

Example:

Hi Mr. Smith, I understand you are having significant pain in your back, is this correct? The medication we will be using to control your back pain today is called Ketorolac. Ketorolac will take about 30 minutes to start working and should help to control your pain for 4-6 hours. This medication works like Advil and will decrease the inflammation in your back which is likely causing your pain. You should not experience any side effects from this dose. Our priority is to control your pain appropriately and will continue to check in on how you are feeling. If this medication does not control your pain, we can talk about alternatives that may help. Do you have any questions? Thank you for your time, I am confident this medication will help to control your pain. Please let me know if you have any additional questions or concerns. I hope you start feeling better soon.

Niagara Region | niagararegion.ca/seniors

Medication Administration Script

- Ensure you are talking to the correct resident and acknowledge the resident's chief complaint
- Introduce the medication you will be using for their chief complaint
- Explain how long the medication will take to work and how long it will work for
- Explain to the resident how the medication will work. Discuss possible side effects, adverse effects and monitoring.
- Answer all the resident's questions and address any concerns
- **Thank the resident for their time and make sure they understand the plan**

There are five main subjects that should be covered when obtaining consent or providing education

- Purpose of the medication
- Name of the medication (brand/generic name), dose of the medication
- Duration and frequency of the medication administration
- Side effects, possible monitoring and adverse effects
- Answer all the resident's questions and address any concerns
- **Thank the resident for their time and make sure they understand the plan**

Engagement

DATE/TIME: [Date]

LOCATION: Choose an item.

INVITE: *(Administrator, DRC, ADRC, Pharmacy, Public-Health, FSM, Medical Director, Resident, family)*

Medication Safety Committee: Administrator, DRC, ADRC, Pharmacy, Medical Director, RN/RPN, Registered Dietitian

REGRETS:

RECORDER:

USER GUIDE

Medication Safety Self-Assessment® for Long-Term Care

Canadian Version III

Strengthening Med Safety in Long-Term Care

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What are the results so far?

- All 8 regional homes have adopted all strategies to improve resident and family engagement
- Qualitative data – residents and families have emphasized improvement in shared decision-making and knowing their medications
- MSSA-LTC will now be done every year to track medication-related indicators including resident and family engagement

Key Learnings and Next Steps

- Residents and families are at the centre of our care
- Knowledge is power, so empower our residents and families
- Resident and family engagement should be integrated in our care model

NEXT STEPS: Senior Services Resident and Family Engagement

Adapting and Implementing a Model Policy

Shirley Drever

Strengthening Medication Safety in LTC Project Manager,

ISMP Canada Faculty

Chester Village

Policy for Automated Dispensing Cabinet

Christine Fleming, Staff Educator

Policy for Automated Dispensing Cabinet

- In July of 2022, a *MedSelect®* automated dispensing cabinet was introduced into the home to replace the Emergency Box

- There was no specific home policy and procedure for the use of the automated dispensing cabinet

- Staff had been trained on using the cabinet but there was no place for new hires or agency staff to refer to if they had questions

Activities Completed to Date

1. Formed a working group to write a DRAFT Home Policy for the automated dispensing cabinet including the Director of Care, the Assistant Director of Care, the Consultant Pharmacist, and the Staff Educator.

2. Reviewed ISMP Canada Model Policy and added items specific to our home using the pharmacy policy and working group feedback.

3. Attended the Process Mapping Workshop and developed a process map of the current process for using the ADC for emergency supplies.

DRAFT Automated Dispensing Cabinet Policy

SECTION: MEDICATION ADMINISTRATION	INDEX I.D.: RCSM-F-??
SUBJECT: AUTOMATED DISPENSING CABINET	PAGE: 1 OF 10
APPROVED BY: DIRECTOR OF CARE	DATE: JANUARY 30, 2023
REVIEWED BY: DIRECTOR OF CARE	DATE: ???????

PURPOSE

This policy outlines the process for provision, storage, tracking and security of medications using an Automated Dispensing Cabinet (ADC)-MedSelect machine in the Home to ensure medication access, potency, and safety.
(See page 10 for Glossary of Key Terms)

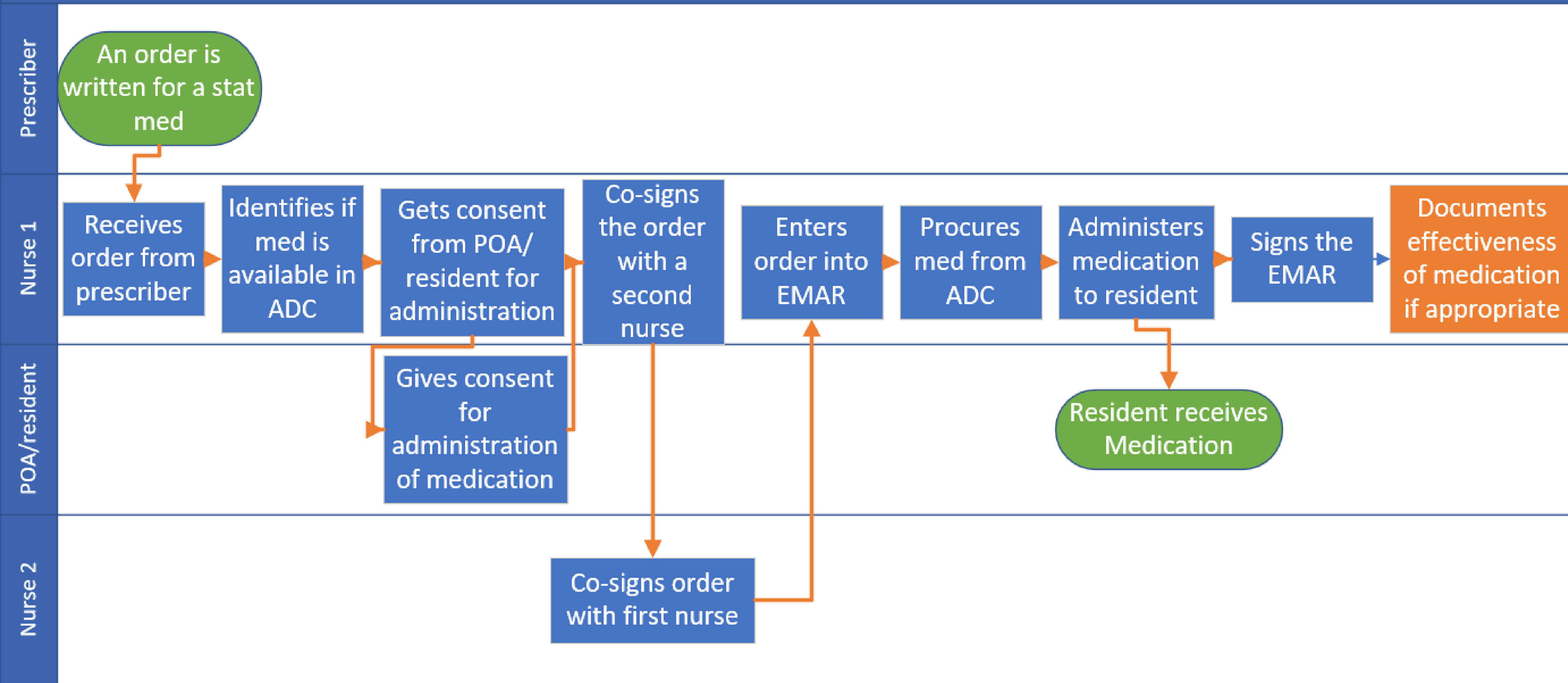
Scope:
This policy applies to all personnel involved in supporting medication management including nurses, pharmacists, pharmacy technicians and assistants, and additional staff (such as leadership, maintenance, and IT), working to support the provision of medications to residents in a LTC Home.

Introduction:
To decrease risk and improve security of medications, automated dispensing cabinets are being used to enhance medication management in Long-term Care. Common uses include:

- replacement of the emergency medication supply box (E-box) to enhance accuracy, accountability, and timely access to medications.
- as an inventory of the most commonly used medications based on historical information in order to enable timely access to first doses; and,
- as an inventory control mechanism to increase accountability regarding access to controlled substances.

Location of ADC-MedSelect machine
Ground floor-Diamond Unit-Treatment Room

ADC-Processes:
There are nine key components to ADC-MedSelect machine use.
A. Authorized Access
B. Medication Provision
C. Medication Returns
D. Wasting Medication
E. ADC inventory
F. Trouble Shooting Problems
G. Cleaning and Maintenance
H. Yearly Review of Emergency Supply Medications


DRAFT Process Map for procuring stat medications from the ADC
Prescriber
Nurse 1
POA/resident
Nurse 2
An order is written for a stat med
Receives order from prescriber
Identifies if med is available in ADC
Gets consent from POA/ resident for administration
Co-signs the order with a second nurse
Enters order into EMAR
Procures med from ADC
Administers medication to resident
Signs the EMAR
Documents effectiveness of medication if appropriate
Gives consent for administration of medication
Resident receives Medication
Co-signs order with first nurse

Activities Completed to Date (cont'd)

Problem Statement:
Home is currently using an ADC for Emergency Medication supplies and has no documented policy to outline the current practice.

Goal Statement: To develop a documented policy to reflect the current practice
of using the ADC for emergency medication supplies over the next 3 months.

4. Wrote a Problem Statement and Goal Statement
5. Attended the Plan, Do, Study Act workshop and planned the implementation of the new DRAFT policy
6. DRAFT Policy undergoing final review
7. Implementation of DRAFT Policy slated for April/May for emergency medication supply
8. In June four more cabinets are coming and we will expand project to include use of ADC for first dose of new medications

Results So Far…

- Model policy was used as the template for the DRAFT policy
- Model policy gave direction on what should be included in the DRAFT policy
- Model policy pointed out areas we had not thought of including in our policy
- Using the Model Policy as the template saved a lot of time for the home
- The Model Policy was easy to follow. The language used was appropriate for all parties that would be using it.

Key Learnings

Key Learnings:

1. The importance of documenting processes in a policy so everyone has a document to refer to - especially new hires and agency staff.
2. The policy is a good education tool.
3. Policy improvement is an ongoing process.
4. Process mapping helps to identify areas of the process you need to work on and include in the policy.
5. PDSA cycles provide us a map to follow for process improvement.
6. Indicators help us to measure and know if we are successful in improving the process.

Advice and Next Steps

Advice for Other Homes:

1. Put in the time to go to the meetings and workshops as it pays off by saving you time in policy development and effective quality improvement reducing resident risk.

2. Use the tools for process improvement for future projects – indicators, process mapping, PDSA

Next Steps:

1. Implementation of the ADC policy

2. Work on the first dose policy so that it can support the ADC policy for the new use of the MedSelect® machines coming in June

Quality Improvement Project

Anurag Pandey

Quality Improvement Consultant,

ISMP Canada Faculty

Ali Shahzada

Quality Improvement Consultant,

ISMP Canada Faculty

Quality Improvement Cohort
Antipsychotic Reduction

Mary Kate Garrity, Director of Care

Midland Gardens Care Community - Scarborough

The Project Team:

Mary Kate Garrity, DOC
Suraya Karzai, Pharmacist
Azieb Goitom, ADOC
Amanda Li, ADOC
Binal Gohel, BSO lead

Activities Completed to Date

- First step was to identify our QI goals and indicators
- Established a interdisciplinary, antipsychotic reduction team
- Created data collection templates for PRN usage and adverse side effects
- Developed a process map describing the steps needed to reduce inappropriate antipsychotic use

Activities Completed to Date

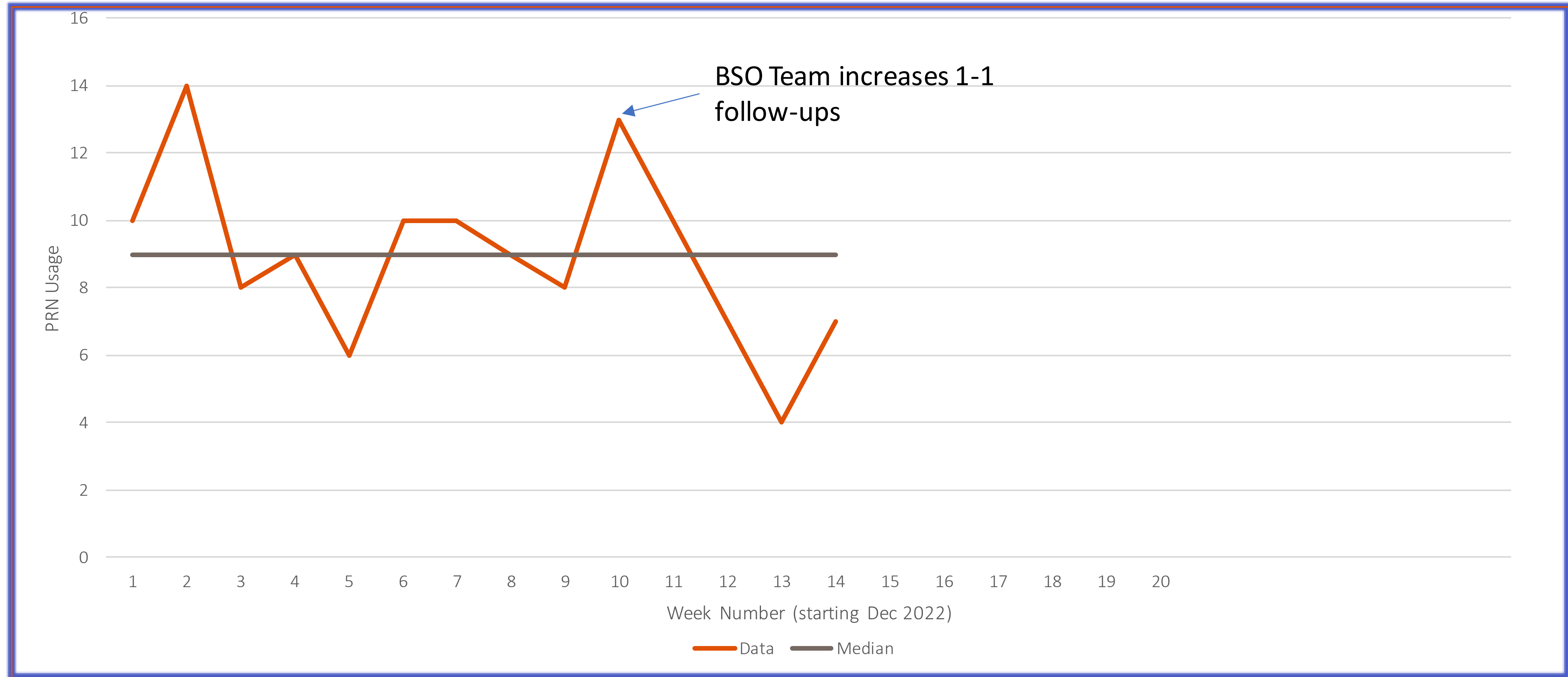
- BSO nurse and pharmacist educated staff on the use of antipsychotics on responsive behaviours.
- Working in collaboration with floor staff to find alternative solutions to help responsive behaviour
- Developed a PDSA template to increase completion rate of iGPA modules by nurses and PSWs

Results So Far

- 52 residents were identified for our cohort
  - 14 residents had their antipsychotics tapered
  - 3 residents had their antipsychotics discontinued
- New tool developed
  - Tracking sheet to identify adverse effects of tapering antipsychotics

Month	Tapered	D/C	Side effects: Tremors, Insomnia, Agitation, blurred vision, Hallucination	Percentage
November	4	1	None	11.53846154
December	2	0	None	3.846153846
January	5	1	None	11.53846154
February	3	1	None	7.692307692

Antipsychotic PRN Usage



Feedback from Team Members

- Staff initially resistive at first when speaking about antipsychotic reduction. Past practice of using antipsychotics to manage responsive behaviours.

- Staff had varying opinions on antipsychotic usage and the importance of dose adjustments

- Follow-up process before and after taper was not very familiar to the staff

Key Learnings

- The home was able to make significant progress in this project by having the management team's involvement
- By following the correct steps and engaging the floor staff, the home was able to taper antipsychotics without any withdrawals
- Causes for the high number of antipsychotics were identified during the process
- The importance of buy-in for antipsychotic reduction.
- Antipsychotic reduction is a collaborative effort from an interdisciplinary team (nursing staff, MD, DOC, ADOC, external partner etc.)

Key Learnings

What advice would you give other Trailblazer Homes?

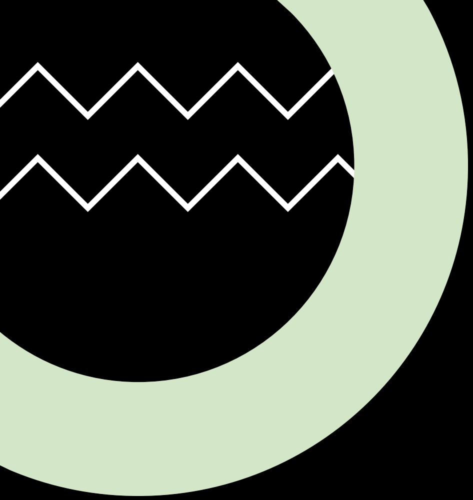
- Important to create SMART goals and indicators to guide the process.
- Meet on a scheduled basis to disseminate results and obtain feedback from the interdisciplinary team
- Identification of problem areas in the beginning (e.g over-prescribing, lack of follow-up etc.) would help with antipsychotic reduction
- Utilizing other measures such as non-pharm or non-antipsychotic treatments should be the first step for behaviours

Next Steps

- Continue data collection
- Continue to analyze data for patterns and trends
- Continue with iGPA training for all Team Members
- Starting a music program

Thank you!!!

Midland Gardens
Care Community



Leading Practices for Medication Reconciliation

Alice Watt
Senior Medication Safety Specialist
ISMP Canada Faculty

Rekai Centres – Sherbourne Place
Medication Reconciliation
Elimar Guaca

March 22nd, 2023

Strengthening Medication Safety in Long-Term Care

Medication Reconciliation

- **Problem identified:**
  - Many discrepancies during the medication reconciliation process

- **Problems that needed to be work on:**
  - Missed orders
  - Missed information
  - Can involved serious injuries to the residents

Activities completed to date

Core Indicators:

- MedRec Quality Audits = Quality Score: 71%

Goal:

- Rekai Centre – Sherbourne place would like to improve on the performance of MedRec completion within 48 hours by 25% in the next 6 months from project kick off (Nov. 2022)

Data Collection:

- Core Medication Safety Indicators
- Completed a Resident and Family Engagement Survey
- Nursing Interviews

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Process map

Rekai Centres – Sherbourne Place

Nurse receives resident to the facility (Admission / Re-Admission)

Nurse to check MAR + D/C Summary (All pages + MAR are complete)

No

Nurse to contact the Hospital/Community/POA

Hospital/Community/POA sends MAR + D/C Summary

Yes

Nurse to complete BPM re/admission interview *(1 hour)*

Nurse to contact MD - Secure Conversation / Email *(15 – 20 min)*

MD approves of order

Nurse to contact POA/PGT to obtain consent (email/phone/left message)

Received consent from POA/PGT on medications orders

Nurse to finalized Med Rec in accordance with BMH *(30 min – 1 hour)*

Nurse to faxed Med Rec to Pharmacy (Call Pharmacy to confirm)

Nurse to file Med Rec in resident's chart – flag nurse to check, MD orders, MD signature

2nd Nurse to check eMAR of the medication that reflects the Med Rec inputted by Pharmacy (Is there any errors?) *(15 – 20 min)*

Yes

Call Pharmacy of missing medication changes

Pharmacy inputs medication changes

No

Nurse to do the final check *(1 hour)*:
- Med Rec completed
- BPM interview was done
- MD approval
- POA/PGT consent
- Pharmacy enter the medication correctly

Finish: Nurse to signature on Second Check

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What are the results so far?

- **Improvements :**
  - Less discrepancies during a re/admission
  - Nurses use the Process Map as a guide to solve problem during the MedRec

- **Data:**
  - Process, Do, Study, Act cycle (PDSA)
  - To use this cycle to implement the change if it really works

- **Feedback from staff or residents:**
  - Staff: Offer more guidance, gives confidence and problem-solving methods
  - Residents: Felt more involved with their medications

Key learnings and next steps

- **What did I learn in the process?**
  - Different perspectives (nurses & residents)

- **Advice to give to another Trailblazer Homes?**
  - Helps strengthen the MedRec process in preventing medication errors and assisting residents with their medications

- **Plans to do next?**
  - To perform another audit using the core indicator questionnaires and Resident & Family Engagement Survey
  - To join another ISMP Canda program to strengthen the home

Report, Learn & Act

Carolyn Hoffman,
CEO, ISMP Canada
ISMP Canada Faculty

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Arbour Creek Care Centre

Brittany Saini, RN BScN
Director of Care

March 22nd, 2023

Activities completed to date

- **Initial Med Incident Reporting and Learning Self-Reflection Exercise**
  - Strengths
    - Electronic Med Incident reporting at the home
    - Registered staff aware and engaged in process
    - Pharmacy readily available for med reviews and incident investigations
  - Initial Areas for Improvement
    - Increase engagement of residents and families
    - Increase the use of system analyses and advance staff, prescriber, and pharmacy engagement in the learning and follow up actions
- **Attended the ISMP Canada Incident Analysis for LTC Workshop**
- **Overall Goal**
  - 100% of medication incidents are captured, documented, assessed/responded to, and follow-up with residents and families is completed
- **Draft Process Map Completed**

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Nurse

Education and review of each incident with nursing staff to ensure understanding of when to complete a MIRS (nurse driven or pharmacy)

Recognize that a medication Incident occurred

Assess to determine if patient harmed or at risk of harm?

Nurse uses SBAR to collect and report info about incident

Is this a Serious Incident(e.g. hypoglycemia) ?

Yes → Notify prescriber, off hours Manager and POA → Transfer to hospital

No → Notify prescriber and POA (e-mail or text to ADOC/DOC) → Monitor and provide treatment as per MD orders

Report Incident into system

Reminders to nursing staff about keeping login active and extended timeout period to 3 months

Is MIRS login active

Yes → MIRS completed and submitted

No → E-mail or phone ADOC/DOC

The nurse will complete the investigation and share findings with ADOC/DOC

Pharmacist

Recognize that a medication Incident occurred

Opportunity to identify more transcription error/issues

Notify Nurse

Report into pharmacy Incident into system?

Sent to pharmacy for investigation

Pharmacy completes investigation and shares a high level summary of the findings at quarterly med management meeting

Prescriber

Recognize that a medication Incident occurred

Notify Nurse

Nurse notifies Prescriber of an incident

Provide orders for immediate treatment/transport to hospital OR provide orders for monitoring and treatment

Resident/ Family

Education and discussion about med incidents at Resident and Family Council meetings

Recognize that a medication Incident occurred

Notify Nurse

Nurse notifies POA of an incident

For serious incidents related to nursing driven errors, the ADOC/DOC follows up to share actionable items that are to be implemented

For all incidents, follow up with POA to close the loop with actions taken

Follow up survey for residents/POAs after all MIRS to ask if they received sufficient info and if they received follow up regarding action items

ADOC or DOC

Request pharmacy consult?

Yes

Recognize that a medication Incident occurred

Notify Nurse

Investigation

Initial report into MIRS

Follow up investigation to identify contributing factors and actions to be taken

Follow up MIRS report (summary report)

Follow up actions are taken (e.g. coaching, etc.)

ED, DOC, ADOC, Medical Director, Resident Advocate, Pharmacist and Nurses participate in the med management meeting

To incorporate and facilitate a standing agenda item for detailed analysis into quarterly medication incidents (interdisciplinary team approach)

Improving Our Medication Incident Reporting Process

Arbour Creek Care Centre

DRAFT - March 20, 2023

Key Learnings and Next Steps

Next Steps

- Develop and test strategy to increase follow-up with residents and families

What did we learn in this process?

- That a process you think is very straightforward once broken down is not - staff engagement was key when looking for the opportunities

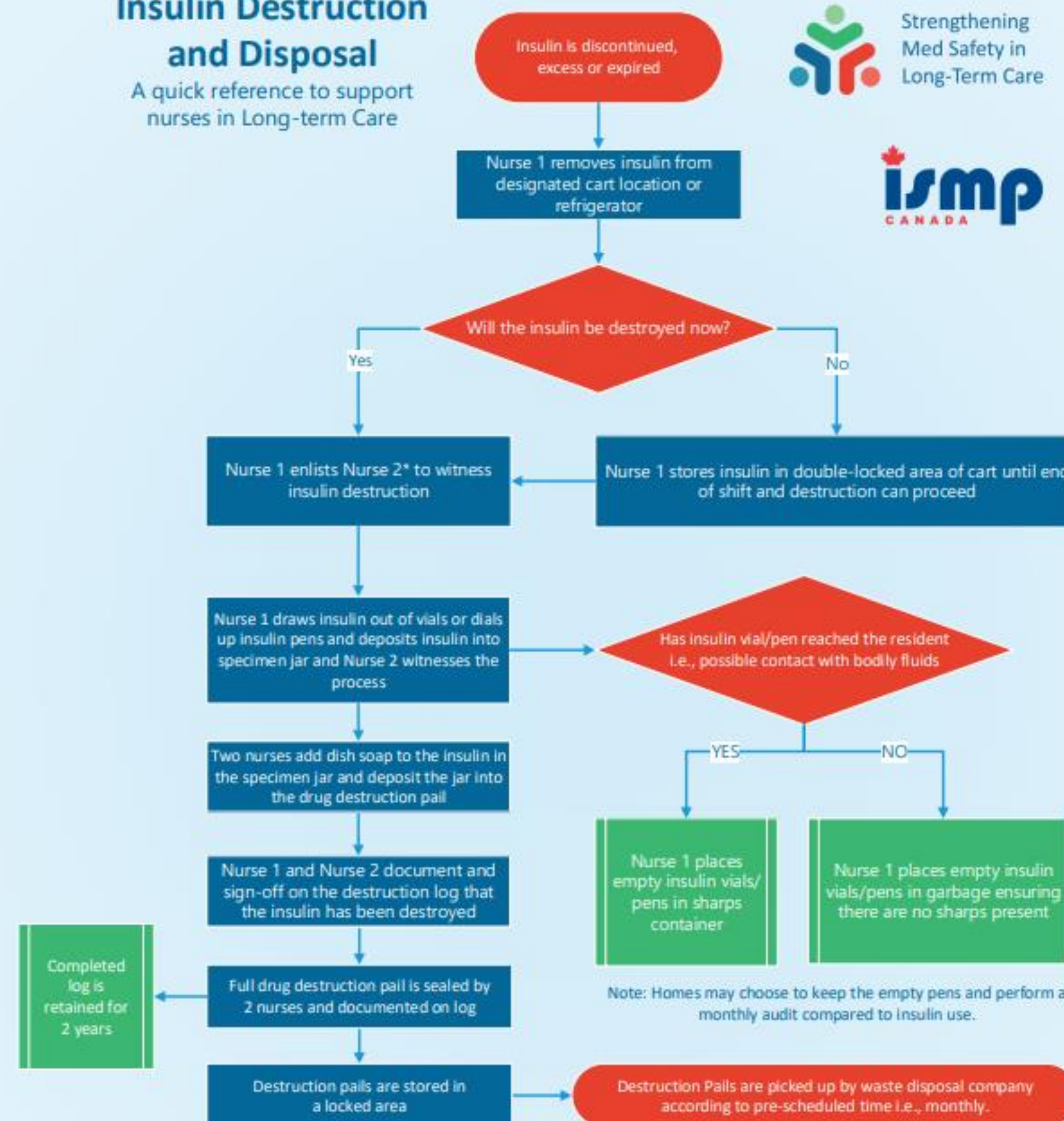
Advice to give to another Trailblazer Homes?

- This process has already helped strengthen our medication incident program and given us a clear direction for further improvement

ISMP Canada Faculty Updates

Practice Tool for Insulin Destruction and Disposal

[Insulin-Destruction-and-Disposal-Practice-Tool-for-LTC.pdf (ismpcanada.ca)]



Med Safety Signal #3

Vulnerabilities in Quarterly Med Review Process

Sign Up: **https://ismpcanada.ca/safety-bulletins/#footer**

Report an Incident: **https://ismpcanada.ca/report/**

Strengthening Med Safety in Long-Term Care

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Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

Volume 2 • Issue 1 • January 2023

Vulnerabilities in Quarterly Medication Review Process

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

In Ontario long-term care homes, prescribers perform quarterly medication reviews during which they authorize needed prescriptions and ensure the appropriateness of each resident's medication regimen. As part of this review, a list of each resident's current medications is typically printed on a quarterly medication review form, where the prescriber can indicate whether each medication is to be continued, discontinued, modified, or held.

In a recently reported incident, a pharmacy printed the resident's quarterly medication review form ahead of time. Between the time the form was printed and the time of the review, numerous medication changes were made for this resident, but the new medication orders were not transferred to the preprinted quarterly medication review form. A "good catch" occurred when the prescriber noticed discrepancies between the recent changes and the preprinted form.

ISMP Canada staff determined the following key contributing factors and considerations for improvement. It is the responsibility of medication safety leaders in long-term care to determine what, if any, actions for improvement are needed in their medication management processes.

Key Contributing Factors:

- The forms used for quarterly medication reviews are separate, stand-alone documents that are not linked to residents' charts and the usual prescribing process.
- Printing of the quarterly medication

Considerations for Improvement:

- Institute computerized prescriber order entry with built-in, real-time medication review capability to eliminate the need to print quarterly medication review forms ahead of time.
- Coordinate timing for quarterly medication reviews with the pharmacy (through just-in-time printing of quarterly medication review forms), nursing (through double-check and manual update processes), and

Thank you and for more information:

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