

Canadian Medication Safety Network

Consumers and Providers Sharing and Learning About Medication Safety Together

Building a Culture of Safety Webinar

Summary of Participant Feedback



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



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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 the second webinar which was held on May 8, 2024, from 12 – 1 PM EST. There were 70 attendees.

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

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 most frequently suggested by webinar participants that completed a post webinar survey after the first webinar on February 7, 2024.

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. The first webinar was held on February 7, 2024, and there is a plan to host more.

2. Methodology

An e-mail invitation for this webinar was sent to the approximately 850 network registrants. They were asked to complete a Zoom registration form that included a request to select one of 5 topic options under the theme of ***Building a Culture of Safety***. Based on their selection, participants were assigned to that small group discussion (breakout room) during the webinar.

1. Current State
2. Opportunities
3. Resources and Education
4. Safety Culture in Long-Term Care
5. 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=54
 - Pharmacy Team Member 35%
 - Nurse 22%
 - Person with Lived Experience 6%
 - Quality Improvement or Patient Safety Professional 33%
 - Other Experts 4%
- Have you or someone you know experienced an issue with the safety of medications?
 - Yes: 89% No: 11%
- Is this your first network webinar? No 65% Yes 35%

Jessica Kayitesi, RN, MScN, Sr. Assistant Director of Care Shepherd Lodge LTC gave a keynote address to the webinar attendees. Jessica shared about her team's experience as a Trailblazer home in ISMP Canada's *Strengthening Medication Safety in Long-Term Care Ontario* initiative. Jessica shared her perspective on building a safety culture – how to

develop and how to sustain it. She indicated that the multi-disciplinary team's work was rooted in qualitative and quantitative data and was obtained through various channels such as the ISMP Canada Medication Safety Self-Assessment (MSSA-LTC) tool.

Examples of interventions that they implemented are a shared accountability framework, addressing systemic issues and preventing recurrence, improving communication through methods such as use of a bulletin board and employing technology. The full presentation can be viewed in the video recording:

<https://www.youtube.com/watch?v=b5jV9UTLlzQ&t=1607s>

The next stage of the webinar was the 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

- Current State
- Opportunities
- Resources and Education
- Safety Culture in Long-Term Care
- Open Dialogue: Emerging Issues (discussion open to all medication safety topics based on the initiative of the participants).

Each breakout room was facilitated, and feedback recorded (through written notes) by an ISMP Canada staff member. Facilitators and note takers were prepared for this role as they had participated in the last webinar in these roles. 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 some 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.

- The impact of technology in medication safety 33%
- Medication Safety during times of shortages (various shortages) 19%
- Advocacy 101: What does it look like and how do you do it? 19%
- Polypharmacy – Patients taking more than 5 medications 11%
- Overprescribing of medications 10%

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 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.

Safety Culture: Current State

Continuous Safety Curiosity

- Need to foster a constant state of vigilance and curiosity about safety.
- Ensure safety for both patients and healthcare professionals, fostering a just culture for reporting safety events.
- Safety culture is a collective effort involving all stakeholders, from drug companies to healthcare providers.
- Ensure patients understand medication safety in clear, comprehensible language.
- Ensure leadership supports staff in speaking up about safety issues.
- Focus on making real improvements in safety practices, not just discussing them.
- Have tools available to facilitate measurement of change and culture.
- Fragmentation or siloes exist between programs/departments/organization. It is important to connect between the different areas.
- Let front line staff know to buy into safety culture. Training is available but they don't really understand all the information.

Psychological Safety and Support

- Create an environment of psychological safety with appropriate systems and structures.
- Commit to prioritizing safety in a non-judgmental environment.
- Encourage teams to feel comfortable reporting incidents and collaborate on improvements.
- Emphasize the importance of strong teams and clear communication.
- Foster an environment where staff feel safe to learn, report, and improve continuously.
- Share safety events widely to ensure learning across all units.
- Address challenges in maintaining a blame-free environment while ensuring accountability and transparency.
- Encourage learning and accountability without punishment.
- Maintain open, non-punitive dialogue about medication safety events.
- Encourage open discussions about risks and how to address gaps when issues arise.
- Being psychologically safe and supported requires a “team” culture.

Language

- The term “safety culture” is better framed as a “culture of safety”.
- Need for a clear definition of what “safety culture” is, and then to share it throughout the organization.
- “Clarity on culture and safety would be helpful as right now I feel it has become a catch phrase without much meaning.”

Safety Culture: Opportunities

- Connect with front-line staff to share the *why* of incident reporting and close the loop to eliminate reporting as a “black hole”.
- Create a safe and open environment to report errors, discuss safety issues, and work on improvements. Encourage a no-blame culture to increase reporting.
- Engage with a multi-disciplinary medication safety group.
- Share safety improvements across organizations.
- Start early! Incorporate a culture of safety during new staff orientation as well as continuously encouraging reporting and safety.
- Celebrate successes!
- Ensure psychological safety for patients.
- Simplify incident reporting fields to make it easy to report.
- There are lots of opportunities to report near misses.

Safety Culture: Resources and Education

1. *What resources/education have you found helpful?*
 - Best Possible Medication History (BPMH) Workshop - new BPMH Interview Guide: <https://ismpcanada.ca/wp-content/uploads/BPMH-Interview-Guide.pdf>
 - Huddles, newsletters.
 - An example of a local learning strategy shared was the nursing team collaborating with a pharmacist to do a “roadshow” presentation where they provided high-level presentations on BPMH and Medication Reconciliation.
 - Important to rely on local/provincial policies.
 - ISMP Canada [Safety Bulletins](#) and accreditation standards were referenced.
 - Also, recent work from the Health Quality Council of Alberta (HQCA) on Just Culture was highlighted. In particular, there is a new [Just Individual Assessment](#) that can help health care providers consider next steps when an incident occurs. It includes considering health care provider wellness.
 - A United Arab Emirates Newsletter describes High Reliability Organizations and is a reminder of what we can learn from other organizations: <https://www.linkedin.com/newsletters/extreme-operational-excellence-7016790947631951872/>.

- ISMP Canada resources such as the [Medication Safety Culture Assessment](#) workshop and the Safety Attitudes Questionnaire (SAQ) were highlighted and referenced as potential resources.
- Timely, ongoing communication is important, toolkits that are posted in hospital and online are helpful including staff meetings. Proactively developing these toolkits and resources (with direct links for frontline staff).
- Provide links in documents that direct people to the toolkits and learning resources.
- [CADeN](#) brochures highlight various drug classes and are helpful for providers and consumers.
- [Supporting a Just Culture in Long-Term Care](#) document was also highlighted as helpful.

2. *What resources/education are needed and why?*

- Important to link information to applicable quality improvement resources.
- There can be conflicting information from different sources.
- More information needed on how organizations can use safety reports to impact clinical care. There is a lack of existing resources to address this.
- More resources needed regarding: How do we support the people providing care at the bedside? How do we translate this information to the bedside?
- Confusing to understand the different venues for reporting currently available in Canada.
- New knowledge products for patients' roles in advancing a positive safety culture are needed.
- Important to ensure clarity of accountability for a safety culture in education and resources provided.
- Need to celebrate "good catches". One organization selects the Best Good Catch and provides an award.
- Staff shortages: can you have a safety culture if you have less staff?
- Important to close the loop and "Do something" with incident reports.
- Participant shared an example of having large volumes of incident reports but don't have the time to respond to every report. People may stop reporting if they feel no change is happening, may end up undoing all the work that went into establishing a just culture.
- Using emails and memos to disseminate learning not always effective as people do not have the time to read these and it adds to workload.
- Need tools that help communicate the learning from incidents without significantly adding to workload.

Safety Culture: LTC

1. *What are some strategies for improving safety culture in LTC?*
 - Develop and implement standardized processes.
 - Ensure the Community pharmacist attends meetings.
 - Ensure staff are aware of how pharmacist can help.
 - Interdisciplinary medication safety teams including pharmacists, data and informatics specialists. Need to use the data to understand where systems can change.
 - Tie medication safety to accreditation standards to motivate staff.
 - Limit the number of meetings to create capacity for leadership engagement.

2. *What hinders safety culture in LTC? How can it be improved?*
 - Staff not always familiar with when and how to work with pharmacists.
 - Ministry/media attention can create some worry and reduce open dialogue at times.
 - Psychology safety and just culture in the organization is not always openly valued by leadership.
 - Need to provide education to leadership to support building of the culture.
 - Sometimes staff have been there longer than the leader and they also influence culture.
 - Consider bringing in subject matter experts for education.
 - Managers don't have capacity – may be working on the frontline to fill staffing needs.
 - COVID still creating fatigue throughout the system.
 - Working with agency nurses creates high variability in the ability of frontline providers to feel safe and know applicable policies/procedures.
 - All communication should be in plain language to support understanding and engagement.

3. *What strategies didn't work?*
 - There is feedback of data to leaders on their responsiveness, for example time to open/close a report, but little support for analysis and action.

Open Dialogue Room & Emerging Issues: Informal Sharing of Feedback on Medication Safety

The following are concerns that were discussed in this group.

1. Advertising of drugs – addressing concerns that drugs such as GLP-1 e.g., Ozempic, are being advertised on billboards, but related risks involved are not displayed.
2. A concern shared that there is an increase in intentional and unintentional overdoses of acetaminophen.
3. Need to share learning from Computerized Prescriber Order Entry (CPOE) system implementations from across Canada.

Some problems associated with implementation of electronic systems were shared. For example:

- 3rd party systems can't connect with organization's systems
 - Takes time to implement and connect plus there are merging issues
 - 500 bed hospitals with no WIFI; infrastructure lacking
 - Lag in time between assessment and implementation of systems
 - No CPOE in Saskatchewan - have some electronic health records
 - Limited resources available
 - Ongoing issues with electronic systems in acute care
 - Data retrieval not accurate
 - Need to improve quality of electronic BPMH.
4. Medication reconciliation is not being done properly and accurately; in many locations it is stated as implemented only to satisfy compliance needs.
 5. There are safety gaps with hybrid medication systems - paper and electronic.
 6. One organization is facing the challenge of sourcing new IV pumps to integrate with their existing electronic record system.
 7. In another example, it was noted that a closed loop medication management system, with electronic health records, had some steps bypassed and therefore medication errors were happening.
 8. Regarding bar code scanning, there needs to be a mechanism to ensure this is occurring, especially in emergency departments.

Suggestion:

"Would love to see a voluntary community of practice where names and professional emails are available so we can reach out to each other and ask questions."

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 on ismpcanada.ca.

These resources will include the following.

- The Zoom recording of the main presentation:
<https://www.youtube.com/watch?v=b5jV9UTLzQ&t=1607s>.
- 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.

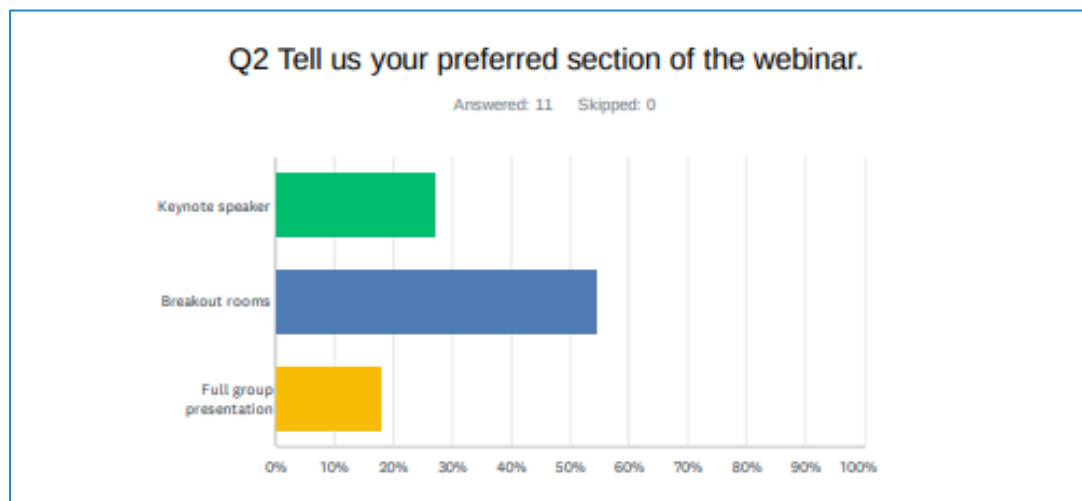
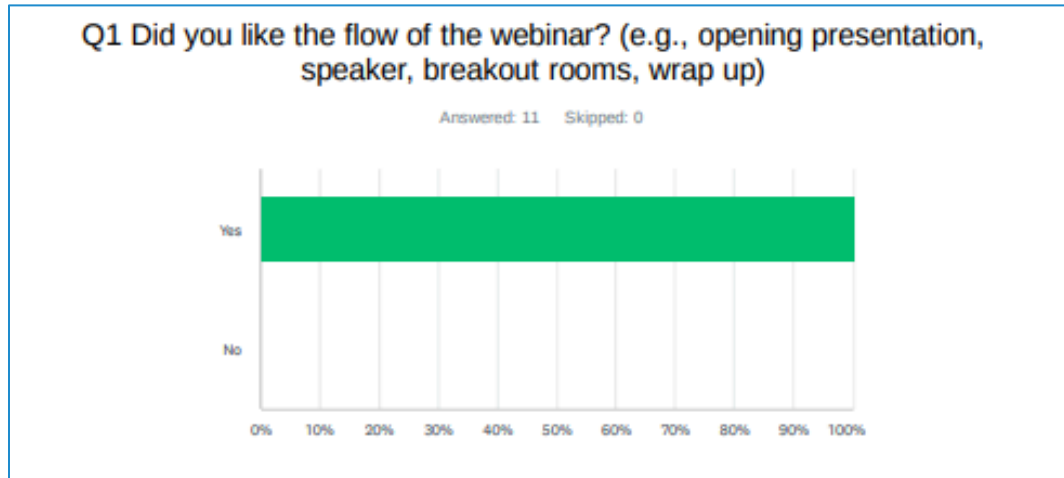
1. Continue to use the webinar format, including the use of the facilitated small group sessions in breakout rooms.
2. Schedule the next webinar for Wednesday October 16, 2024, at 12 – 1 ET, using a similar format and approach as the previous Network webinars.
3. Based on participant feedback, the next webinar will have the theme, *The Impact of Technology on Medication Safety*.
4. Explore the creation of tools suggested by the participants, e.g., those that help communicate the learning from incidents without significantly adding to workload. See Resources and Education breakout room for more examples.

4. Conclusion

This Canadian Medication Safety Network webinar was successful in its goals. 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: 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 11 people (20% of attendees) completed the survey, results are below.



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

Answered: 11 Skipped: 0

	STRONGLY AGREE	AGREE	NEUTRAL	DISGREE	STRONGLY DISAGREE	TOTAL
The quality of the content was relevant to my interests.	54.55% 6	45.45% 5	0.00% 0	0.00% 0	0.00% 0	11
The keynote speaker was engaging.	36.36% 4	63.64% 7	0.00% 0	0.00% 0	0.00% 0	11
The time in the breakout rooms was well used.	45.45% 5	45.45% 5	0.00% 0	0.00% 0	9.09% 1	11
The conversation in the breakout room was meaningful.	54.55% 6	36.36% 4	0.00% 0	0.00% 0	9.09% 1	11

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

Answered: 7 Skipped: 4

#	RESPONSES	DATE
1	The need for transparency at all levels.	5/10/2024 3:02 AM
2	Medication Safety in LTC Homes	5/9/2024 4:15 PM
3	Technology and med safety	5/9/2024 1:38 PM
4	How to shift to a safety culture. - examples of streamline questions, more on sharing trends, and specific lessons learned.	5/9/2024 1:25 PM
5	A few ideas in no particular order: Practical tips for building/sustaining safety culture What do patients want to see from their HCP when it comes to safety and quality improvement? Discussion of incident case reports if there are particularly insightful learnings from them.	5/9/2024 1:14 PM
6	How to give and share effective feedback for any reported incidents	5/8/2024 1:02 PM
7	medication safety in home care	5/8/2024 12:59 PM

Q5 Any other suggestions?

Answered: 5 Skipped: 6

#	RESPONSES	DATE
1	Ultimately I would like these discussions to be a place to make change from the top down not just to talk about the need to make change and why and leave it to some other groups to make change but not all groups.	5/10/2024 3:02 AM
2	Make meeting a bit longer (90 mins)	5/9/2024 1:38 PM
3	This webinar was worthy and necessary, thank you!	5/9/2024 1:25 PM
4	I really enjoy and value these sessions. Thank you for putting them on.	5/9/2024 1:14 PM
5	Would love to learn different tools to effectively use the incident report for a project	5/8/2024 1:02 PM