Strengthening Med Safety in Long-Term Care

ISMP CANADA

Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

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Family Identifies Missed Medication

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

A resident who was taking multiple medications had a recent diagnosis of advanced cancer. The prescribed oral chemotherapy medication was available only through the regional cancer centre and was dispensed directly to the family, who took it to the home.

The new treatment involved a 21-day cycle, followed by 14 days off, and then another 21-day cycle. The first cycle was completed correctly. About halfway through the second 21-day cycle, the family took the resident on a short leave of absence. The home provided 2 days' worth of medication strips and the vial of medication from the regional cancer centre. The family noticed that the vial contained more pills than expected. Specifically, 19 pills remained, indicating that the medication had been administered on only 2 days of the second cycle at the long-term care home (LTCH).

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

Key Contributing Factors:

- The medication was not packaged by the LTCH's pharmacy in the usual medication strip/compliance package. Rather, it was supplied by the regional cancer centre in a separate medication vial.
- There was no warning or flag on the electronic medication administration record (eMAR) to alert staff that the medication was in a separate vial.

Considerations for Improvement:

- Implement a process for managing medications brought in by the resident or family/caregiver, including special access or investigational medications, vitamins and supplements, complementary therapies, or cannabis. The process should account for handling and storage considerations.
- Ensure that an effective warning or flag appears on the medication administration record (MAR) or eMAR alerting staff to routine medications that are not provided in the medication strip or compliance pack.
- Implement regular audits to ensure that medications not packaged in medication strips or compliance packs are being administered as scheduled.

Resources: Get Involved! Residents and Families Play an Important Role in Medication Safety

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