Provincial Update Webinar

June 22nd, 2022

Strengthening Medication Safety in Long-Term Care

ismp CANADA

Zoom Webinar Platform

- **Maximize the Zoom window**
- **Set appropriate volume**
- **Audience settings**
  - Audience is automatically muted
  - Audience video is turned off
  - Enter questions and comments into the Zoom Chat

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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-related Calls to Action.

Nous tenons à souligner que nous sommes accueillis sur le territoire traditionel des Mississaugas, des Anichinabés, des Haudenosaunees et des Wendats. Nous voulons également reconnaître la pérennité de la présence 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 appels à l'action de la Commission de vérité et de réconciliation 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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Agenda

Welcome and Brief Overview of the Initiative

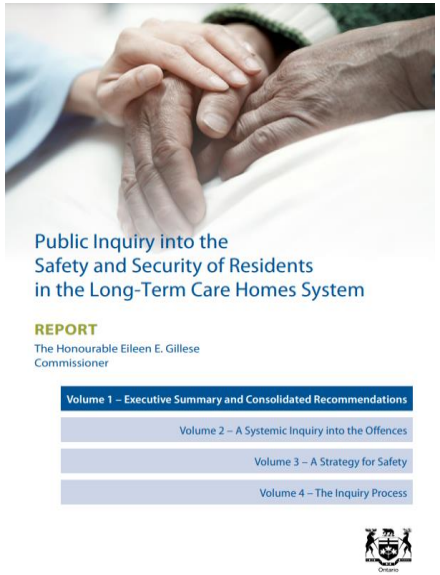
Champion Home Updates

- Resident & Family Engagement Survey & Projects
  peopleCare Hilltop Manor, Cambridge
- Process Mapping the MedRec Process for Improvement
  Bendale Acres, Scarborough
- Data Collection on Distractions During Med Passes
  Upper Canada Lodge, Niagara-on-the-Lake

Faculty Updates

- Latest information on resources available for all homes
  - Launch of MSSA-LTC Resurvey (2022)
  - The Next 100 Homes!

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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ISMP Canada LTC Team

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Vice President

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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

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Champion Homes

Public Launch of the 10 Champion Homes on November 24, 2021

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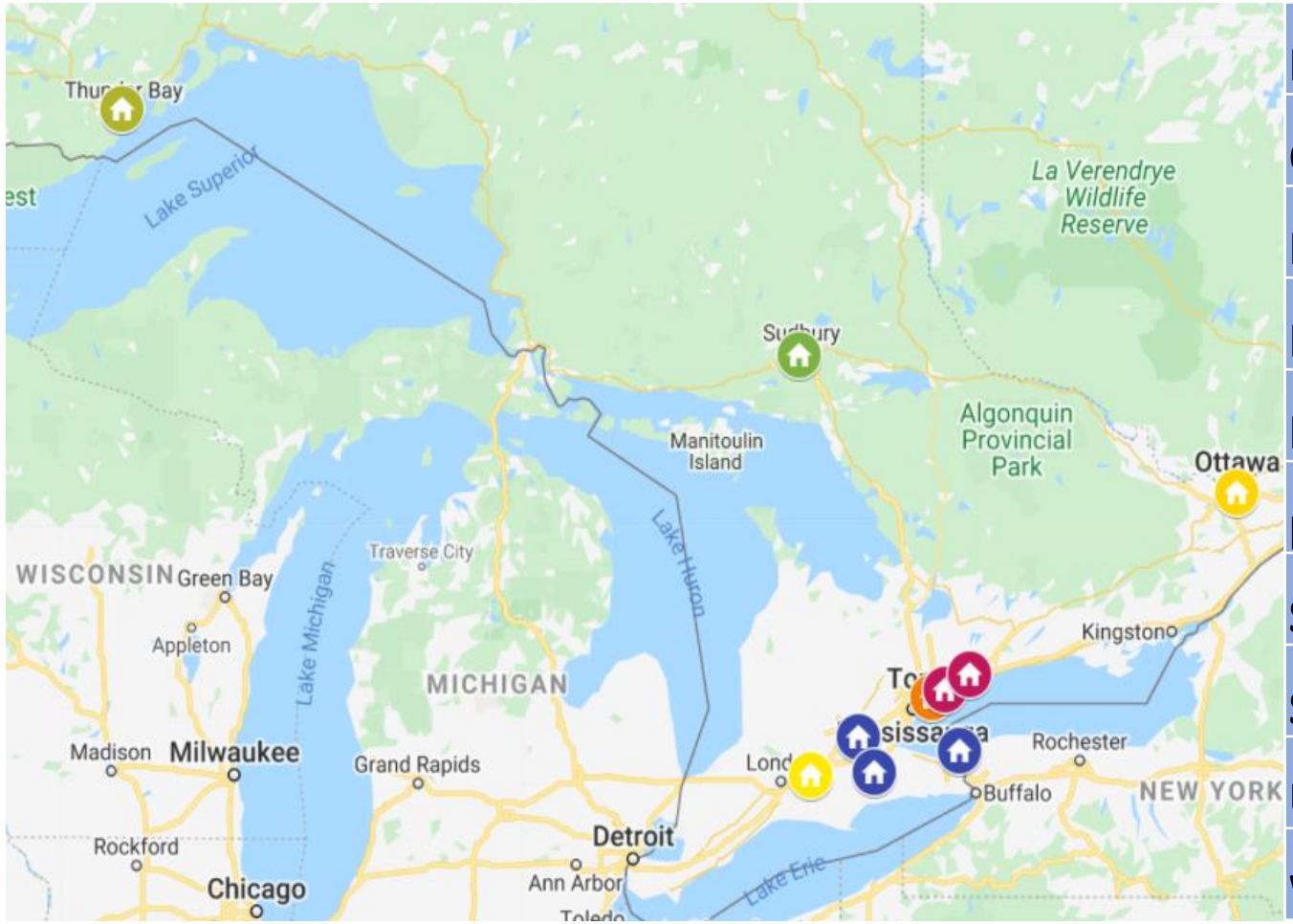
10 Champion Homes



- 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

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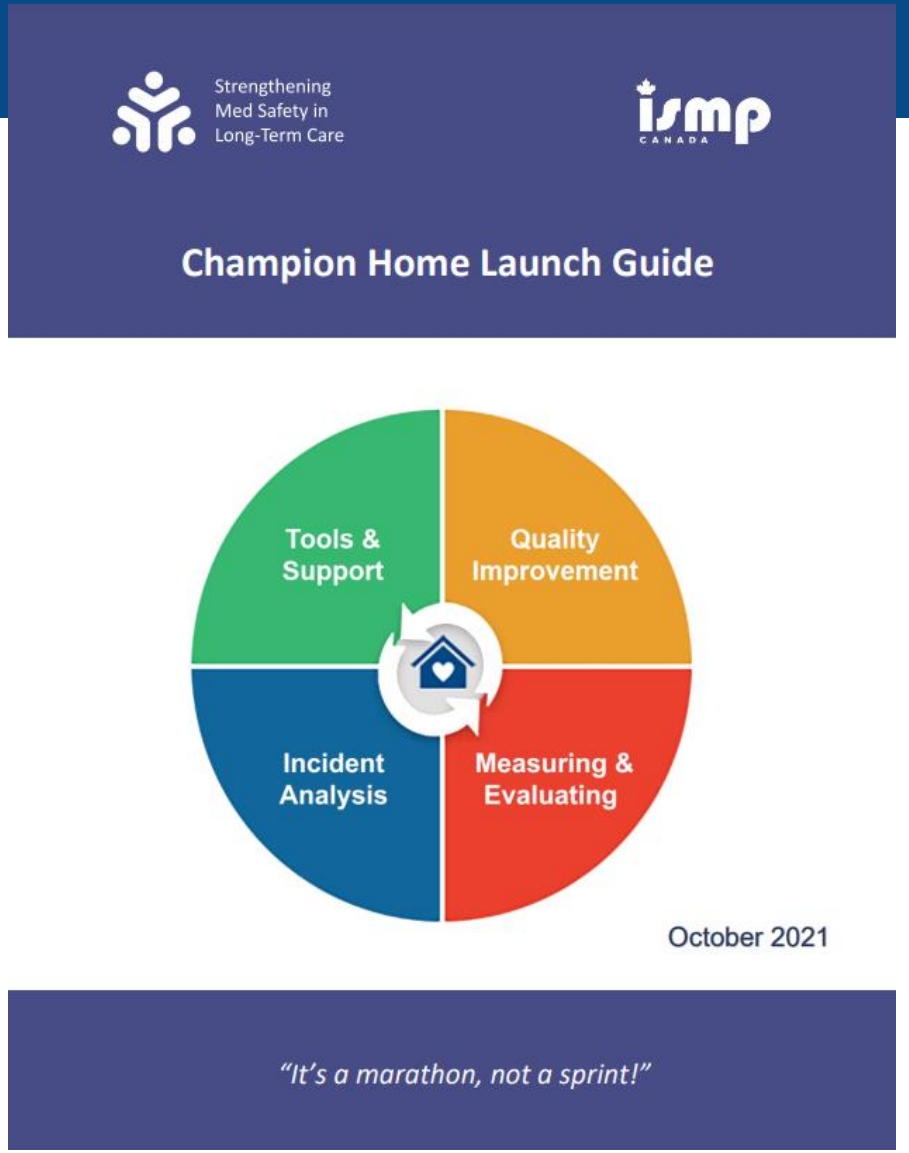
Launch Guide

- Champion Home Launch Guide outlines the key activities (available at ismpcanada.ca)
- Key focus now:
  - Finishing Baseline Med Safety Assessment at each Home (including analysis of 2 med incident reports)
  - Home selection of 2 Med Safety QI Projects
  - Education & facilitation to process map the selected med processes; brainstorm and test changes through Plan-Do-Study-Act cycles; and sustain the impactful changes



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Champion Home Status Report

Home	Baseline Med Safety Assessment Shared Folder	Pre-meeting	Faculty Meeting	2 De-identified incidents meeting	Goals/Indicators and Project Plan Finalization Mtg	Advanced workshop on Process mapping	Project 1 Data Collection
A							
B							
C							
D							
E							
F							
G							
H							
I							
J							

Complete	In Progress	Pending

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peopleCare Hilltop Manor

Medication Safety Champion Team

peopleCare communities

Changing the world of senior living

peopleCare.ca

peopleCare communities

Medication Safety Champion Team

Resident – Brenda

Resident - Dianne

Family Member – Val

Pharmacy Member – Sorina Cvijovic

Executive Director of Care - Deborah Beckman RN

Director of Resident Care – IPAC Lead – Vickie Cook RPN

peopleCare communities

Introductions & Background

- peopleCare Hilltop Manor is a 185 bed LTC home in Cambridge Ontario
- Implemented in 2016, a clinical pharmacy model (CPM) that is supported with onsite pharmacy technicians, 24/7 clinical telepharmacy, and Automated Dispensing Cabinets for sourcing of all new orders, prn, and high alert medications
- Long History of high scores across annual Medication Safety Self-Assessment in Long-Term Care reviews because of the CPM
- We are thrilled to have been named one of 10 Medication Safety Champions in Ontario to support development of quality improvement projects to elevate the safety outcomes already achieved

Data Review

- Medication Error Reports
- Clinical Quality Indicators
- MSSA

Resident & Family Survey Process

- Invited residents and family member to create our team to have their representation
- 10 question survey was created between ISMP Canada and us
- Survey completed in 2 separate ways –
  1. A family member and resident together went through the home and spoke with as many of our residents who were able and willing to answer the survey.
  2. A survey was sent to POA's to complete on Survey Monkey
- 25% of residents were able to complete the survey

Resident & Family Survey Process

- For the residents this was an opportunity to talk to someone who was not in the medical profession and they were able to express how they felt
- This process brought to light other situations that need to be addressed and the staff would also listen to the answers – ie – want more briefs in room, more walks, etc
- Residents brought forward additional information that was not previously shared with nursing staff (ie. dry mouth after taking medication)
- 9% of the families emailed responded to the survey monkey

Survey Data Review & Project Selection

- Survey results concluded a positive impact on residents
- Our surveyors interviewed our residents and received feedback in question one addressing their involvement in decisions for medications but had contradicting answers in question 3 addressing their desire of level of engagement – they expressed that they do not get follow up post medication changes but are as engaged as they want to be
- On the other side with minimal family response is it due to complacency or confidence – If we can inject information about medications to families in different ways we aim to engage them in hopes of increasing their understanding and engagement

Project Selections

- Project #1 - to increase resident and family understanding and engagement in their medication management
- Project #2 - to reduce our antipsychotic usage or establish Diagnosis as relevant to each case

Outline of Project & Goals – Project #1

- We will add a resident and family member to our medication safety committee
- We will have a 30% family involvement in the follow up survey
- We will maintain 25% of resident engagement with an increased ownership of their knowledge and satisfaction
- Develop our QI team to determine action items to achieve these goals - this will include physician, pharmacist, nurses, resident, family, PSWs

Outline of Project & Goals – Project #2

- QI antipsychotic usage without diagnosis – this QI has substantially increased over the past couple years with our focus being on COVID
- Reduce our antipsychotic usage by (25%) by reviewing RAI and consult with pharmacy
- Rebreathe life into some of our previous practices for monitoring and review of antipsychotic usage
- Develop our QI team – including physicians, pharmacist, nurses, families, residents PSW's
- From our CIHI report in the quarter of Jan – Mar 2020 we were 27.4% and our Oct – Dec 2021 was 32.5%

Outline of Project & Goals

- We will revisit our previous QIP's and rebreathe life into the interventions by:

1. Utilizing our Behavioural Supports Ontario team to support antipsychotic evaluations
2. Getting back on track with our physician and pharmacist to evaluate medications

peopleCare communities

Questions?

- **Deborah Beckman**

Executive Director, Resident Care dbeckman@peoplecare.ca

- **Vickie Cook**

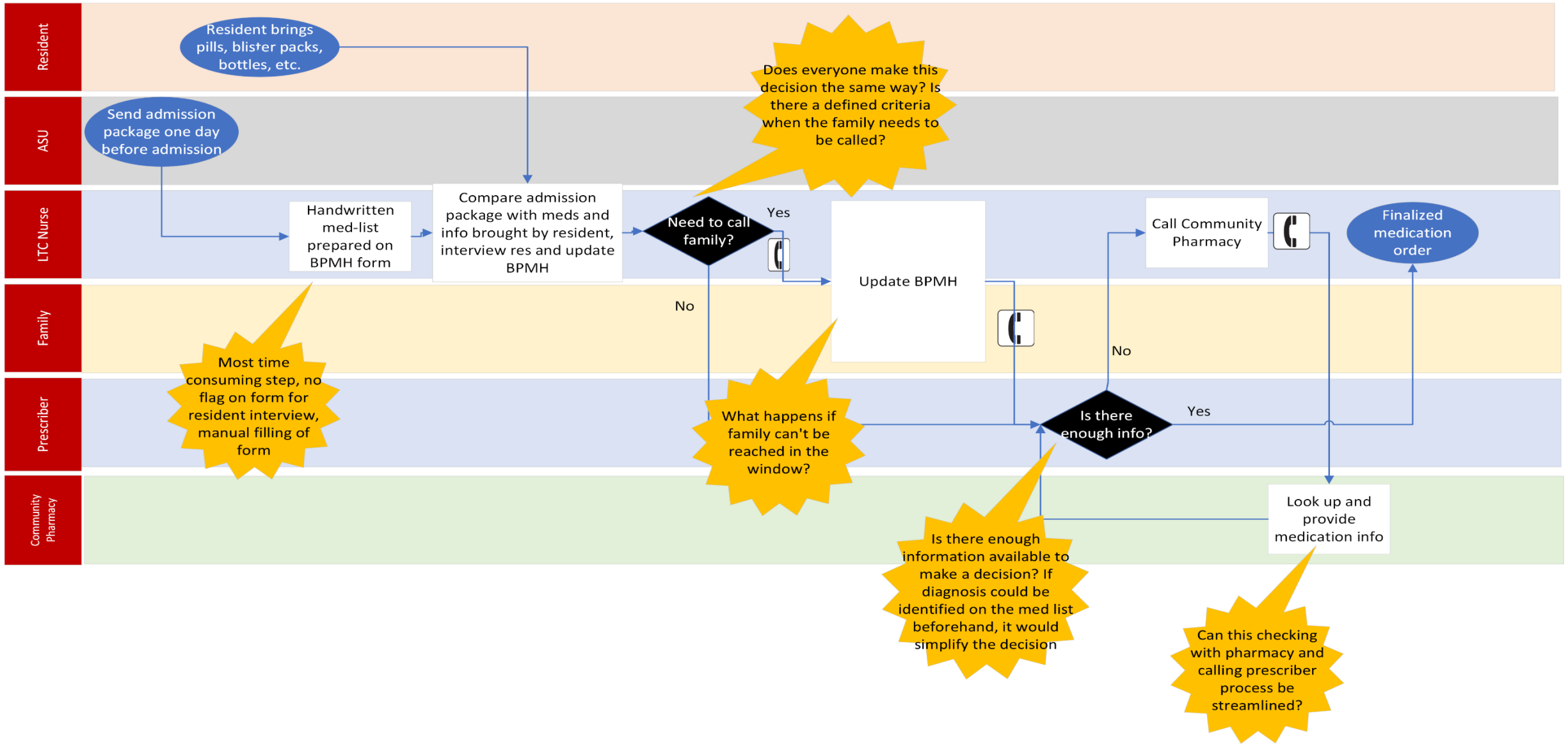
Director, Resident Care vcook@peoplecare.ca

Process Mapping

Medication Reconciliation
New Admissions From Community

Presented by Alice Jyu, Director of Nursing,
Project Lead, Bendale Acres

Bendale Acres New Admissions from Community



TORONTO Seniors Services and Long-Term Care

What did we learn?

- There are two decision points to help clarify the information to improve the quality of BPMH and protect against medication error
  - Whether family needs to be called
  - If more clarification is required after the call with prescriber
- The first step of building the medication list is the most time consuming and is completely manual at this time.
- Prescriber doesn't always have the complete information about diagnosis for each medication.
- All the communication is by telephone, and usually with a single stakeholder (family, community pharmacy, or prescriber) with possibility of delays (phone tag, etc.).
- Process Map is a great tool to help visualize MedRec process and improvement opportunities in a concise and straightforward way.
- Principles of Process Mapping would apply to everything, they enable us to pull different departments and sources together to construct a safer and more efficient processes - kind of like trying to create order within the universe after the Big Bang!

Next steps

- Observe a two weeks of new admissions from the community that are not BOOMR admissions and validate the process map and also collect data for quality and timeliness.
- Identify 2-3 areas for improvement and brainstorm the changes that the team would like to test.
- Goal is to improve the quality of the MedRec (especially regarding the verification with resident/family and prescriber documenting the rationale for holds and discontinued medications) while ensuring that it is still performed in a timely manner.

SENIORS SERVICES

Niagara Region

We are the Champions

Quality Improvement Project: Medication Interruptions

Presented by Alex Lamsen BScN RN, MScN, GNC © IIWCC
Manager of Clinical Practice

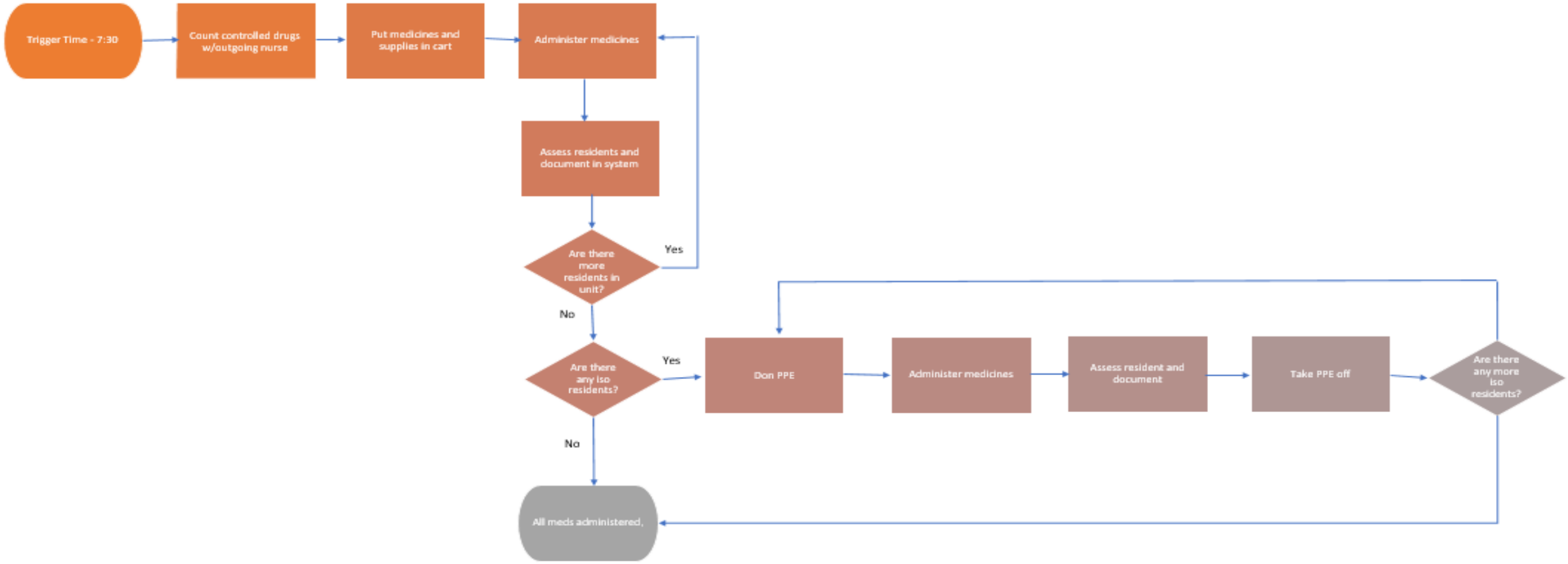
QI Project: Reducing Medication Interruptions

Process Indicator	Outcome Indicator(s)	SMART Goals
Dose Omissions	Number of Reported Medication Incidents	Reduce the percentage of dose omissions (non-strip medications or for orders with pending nursing confirmation) by 25% within 6 months
Average time spent for medication administration per med pass	Self-Report	Increase the percentage of survey respondents agreeing/strongly agreeing that medication administration has gotten easier by 25% over 6 months

Medication Interruptions

- Many perceived causes of medication incidents, including distractions and interruptions, failure to follow the rights of medication administration and workload
- Interruptions are perceived by nurses as the leading cause of medication incidents (Hand & Barber, 2000; Hemingway et al., 2015) and interruptions have been found through direct observational studies to be associated with an increase in frequency (Scott-Cawiezell et al., 2007)
- Interruptions also create longer task completion times, leading to decreased task efficiency (Brumby et al., 2013)

Medication Administration Process



Sample and Setting

- No sampling method used
- Convenience sampling

Ethical Considerations

- The Administrator and Nurses were informed that the purpose was to observe medication administration processes
- All nurses provided informed consent
- It was anticipated that some nurses may develop a mild feeling of anxiety due to the interruptions or because they are being observed by the project lead

Data Collection

- The one member of the UCL team collected all data to decrease the risk of researcher bias
- The one member of the UCL team collected data on interruptions via direct observation in real-time on three different days
- **Materials**
  - Medication Interruption Data Collection developed by ISMP Faculty
  - Stopwatch
- **Time Commitment**
  - Shifts 2 day shifts and 2 evening shifts
  - 0700-1030; 1500-1800

Data Collection

- The UCL team documented the observations on an excel file
- Hawthorne effect refers to an alteration of behaviour by participants in a study due to their awareness of participating in research (Brink & Wood, 1998)
- In order to minimize the Hawthorne effect, assuring the nurses that the purpose of the study is not to evaluate performance, and when possible to collect data in an unobtrusive manner.

Data Collection

- The nurses were assured that the observation was for research purposes only and quantitative data were collected in an unobtrusive way from a distance

Data Collection Tools

Strengthening Med Safety in Long-Term Care

UCL Medication Pass Data Sheet		
Date:		
Time when Med Pass started (Start of Controlled drugs count):		
Time when med pass completed (All meds administered, cart back):		

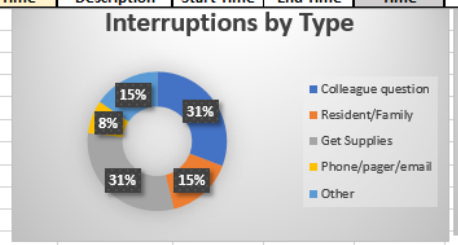
Interruptions			
#	Reason	Start Time	End Time
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

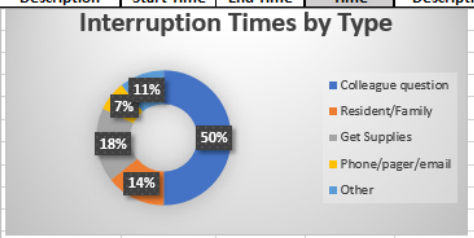
Strengthening Med Safety in Long-Term Care

UCL Medication Pass Data Sheet Timestamp

Date:

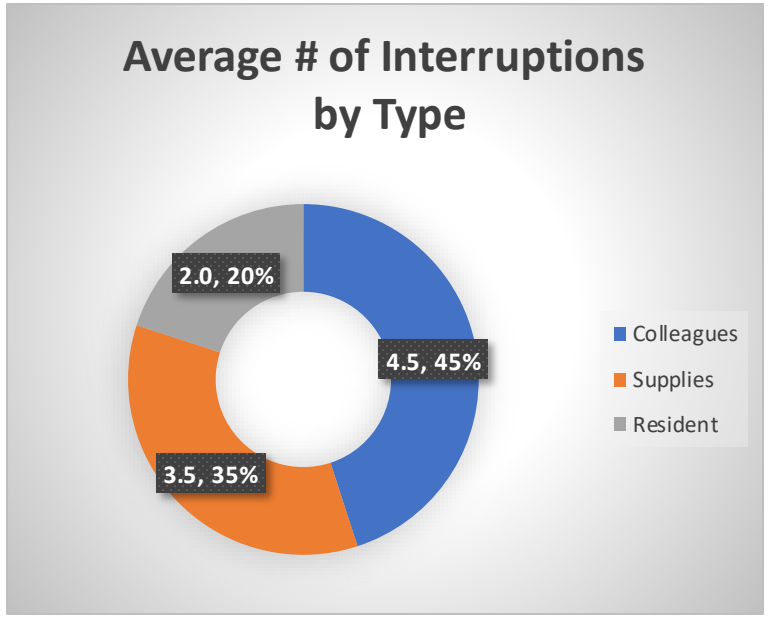
ACTIVITIES			INTERRUPTIONS											
			Interruption 1				Interruption 2				Interruption 3			
Description	Start Time	End Time	Description	Start Time	End Time	Time	Description	Start Time	End Time	Time	Description	Start Time	End Time	Time
Colleague question	4													
Resident/Family	2													
Get Supplies	4													
Phone/pager/email	1													
Other	2													
Total Time for Interruption	0:28													
Colleague question	0:14													
Resident/Family	0:04													
Get Supplies	0:05													
Phone/pager/email	0:02													
Other	0:03													



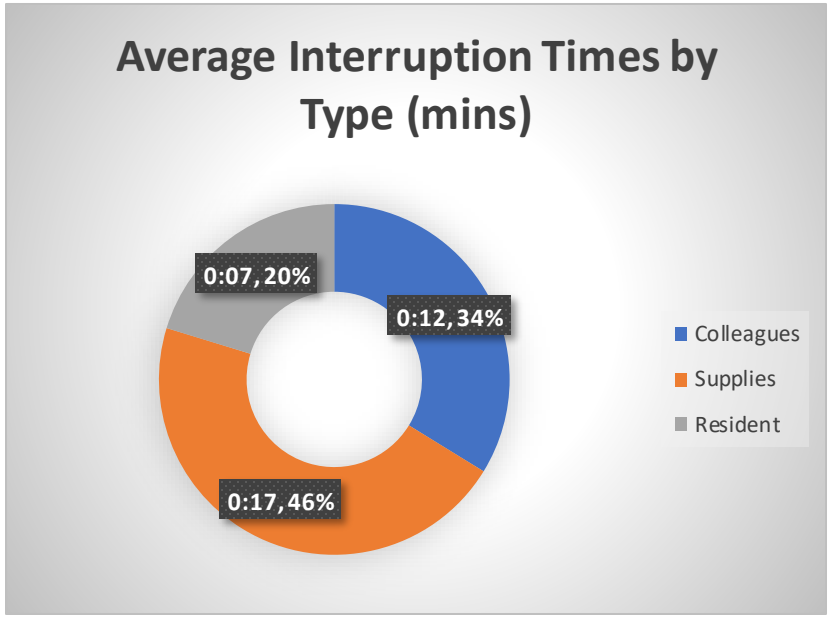


Preliminary results – Morning Medication Pass

Average Med Pass Time	3:10
Average Interruption Time	0:37



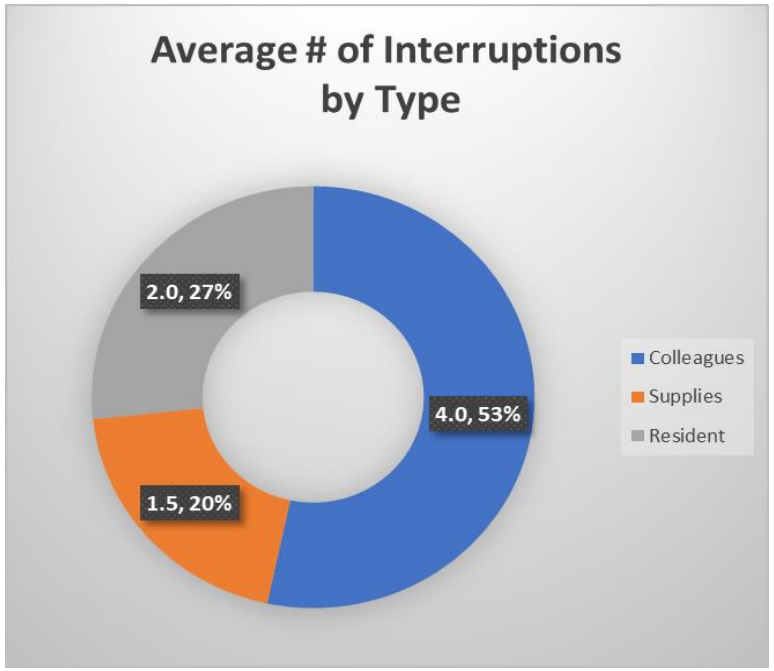
Average Interruptions by Type	
Colleagues	4.5
Supplies	3.5
Resident	2.0

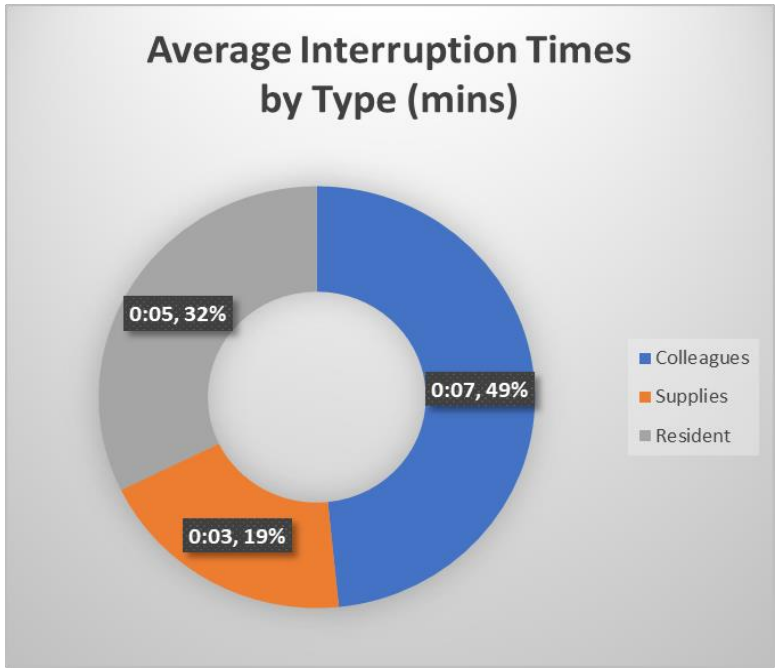


Average Interruption Times by Type	
Colleagues	0:12
Supplies	0:17
Resident	0:07

Preliminary results – Afternoon Medication Pass

Average Med Pass Time	2:15
Average Interruption Time	0:15





Average Interruptions by Type	
Colleagues	4.0
Supplies	1.5
Resident	2.0

Average Interruption Times by Type	
Colleagues	0:07
Supplies	0:03
Resident	0:05

Strengths and Limitations

- Rigor was demonstrated in the project through various means including defining medication interruptions, data collection tool, and adherence to current standards on direct observation
- Limitations include Hawthorne effect, date and time of the observation, and nurse giving the medication

Qualitative Data

- Qualitative data on the strategies will be collected via individual semi-structured interviews following the direct observation

Examples of questions regarding the interruption management strategy used	Examples of questions regarding associative cues
Can you explain how you handled or dealt with the interruptions when you were preparing medications?	Can you explain how you were able to recall what step you were on in the medication administration process after you were interrupted?

Next Steps

June/July	August	September
• Map out process • Action Plan	• Initiate project change • Monitor impact	• Finalize all changes and continue to embed • Update process map • **CELEBRATION**

Faculty Updates

See ismpcanada.ca for more information

Or contact us at: LTC@ismpcanada.ca

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**

Model Policies Update

The first 6 Model Policies for testing are available on the ISMP Canada website for any 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
Drug Destruction and Disposal

Coming soon:
Medication Storage
Automated Dispensing Cabinets
Incident Reporting and Learning

What's Coming Next...

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

What's Coming Next...

Next 100 Homes!

Launching in the fall

For more info:
LTC@ismpcanada.ca

MSSA-LTC Re-survey

- Additional survey credit added on June 1, 2022
- Reassessment should be started after **at least 12 months** have elapsed since the completion of the initial assessment
- To access your MSSA-LTC results and reassessment, visit: https://mssa.ismp-canada.org/ltc

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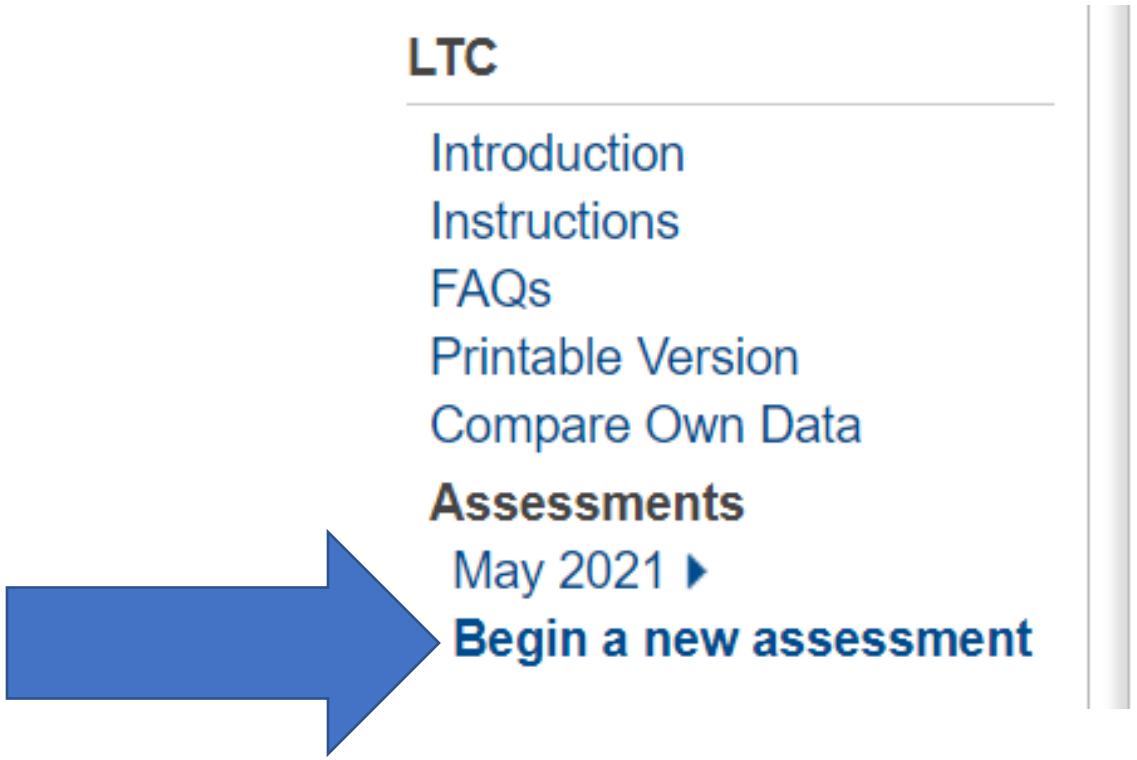
MSSA-LTC Re-survey



FAQ

Additional FAQs for some items, especially in Key Element VIII (Medication System Technology)

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Resident and Family Engagement


Strengthening
Med Safety in
Long-Term Care

Resident and Family Engagement

"I have had an opportunity to become acquainted with my doctor, and he with me. That rapport, that bond and relationship is critically important for me and for many other residents in long-term care." Barry, resident in long-term care, Ontario.

Residents in Ontario's long-term care are the heart of every home. They have reached a stage in their life where they need to rely on others to support and to care for them, and while there are some residents who cannot be autonomous in their own care, there are many who are able to self-advocate and make decisions for themselves in their medication management. Engaging residents is essential to increasing medication safety and this initiative aims to support you, with resources and education, to do so authentically. Collaboration between staff and residents gives the best possible chance for safe medication experiences.

"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 long-term care, Ontario.

Toolkit

This toolkit has been designed for all staff in long-term care homes in Ontario as a landing place to find resources and information to support resident and family engagement in the home. Whether this practice is already embedded in your setting or whether you are looking for ways to increase engagement, there is information in the following pages that will support any improvement efforts and/or projects.

Institute for Safe Medication Practices Canada
ismpcanada.ca

Share the toolkit resource with staff!

Engage residents in meaningful conversations about their medications.

https://bit.ly/3nbOJgV

Watch this video at your next Residents' Council meeting!

https://bit.ly/3zP4nGM

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MedRec and BPMH Training

Thursday, September 23, 2022
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

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MedRec e-Learning module

https://elearn.ismp-canada.org/course/index.php?categoryid=9

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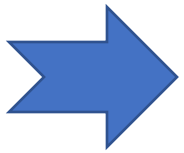
Incident Analysis – it's a journey

Incident Analysis



Report

- #, type and trend of incident reports
- Contributing Factors

Learn

- Analysis
- Recommendations to address contributing factors

Act

- Implement actions
- Monitor and celebrate!

Med Safety Signal Issue 2

Transdermal Fentanyl Safety

Coming soon!

- **Via:**
  - **ISMP Canada email distribution list – sign up LTC@ismpcanada.ca**
  - **Social media**

- **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

A Patchy Approach to Transdermal Fentanyl Safety

Volume 1 • Issue 2 • July 2022

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

A resident had a prescription for a fentanyl 12 mcg/h transdermal patch, to be changed every 72 hours, to treat chronic pain. Because of specified provincial drug benefit coverage, fentanyl 25 mcg/h patches are typically dispensed by the pharmacy with instructions to place half of the patch over an occlusive dressing placed on the resident's skin. This practice allows only half of the patch to contact the skin, thus delivering an approximation of the prescribed dose. On 2 separate occasions within a month, nurses noted that upon removal of the previous patch, no occlusive dressing was present. Although no harm was reported, this resulted in the resident receiving a 2-fold overdose of this high-alert opioid. Given the occurrence of similar incidents over the past few years, the long-term care home has decided to pay for the 12 mcg/h patch when that dose is prescribed to reduce the risk of harm to residents.

ISMP Canada staff identified 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 particular medication management processes.

Key Contributing Factors:

- Constraint of the provincial drug benefit program, which reimburses the 25 mcg/h fentanyl patch but not the 12 mcg/h patch, often leads pharmacies to dispense the 25 mcg/h patch.
  - The 12 mcg/h patch is available outside the provincial drug benefit program if the resident, family, or a third party agrees to pay out of pocket.
- Preparation and administration of the medication, when provided as a 25 mcg/h patch, required the atypical extra preparation step of occluding half the patch on the skin.
  - The patch cannot be cut or folded to adjust the dose.
- Lack of a systematic process to check for proper occlusion of the patch decreased the chance of detecting the error in the 3 days between patch changes.

Considerations for Improvement:

- Eliminate the need to occlude half of the patch by dispensing the 12 mcg/h fentanyl patch for applicable prescriptions.
  - Consider other payment options for the 12 mcg/h fentanyl patch (e.g., third party, out of pocket).
  - Ask the provincial drug benefit program to provide coverage.*
- If using a 25 mcg/h fentanyl patch for a 12 mcg/h dose:
  - Place a reminder on the package/medication administration record to occlude half the patch.
  - Ensure a systematic, independent double-check process for assessment of occlusion at the time of application and daily checks of patch and occlusion thereafter.
  - Dispense the patch in combination with an appropriate occlusive dressing.
- Always indicate the date and time of application on the patch.

Ontario Drug Benefit fentanyl decision: https://www.health.gov.on.ca/en/pro/programs/drugs/ced/pdf/fentanyl.pdf
ISMP Canada Safety Bulletin: https://ismpcanada.ca/wp-content/uploads/ISMPCSB2006-05Fentanyl.pdf
*ISMP Canada has provided a copy of this Med Safety Signal to the Ministry of Long-Term Care

Report an incident to ISMP Canada https://ismpcanada.ca/report/

A product of the Strengthening Medication Safety in Long-Term Care initiative – https://ismpcanada.ca/resource/ltc/

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

Quality Improvement Advanced Workshops

I – Map your processes to identify improvement opportunities

II – Designing Tests of Change – the PDSA method

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Selecting QI Projects from many ideas

Would the selected projects -

- Improve the quality of life for residents at your home? (*Would the residents "feel" the improvements?)*
- Have a direct or indirect impact on a sizeable number of residents at your home?
- Have a noticeable impact on some measures that are reported provincially (like ED transfers from your home)?
- Have a realistic chance of being implemented in 6-8 months?
- Be prioritized at your home by merging/deferring/stopping existing improvement initiatives?
- Simplify medication management and free up more time for direct care of residents?

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Thank you for participating

Any Questions or Comments?
Use Chat box

For follow-up
LTC@ismpcanada.ca