



Strengthening
Med Safety in
Long-Term Care



Trailblazer Home Workbook

Report, Learn & Act After a Medication Incident



November 2022

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

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Contact for Questions or Consultations

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1. Introduction and Overview

Welcome to the *Report, Learn & Act After A Medication Incident Project* group!

Over the next 6 to 9 months, you will receive education, facilitation and coaching from ISMP Canada staff in establishing or advancing effective medication incident reporting, learning and acting structures and processes.

Our first focus is on the medication incident reporting and learning structures and processes currently in each Trailblazer Home.

2. Reflecting on Medication Incident Reporting & Learning

Meet with the team at your home and complete the Long-Term Care Home Medication Incident Reporting & Learning Reflection Exercise (**see Appendix A**).

Describe the results of your reflection exercise.

Strengths

- _____
- _____
- _____
- _____

(add additional pages as needed)

Opportunities for Improvement

- _____
- _____
- _____
- _____

(add additional pages as needed)

2. Reflecting on Medication Incident Reporting and Learning (continued)

What are your initial ideas for improving reporting and learning process in the Home?

a.

b.

c.

Before you make any changes, continue through the Workbook to learn more about improving medication incident reporting and learning in long-term care.



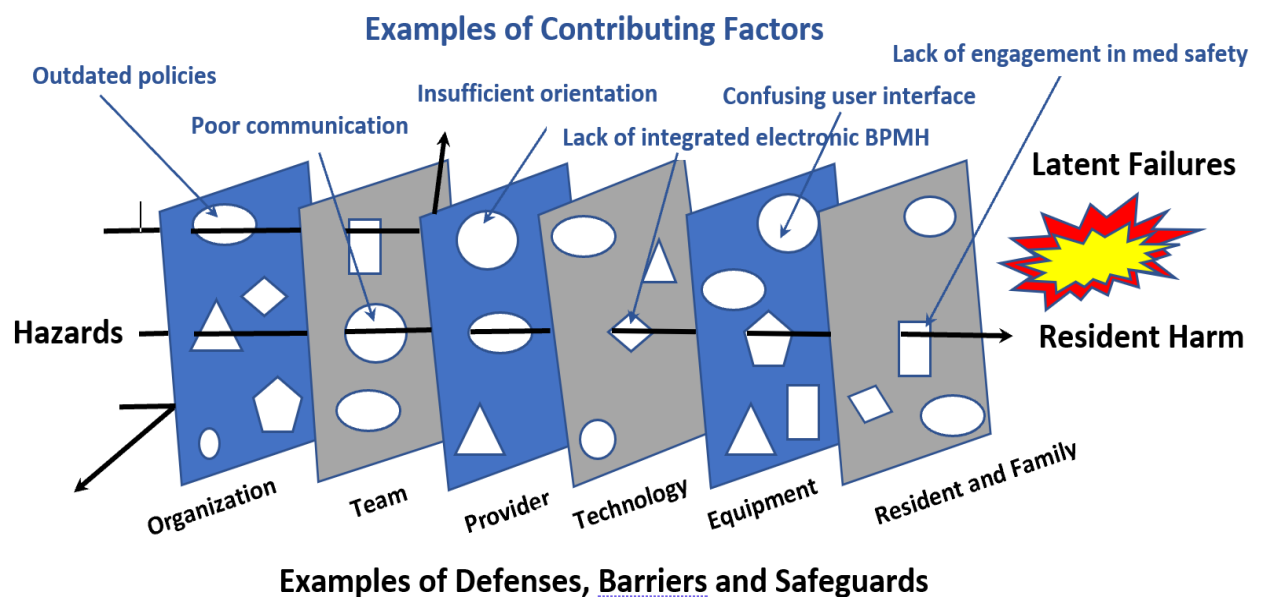
3. A Systems Approach

Two of the key concepts to consider for ensuring an incident and analysis process reflects the complexities of the health care system while remaining practical are:

- the systems approach (as illustrated by the Swiss Cheese Model in Figure 1) and,
- human factors engineering.

These concepts support a deeper understanding of how and why incidents occur in health care, including the identification of specific contributing factors.

Figure 1. Reason's Swiss Cheese Model



Adapted by ISMP Canada 2022 from J. Reason's Swiss Cheese Model (BMJ, 2000)

James Reason's Swiss Cheese Model provides a framework for understanding and analyzing the complex and dynamic nature of resident care from a systems perspective. The model explains how the defenses, barriers, and safeguards that exist in a system are not impermeable and can be penetrated. This occurs when active failures (unsafe acts; e.g., inappropriate procedures being followed) and latent conditions (dormant system conditions; e.g., poor lighting when preparing medication) align and create the opportunity for an incident.

Latent conditions can be identified and corrected. Targeted strategies can also mitigate the frequency and severity of unsafe acts. **It also points to the fact that humans are fallible, and errors will occur even in the best organizations because people are incapable of perfect performance every time.**

Human Factors

This is even more relevant in the current healthcare setting because technology is becoming more advanced, residents are presenting with more chronic health conditions, and healthcare teams and systems are complex.

Moving through the different layers of an incident can be daunting, and so having a systematic approach to guide reasoning through an incident analysis is beneficial. Human factors and human factors engineering take into consideration the limits of human capabilities to look at the physical, social, and organizational environment we work in, the tasks we are assigned, and technology in use, to determine which areas have shortcomings.

Some examples of human factors to consider are the size, font and placement of information on a medication label or the number and type of interruptions during a med pass. Human cognition is important for making the workplace efficient and user friendly. By recognizing all the key contributing factors related to a medication incident, it becomes easier to find where the most impactful changes should be implemented.

Through the guided approach, it becomes easier to determine contributing factors to an incident and make appropriate recommendations. Recommended actions for improvement will vary significantly and may range from physically changing the design of a software interface, sign, form, or medical device to redesigning a room in a facility to optimize safety and efficiency. Changes at various levels of the system are supported through human factors and human factors engineering.

Trailblazer Tip: To increase your understanding and application of Human Factors, access [Module 2: Human Factors Design: Applications for Healthcare](#). This Module is part of The Patient Safety Education Program Canada by the Canadian Patient Safety Institute (now Healthcare Excellence Canada).



One example of Human Factors is how easily providers can see and understand key information on medications. Vials are one example of where errors in correctly identifying the medication or concentration can cause harm or death.

Reference: ISMP Canada Safety Bulletin, May 26 2022. [ALERT: Substitution Error with Tranexamic Acid during Spinal Anesthesia](#)

4. Mapping the Reporting and Learning Process

To improve a process, it is important to ensure a clear and common understanding of all the steps involved. There are often different views on who does what step of the process and when.

To understand the current state of the reporting and learning process, map it! See Figure 2 below for an example of a Reporting and Learning Process Map from St. Patrick's Home of Ottawa.

Step One

- Gather your team together and brainstorm the steps for each person involved in identifying, reporting and analyzing a medication incident

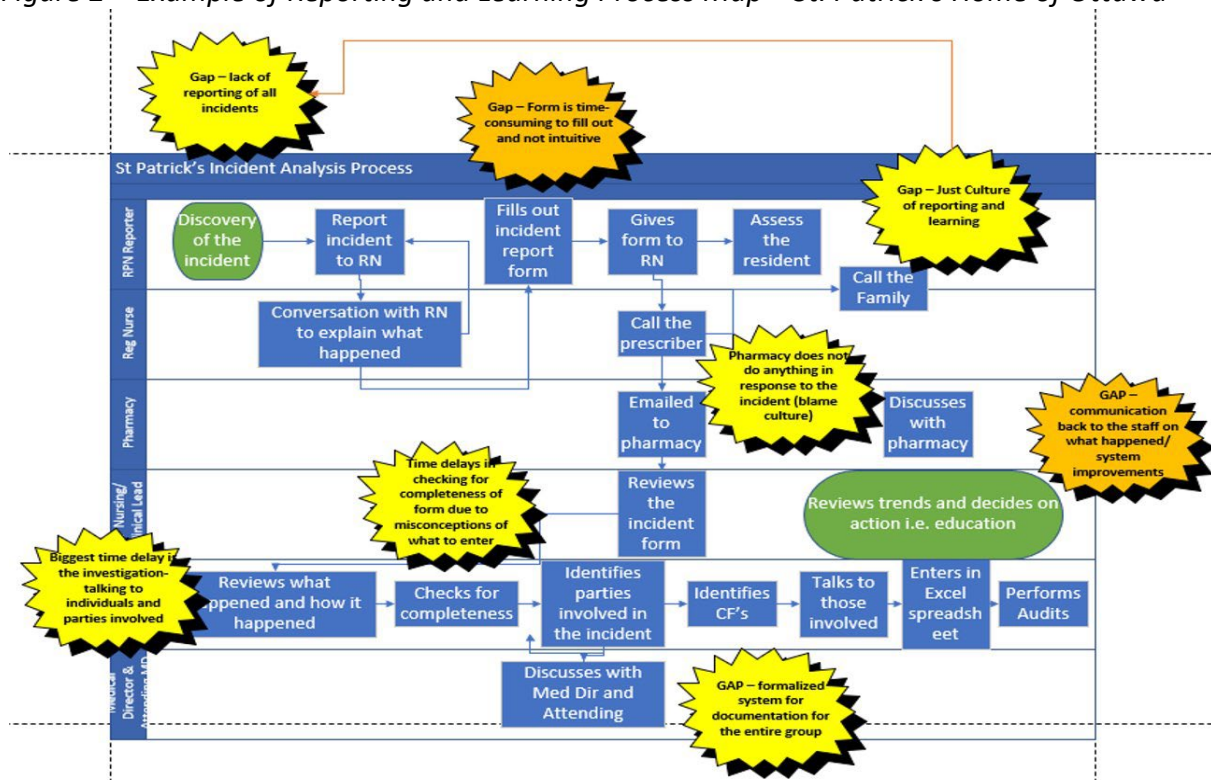
Step Two

- Identify potential/actual issues or gaps in the process together as a team

Trailblazer Tip: The Quality Improvement (QI) team at ISMP Canada has created eLearning modules that your team can access anytime. There are a variety of modules that you can choose from located [here](#).

Process Mapping – an Introduction is one of the modules. These foundational courses will also support your improvement work going forward.

Figure 2 – Example of Reporting and Learning Process Map – St. Patrick's Home of Ottawa

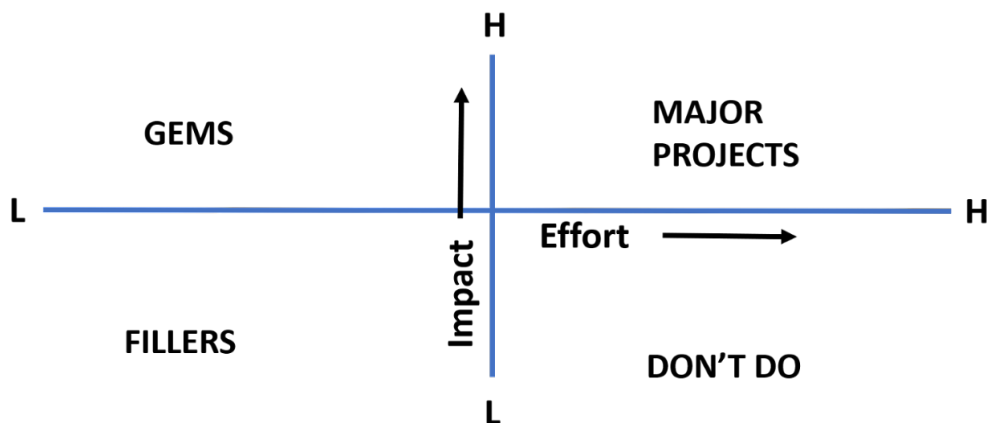




Step Three

Take the time to share the draft process map with other staff, physicians, residents and families to ensure it is accurate before brainstorming and prioritizing where changes will occur using the Impact-Effort Matrix in Figure 3 below.

Figure 3: Impact-Effort Matrix



5. Improving the Reporting and Learning Process

Just Culture

One way to improve medication incident reporting is to advance a [Just Culture](#) in the Home.

Culture is a set of shared attitudes, values, goals, and practices that characterize an organization.

A just culture is a small part of a larger healthcare organizational culture – ‘the way we do things around here’ – that strives to make care as safe as it can be.

When healthcare organizations work within a just culture, there is trust that everyone will be treated fairly when something goes wrong with patient care. It creates an environment in which people (healthcare providers and patients) feel safe to report errors and concerns about things that could lead to preventable patient harm. Reports of errors and patient safety hazards are important sources of information about weaknesses in the system that are addressed to improve patient safety.

As described by Justice Gillese, “Just culture is an important part of a safety culture, and it is founded on the assumption that all human beings make mistakes, and that those mistakes give us insight into how to avoid repeating them in the future.”

Further, in a just culture, a distinction is drawn among intentional acts, reckless acts, and acts that arise from unforeseen circumstance or complications of care. People are accountable for the care they deliver and should be informed about how their actions and errors will be reviewed when something goes wrong with patient care. Most importantly, the learnings are used to improve the safety of the system.

Consider using the following questions to discuss a Just Culture with staff, physicians, residents and families.

Adapted from: [SOPS Nursing Home Survey Items and Composites \(ahrq.gov\)](#)

Nonpunitive Response to Mistakes
1. Are staff blamed when a resident is harmed?
2. Are staff afraid to report their mistakes?
3. Are staff treated fairly when they make mistakes?
Feedback and Communication About Incidents
4. In this long-term care home, do we talk about ways to keep incidents from happening again?
5. Does the staff tell someone if they see something that might harm a resident?
6. In this long-term care home, do we discuss ways to keep residents safe from harm?
Communication Openness
7. Are staff ideas and suggestions valued in this long-term care home?
8. Is it easy for staff to speak up about problems in this long-term care home?

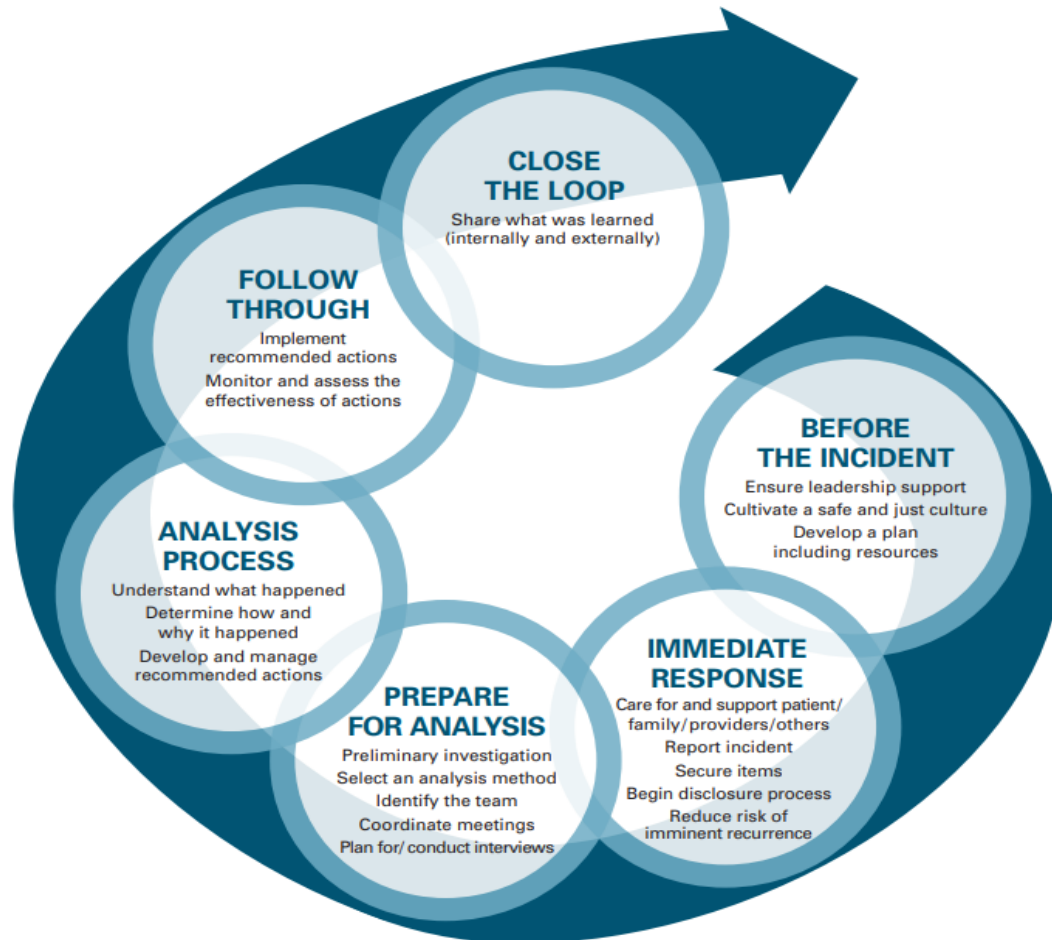
The entire survey is available on-line and can be used as an anonymous patient safety culture staff survey.

For all references see the ISMP Canada resource on a [Just Culture](#).

6. Incident Analysis

The [Canadian Incident Analysis Framework](#) (2012) is used across Canada to guide the process of incident analysis in all areas of the healthcare system. The Incident Management Continuum, which includes the incident analysis process, is outlined in Figure 4.

Figure 4 Canadian Incident Management Continuum (Canadian Incident Analysis Framework)



ISMP Canada Faculty Request

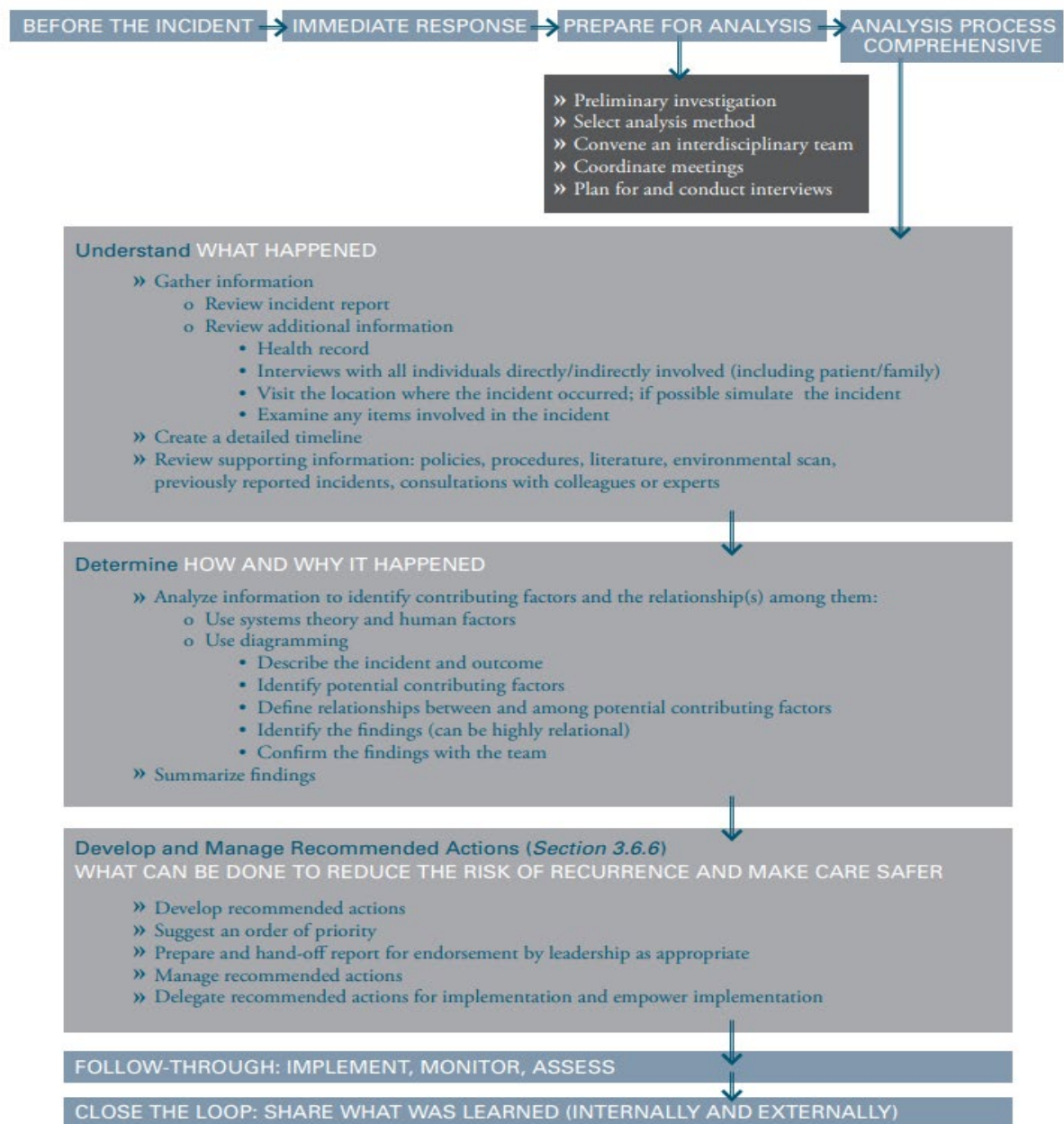
Each Trailblazer Home is requested to send a minimum of one representative to the ISMP Canada Incident Analysis in Long-Term Care Workshop. Other representatives are also welcome. The sessions are free and offered on the following dates. More dates will be added as needed.

Comprehensive Incident Analysis Methodology

The Comprehensive Analysis methodology is the foundation upon which other types of incident analysis can be advanced. Figure 5, page 39 of the Canadian Incident Analysis Framework describes the steps below.

Figure 5 Overview of the Steps for a Comprehensive Incident Analysis Process

3.6.3 Comprehensive Analysis



7. Developing Effective Improvement Strategies

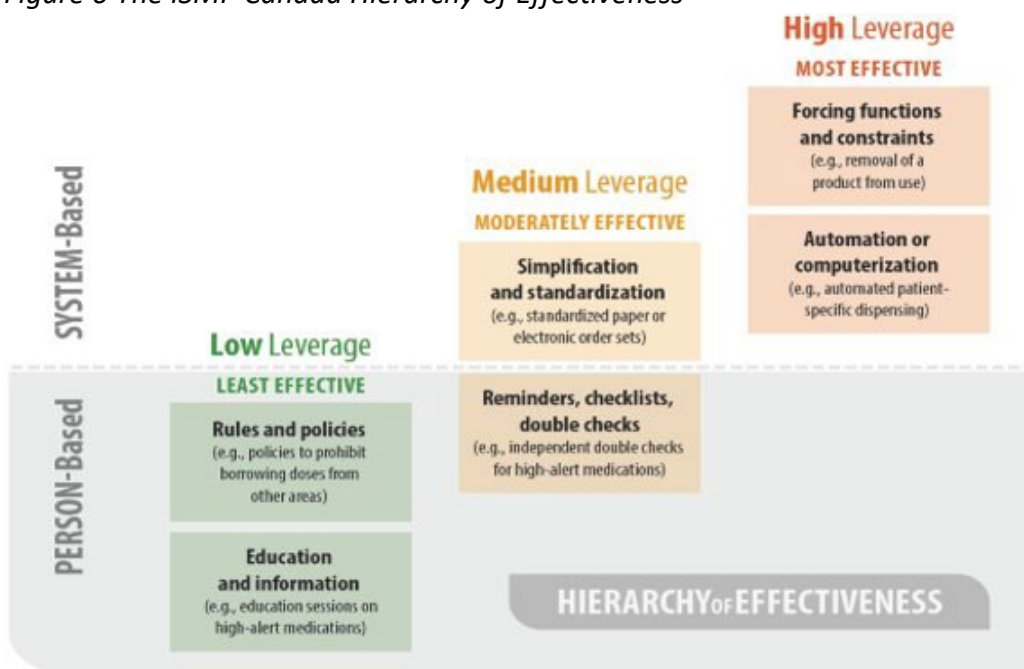
Developing effective improvement strategies after an incident analysis is challenging. Staff and Physicians are busy with resident and family care so it is important to focus on a “critical few” actions that will have the most positive impact.

The goal is to make it easier for staff and physicians to do the right thing with medications.

Trailblazer Tip: The Quality Improvement (QI) team at ISMP Canada has created eLearning modules that your team can access anytime. There are a variety of modules that you can choose from located [here](#). **Ideas for Most Impact** is one of the modules. These foundational courses will also support your improvement work going forward.

Use the hierarchy of effectiveness in Figure 4 to rate the actions as having high-impact, medium-impact or low-impact and then work to implement the highest-impact strategies.

Figure 6 The ISMP Canada Hierarchy of Effectiveness ¹⁴



The Impact-Effort Matrix is a decision tool that will also help to ensure that teams select the fewest possible actions that would achieve the objectives.

Setting SMART goals for each action selected for implementation

Writing down goals for each action increases the chances that the action will get implemented. It also provides a quick documentation of what changes were made, what the impact of the changes were and builds the organizational capability for change.

The goals should be:

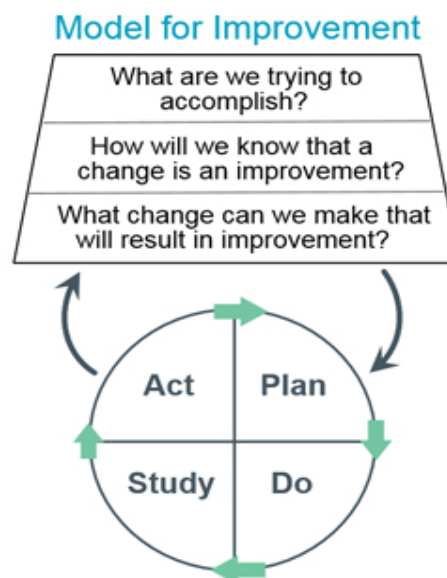
- Specific – tackle a clearly defined issue and have a clear scope;
- Measurable – can demonstrate impact on process and outcomes;
- Achievable – Is the action attainable with available or planned resources and support by a defined date;
- Relevant – ensure that the action is appropriate to the situation and possible; and,
- Timely – have a timeframe for implementation.

Testing the actions on a smaller scale before full implementation

After the team has selected the actions and has put measurable goals (predictions) for each, it's time to test the ideas on a small scale before full-scale implementation. This has a few advantages – one, the team gets to see if the idea works in practice and if the predicted improvement happened, and second, it is a way to provide some comfort to team members or other staff members who might otherwise be reluctant to take the risk of trying something new.

The tests of change are called Plan-Do-Study-Act (PDSA) cycles and are also a component of IHI's Model for Improvement shown below.

Figure 7 Model for Improvement



Developed by Associates in Process Improvement Model for Improvement

Some important principles for conducting effective PDSA cycles are listed below:

- Document each component of the PDSA cycle (preferably on one page);
- Write down an explicit prediction for the test (from the SMART goals written earlier);
- In multiple iterations, incrementally increase the scale of the test; and,
- Use regular data collection over time (run charts) throughout all the iterative tests of change.

Sustaining the improvements

After the improvements have been tested and the most effective actions have been selected for full-scale implementation, it's critical that the new processes are embedded into how work happens. Some of the steps that improvement facilitators and teams can perform to achieve sustainability are listed below.

- Involve the process owner (this is typically the manager or supervisor of the department where the new process is being implemented) in the planning for full-scale implementation.
- Create a new process map for the changed process (this enables staff to be easily educated in the new process using the map).
- Educate staff in the new process.
- Demonstrate how measurement has been implemented to monitor the process and prevent backsliding to the prior process.
- Create templates for auditing the process periodically so that the process owner is comfortable with the expectations of the new process and the monitoring requirements.

Share learning

The general lessons and findings should be disseminated within, and where applicable, outside the organizations to prevent harm recurrence.


Possibilities for sharing the lessons learned include the Home staff and physicians, the Medication Safety Committee and other committees in the Home, Resident or Family Council meetings at the Home, and other organizations.

This sharing is the final objective of the analysis. Without learning and sharing, the organization and/or external organizations, remain vulnerable because the same or similar incidents could happen again in another area. Results of the analysis should roll up into an organization-wide reporting and learning system and be shared with the senior leadership and Board.

Share learning (continued)

Learning from the incident may also be shared provincially and nationally (e.g., by [submitting the medication incident reporting and analysis information to ISMP Canada](#)). The Med Safety Signal is an example of the provincial learning that is now in place as a result of the Strengthening Medication Safety in Long-Term Care initiative. **See the most recent Med Safety Signal in Figure 6 below. Anyone can sign up to receive the Signal on the ISMP Canada website: <https://ismpcanada.ca/safety-bulletins/#footer>**

Figure 8 – ISMP Canada Med Safety Signal (July, 2022)



The graphic features the logos for 'Strengthening Med Safety in Long-Term Care' and 'ismp CANADA' at the top. Below them is a red banner with the text 'Med Safety Signal' and 'Risks in medication safety reported by LTC Homes in Ontario'. The main title 'A Patchy Approach to Transdermal Fentanyl Safety' is in red, followed by 'Volume 1 • Issue 2 • July 15, 2022'. The text describes a reported incident where a resident's fentanyl patch was incorrectly used, leading to a 2-fold overdose. It lists key contributing factors like reimbursement issues and preparation errors, and provides considerations for improvement such as payment options and double-check processes. At the bottom, there is a link to report an incident to ISMP Canada.

Strengthening Med Safety in Long-Term Care

ismp CANADA

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 15, 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:	Considerations for Improvement:
<ul style="list-style-type: none">• 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.<ul style="list-style-type: none">◦ 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.<ul style="list-style-type: none">◦ 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.	<ul style="list-style-type: none">• Eliminate the need to occlude half of the patch by dispensing the 12 mcg/h fentanyl patch for applicable prescriptions.<ul style="list-style-type: none">◦ 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:<ul style="list-style-type: none">◦ 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/>

8. Finalizing Your Priority Improvements

Use this entire workbook, the finalized Reporting and Learning Process Map, and the Impact-Effort Matrix in Figure 1, finalize 1 to 3 priority changes that would most effectively help you improve the reporting and learning process in the Home.

Trailblazer Tip: The Quality Improvement (QI) team at ISMP Canada has created eLearning modules that your team can access anytime. There are a variety of modules that you can choose from located [here](#). ***Ideas for Most Impact*** is one of the modules. These foundational courses will also support your improvement work going forward.

Priority Changes for Improving the Reporting Process in the Home (write them out below)

✓ _____

✓ _____

✓ _____

9. Our Schedule Together

Report, Learn & Act After a Medication Incident Cohort

November	December	January	February	March	April
<ul style="list-style-type: none"> •November 3 – Launch Conference! •November 10 – Option 1* for Incident Analysis Workshop (9:00 am to 3:00 pm) 	<ul style="list-style-type: none"> •December 7 – Provincial Initiative Update (12:00 – 1:00 pm) •December 8 – Option 2* for Incident Analysis Workshop (09:00 am to 3:00 pm) •December 14 – Our Cohort Webinar (12:00 to 1:00 pm) •December 15 - Option 3* for Incident Analysis Workshop (09:00 am to 3:00 pm) 	<ul style="list-style-type: none"> •January 12– Option 4* for Incident Analysis Workshop (09:00 am to 3:00 pm) •January 18 – Our Cohort Webinar (12:00 to 1:00 pm) 	<ul style="list-style-type: none"> •February 15 – All Trailblazers Webinar (12:00 to 1:00 pm) •February 22 – Our Cohort Webinar (12:00 to 1:00 pm) 	<ul style="list-style-type: none"> •March 22 – Provincial Initiative Update (12:00 – 1:00 pm) •March 29 – Our Cohort Webinar (12:00 to 1:00 pm) 	<ul style="list-style-type: none"> •April 19 – All Trailblazers Webinar •April 26 – Last Planned Cohort Webinar (12:00 to 1:00 pm) <p>All Trailblazer Homes Celebration and Learning Conference in May or June (TBD)</p>

All Trailblazer Homes working on Report, Learn & Act After a Medication Incident to ensure at least 1 representative attends the Incident Analysis for Long-Term Care Workshop on Nov 10, Dec 8, Dec 15 or January 8. More representatives from each Home are welcome to attend.

Register here: <https://ismpcanada.ca/education/>

Note: no fee for the workshop just note on the form that you work in LTC in Ontario.

Note: Cohort Homes can arrange individual coaching Zoom meetings with Carolyn Hoffman by sending a message to Carolyn.Hoffman@ismpcanada.ca

10. Your Preliminary Schedule

Activity	Who is Involved?	Timeframe Estimate	Done?
1. Medication Incident Reporting & Learning Self Reflection	Team Lead and Working Group*	2 - 4 hours in November	
2. Report Core Indicators by Nov 30, Jan 31 and April 30	Team Lead	Send to LTC@ismpcanada.ca	
3. Incident Analysis Workshop Facilitated by ISMP Canada Faculty (register here)	Team Lead Attends Members of Home Working Group Encouraged to Attend	6 hours in November or December or January ISMP Canada will provide templates to support use in the Home	
4. Cohort Webinar Together on December 14 (12:00 to 1:00 pm)	Team Lead Attends and Working Group Encouraged to Attend	1 hour in December All Team Leads share a summary of their results of the Reporting & Learning Exercise at the meeting	
5. Map Reporting & Learning Process	Team Lead and Working Group*	6 - 8 hours ISMP Canada will provide templates	
6. Cohort Webinar Together on January 18 (12:00 to 1:00 pm)	Team Lead attends and Working Group Encouraged to Attend	All Team Leads share their Process Map at the meeting	
7. Resident & Family Engagement (Jan)	Team Lead	Survey Summary to ISMP Canada	
7. Decide on 1 to 3 priority changes to improve reporting & learning (use Impact-Effort Matrix to decide) and begin to brainstorm PDSA Cycles	Team Lead and Working Group*	6 - 8 hours	
8. Cohort Webinar Together on February 22 (12:00 to 1:00 pm)	Team Lead attends and Working Group Encouraged to Attend	1 hour in February All Team Leads share their priority changes and rationale	
8. Begin to implement PDSA cycles and finalize changes	Team Lead and Working Group*	8 hours monthly	
9. Cohort Webinar Together on March 29 (12:00 to 1:00 pm)	Team Lead attends and Working Group Encouraged to Attend	1 hour in March All Team Leads share	
10. Finalize improvements and measurements for Home reporting and learning process – prepare summary for sharing	Team Lead and Working Group*	8 hours monthly	
11. Cohort Webinar Together on April 26 (12:00 to 1:00 pm)	Team Lead attends and Working Group Encouraged to Attend	1 hour in April	
12. Celebration and Shared Learning – Date and Time to be confirmed	Everyone!	TBD	

***Team Lead to access Carolyn Hoffman for facilitation and coaching as needed**

11. APPENDIX A Medication Incident Reporting & Learning Reflection Exercise

a. MSSA-LTC Related Questions

Use this table to organize your results at a glance. Please note that this function is also available as part of the MSSA program. Note: Number values coordinate with MSSA rating scale: **Never=0 Rarely=1 Sometimes=2 Often=3 Always=4**

Characteristic	2022
#1 Resident & Family Engagement	
1.6 When a resident experiences a medication incident, the resident and/or their family caregivers are given an opportunity to share their perspective as part of the information gathering step of an incident analysis and are invited to provide input into possible preventive actions.	
#5 Orientation	
5.3 Best practice principles for resident safety, including system based approach, influence of human factors, “just culture”, and high-leverage strategies for error reduction (e.g., standardization, process constraints, redundancy for critical functions and the hierarchy of effectiveness) are shared with practitioners during orientation and incorporated into medication safety initiatives.	
5.4 Practitioners receive ongoing information about medication incidents and high-risk situations occurring within the Home, relevant incidents occurring in other Homes (e.g., published in ISMP Canada Safety Bulletins), and strategies implemented to prevent such incidents.	
#8 Monitoring of Med Therapies	
8.10 The Home documents severe or unresponsive hypoglycemia as a medication incident, with appropriate investigation to identify possible adverse drug events (preventable and nonpreventable).	
8.11 There is a standardized process to track and document the use of glucagon and unexpected use is investigated to identify possible adverse drug events (preventable and nonpreventable).	
8.15 The possibility of a medication error or adverse drug reaction is considered when a resident presents with new concerning signs and symptoms, with appropriate investigation to identify possible adverse drug events (preventable and nonpreventable).	
#12 Medications Available as Ward Stock	
12.3 A standardized process is followed in investigating discrepancies in counts of narcotics, controlled drugs, benzodiazepines and other targeted substances that includes reviewing previous incidents and discrepancies to assess for possible diversion.	
#22 Medication Safety Committee	
22.6 Medication incident reports and trends (e.g., level of harm, medications involved, types of errors) are reviewed to identify system-based contributing factors, determine appropriate intervention(s) for resolution of medication system and practice-related issues, and monitor their effectiveness.	

Incident Reporting and Learning Reflection Exercise - selected MSSA-LTC questions (continued)	
#22 Medication Safety Committee (continued)	
22.7 The implementation of system improvements or redesign strategies recommended following an incident analysis is monitored to ensure completion is in accordance with the planned timelines. In addition, there is sharing about the reporting and learning process with all care team members.	
#23 Identifying, Reporting and Analysis of Incidents	
23.1 All care team members, including unregulated staff, are educated on the need for, and importance of, incident and near miss reporting.	
23.2 Practitioners receive training on how to respond to medication incidents occurring in the Home, including reporting and documentation processes, disclosure procedures and planning for ongoing communication with residents and family caregivers following an incident.	
23.3 All care team members, including unregulated staff, are invited to participate in open discussions about incidents to identify system vulnerabilities and opportunities for improvement	
23.4 Designated practitioners with training in quality improvement methodologies are utilized to enhance detection of medication incidents, oversee systems-based analyses, and coordinate effective incident reduction plans.	
23.6 Medication incidents causing resident harm, or with a high potential for harm, are reviewed and analyzed by an interdisciplinary team, using a structured framework based on safety principles (e.g., Canadian Incident Analysis Framework) and action is taken to address identified vulnerabilities.	
23.7 The structured framework used for incident analysis includes screening for possible intentional harm.	
#24 A Just and Trusting Culture Withing a System-based Approach to Error Reduction	
24.1 Specific medication safety objectives are included in the Home's strategic plan, reflected in standard operating policies and practices, communicated to all staff, and acknowledged in a positive manner when achieved ("celebrating successes").	
24.2 Error prevention strategies focus on system design enhancements that prevent harmful errors and encourage safe behavioural choices, rather than focusing exclusively on the behaviour of individual practitioners.	
24.3 The organizational human resources response to an incident is guided by a consistent, standardized process that is based on the actions leading up to the incident (e.g., human error, at-risk behaviour, reckless behaviour) and not determined by the severity of harm (including no harm) that results.	
24.4 Practitioners involved in serious incidents that result in resident harm are emotionally supported by leadership and colleagues and provided with access to ongoing support or other crisis intervention strategies (e.g., through an employee assistance program).	
Total for Home	
Total Possible for Responses	76

APPENDIX A: Incident Reporting and Learning Reflection Exercise (continued)

- b. Can any staff and/or prescriber complete and submit a medication incident form in your home?

YES or NO

- c. Tick the applicable boxes for describing the information that is requested on a medication incident form. See the Trailblazer Home Medication Safety Indicator [Instruction Book](#) for definitions.

- ☐ Resident name
- ☐ Resident location
- ☐ Date of Incident
- ☐ Time incident occurred
- ☐ Time incident was detected
- ☐ Incident type
- ☐ Incident description (open text field)
- ☐ Healthcare provider who detected incident
- ☐ Healthcare providers who were involved in incident
- ☐ Resident outcomes
- ☐ Degree of Harm
- ☐ Medication name(s) that were involved/related to the incident
- ☐ Dosage Form
- ☐ Batch Number/Lot Number
- ☐ Strength of medication
- ☐ Route of Administration
- ☐ Contributing factors/hazards
- ☐ Notifications
- ☐ Interventions Required
- ☐ Future recommended actions for improvement (open text field)

Incident Type options may include categories such as Supplying, Storage/location, Prescribing, Order documentation, Preparing/dispensing, Presentation/packing, Delivery, Order verification, Administration, Monitoring (post-administration), Advising/counselling

Degree of Harm options may include Identified Risk Only, Near Miss (does not reach the resident), No Harm, Harm, Death

Contributing factors/hazards options may include Task, Environment, Organization, Care Team, Resident, Equipment, Other, with open text option for details

Notifications options may include Resident/Family, Attending Physician, Manager, Other

Interventions Required options may include none, additional vital signs monitoring, lab tests, medications, Visit to ED, Other)

- d. Is it clear what medication incidents need to be reported?

YES or NO

- e. Do staff/physicians receive feedback on their reports?

YES or NO

- f. Is it clear what medication incidents will be further analyzed and how?

YES or NO

12. APPENDIX B References

1. Isherwood, P., & Waterson, P. (2021). To err is system; A comparison of methodologies for the investigation of adverse outcomes in healthcare. *Journal of Patient Safety and Risk Management*, 26(2), 64-73.
<https://doi.org/10.1177/2516043521990261>
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