Canadian Medication Safety Network

Consumers and Providers Sharing and Learning About Medication Safety Together

5 Essential Components to Advance Medication Safety in Your Organization.

Leveraging Success in Ontario Long-Term Care Homes.

Summary of Webinar Participant Feedback

June 11, 2025

Institute for Safe Medication Practices Canada

ISMP 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

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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

Contents

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 a webinar that was held on June 11, 2025, from 12 – 1 PM EST. There were 13 attendees from across Canada plus 12 ISMP Canada staff.

The topic of the webinar was "*5 Essential Components to Advance Medication Safety in Your Organization. Leveraging Success in Ontario Long-Term Care Homes.*" and the agenda 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 (see a summary of the results in Appendix 1).

One of the main goals of the webinar was 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. The feedback has been compiled in this report for public distribution and use by ISMP Canada to advance medication safety across the country.

The link to the recording of the webinar can be found here:
https://youtu.be/mMW4A65VYHo

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. Four webinars have been hosted since the inception of the network in 2024.

2. Methodology

An e-mail invitation for this webinar was sent to the approximately 900 network registrants. They were asked to complete a Zoom registration form that included a request to select one of 6 topic options under the theme of *5 Essential Components to Advance Medication Safety in Your Organization. Leveraging Success in Ontario Long-Term Care Homes.* Based on their selection, participants were assigned to that small group discussion (breakout room) during the webinar.

1. Patient Engagement in Patient Safety
2. Tools and Support: A focus on Medication Reconciliation
3. Quality Improvement
4. Incident Analysis
5. Measurement and Evaluation
6. 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=13
    - Pharmacy Team Member 31%
    - Nurse 31%
    - Person with Lived Experience 0%
    - Quality Improvement or Patient Safety Professional 23%
    - Other Experts 15%
- Have you or someone you know experienced an issue with the safety of medications?
    - Yes: 92% No: 8%
- Is this your first network webinar? No 38% Yes 62%

Keynote Speaker

Shirley Drever, BSc. Phm., RPh, CDE Clinical Medication Safety Pharmacist, Sienna Senior Living, discussed how she transformed her learning from the Strengthening Medication Safety in Long-Term Care (SMSLTC) initiative to system change in a national LTC group of homes. Shirley was the project manager and faculty member at ISMP Canada for the SMSLTC initiative for 3 years and then moved into her current role at Sienna Living where she has been using quality improvement tools to improve medication safety systems across Sienna homes. Two areas of focus that Shirley shared with the audience was enhanced diabetes management to improve the quality of residents' life, and improving personal support worker medication administration processes and procedures.

The full presentation can be heard in the recording found here: https://youtu.be/mMW4A65VYHo

The next stage of the webinar was 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

- Patient Engagement in Patient Safety
- Tools and Support: A focus on Medication Reconciliation
- Quality Improvement
- Incident Analysis
- Measurement and Evaluation
- 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 by receiving targeted facilitation documents as well as their previous experience in these roles during the previous network webinars. Also, each room had prompt questions developed for the facilitators to help support the conversation. Breakout rooms were not digitally recorded so the notetaker'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. (n=12)

- Medication safety during times of medication shortages (83%)
- How to give and share effective feedback for reported incidents (42%)
- Advocacy 101: What does it look like and how do you do it? (33%)
- Labelling and Packaging Issues (33%)
- Multiple Medications (Polypharmacy) (17%)

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 Next Steps

Findings

The notes from each small group discussion were analyzed and themes identified then formalized. They are listed below according to the topic of the discussion.

Patient Engagement in Patient Safety

Overview/Key Messages

Question posed by facilitator: What would you like to learn about with regards to patient safety and are there any other challenges you want to address?

Answer by participant:

- Opportunity to chat with patient partners to learn more, and we want to bridge the gap between patient experiences and theoretical aspect of medication safety. In other words, how can we implement resources in a *practical manner*?
- There is this element of trust we need to consider with our residents. When they [the residents] are aware that a certain decision regarding their care may not be okay, how do we let them know that it is okay to speak up? Additionally, how can we help them to share their concerns when there is a power differentiation with their healthcare provider?
- How can we work on implementing patient safety strategies without making the care team feel as though it is negatively impacting their time for patient care?

Facilitator:

- The best place to start is the voice of the residents and the families, what are the risks they are seeing and what is working well?
- Resources shared by ISMP Canada:
    - The Resident and Family Survey that was developed for the Strengthening Medication Safety in LTC initiative to hear from residents and families. It consists of 9 questions that help staff understand how residents and families see their medication safety and management from their perspective. How do we harness the residents' unique perspective? How involved does our patient want to be in their healthcare journey?

- The Medication Safety Self-Assessment for LTC (MSSA-LTC) begins with a section regarding resident engagement.
- Strengthening Medication Safety in LTC ----> A toolkit has been created that has practical information and resources and is written to be accessible by all staff.
- Your Voice Matters in Medication Safety Video ----> This video is shared with residents that encourages them to bring forth their voice and how they can be part of their safety journey.
- Get LTC residents involved! They can help prevent their own medication errors during medication administrations and while there are a lot of residents that do not have cognitive ability, their families/caregivers can be involved.
- When a Medication Error Happens ---> If there is no safety culture in place, it is very hard to take a proactive approach to incident reporting.
- Consumer Newsletters - these are written for the general public and contain information learned from medication errors that have been reported by the public as well as safety tips to prevent recurrence.

- Resources Shared from Healthcare Excellence Canada: Patient Engagement Framework
- Having a good understanding of the organizational initiatives helps with enhancing just culture. See this document on Supporting Just Culture in LTC.
- Resources shared via chat: https://ismpcanada.ca/education/

Key Insight: It is very important to share valuable resources to enhance just culture in a tangible way. There is a desire to implement strategies that embrace the unique perspectives of our LTC residents and get them engaged in their healthcare journey.

References Requested by Members: Requesting contacts/social groups to stay in touch. Anyone interested can sign up for Safety Bulletins and Consumer Newsletters.

Tools and Support: A Focus on Medication Reconciliation

Key Discussion Points:

- **Med Rec is more than a checklist:** Emphasis on meaningful, patient-centered reconciliation.
- **Patient/family involvement:** Actively including patients and caregivers ensures accuracy and shared understanding.

- **Importance of a Best Possible Medication History (BPMH):** It's the cornerstone of Med Rec. A poor-quality BPMH = missing puzzle pieces. A systematic process is key.
- **Identifying discrepancies:** Accurate BPMH helps distinguish intentional vs. unintentional discrepancies (e.g., omissions, commissions, undocumented changes).
- **Med Rec Quality Audit Tool:** A resource to assess the quality of Med Rec processes at admission.

Discussion Highlights:

- **System Challenges:**
  Transitions from acute care to LTC are prone to medication errors, often due to lapses in **communication** (e.g. Faxed summaries and prescriptions that are hard to read or get misplaced) and due to **documentation** i.e. meds held for clinical reasons (e.g., pending labs) are often not resumed later. Are there guidelines for a second check process or an independent double check that the LTC institutions can implement?
- **Potential Solutions Shared:**
  - Reference to the Better Coordinated Cross-Sectoral Medication Reconciliation (BOOMR) process. DOI: 10.12927/hcq.2017.25075
  - Some interventions include,
    - to start the Med Rec process on "bed acceptance day" before LTC admission.
    - optimizing interprofessional communication with a three-way conference call between LTC physician, nurse, and pharmacist before admission to finalize admission orders and discuss discrepancies.
    - encourage a warm handover (e.g., a direct from pharmacist to LTC staff) to verify fax receipt and discuss any issues or answer any questions.
- **Participant 1:** Asked about getting support from respective health ministries for the Med Rec process.
  - **Response:** consider reaching out to respective Ministries of Health for support and advocacy.

Key Insight: Ongoing challenges during transitions from acute care to LTC, especially with paper-based systems and last-minute discharge changes that are often not communicated well. Key takeaways included implementing a warm handover to ensure accurate handovers. A warm handover—ideally a pharmacist-to-a LTC care staff member—is preferred to catch missed updates and confirm receipt of discharge details.

Quality Improvement (QI)

Key discussion points:

- Participants are interested in learning more about human factors / system design
- There is still a lot of work to do in deprescribing antipsychotics and deprescribing in general
- They want to learn from other homes of similar size
- A possible area for quality improvement has been identified as the need to look at the time it takes to administer meds, but nurses have a lot of other tasks to complete
- They *are* improving efficiencies, and they are doing their best to mitigate medication errors. The goal is to reduce risk for recurrence to improve quality of life for residents
- Knowledge gaps exist around QI and that holds people back
- People are afraid of being disciplined
- Coaching is needed: what do you think could have been done differently to prevent this? What were your challenges, or what you feel is the root cause?
- The issue is *root causes are not being addressed*
- There is wasted time due to redundant steps and documentation. Time could be better used for med admin/other clinical tasks.
- Supplemental documentation takes 1 hour, which could be better used elsewhere. Frustration surrounding this as requests for projects/options to improve this are being denied
- Looking for ideas from this session to help improve
- System factors: lack of time, rushing. It's not the person making the mistake, it's the system
- There is an overall feeling of being deflated and any celebrations are short lived.
- We need to ask, what are the "wins"?
- Need to celebrate successes and provide positive feedback
- Need to have a quality improvement information sharing board to display what numbers they are tracking and to celebrate successes
- One home has reduced antipsychotic use.

Facilitator comments:

- Use a huddle board to create engagement with staff
- What are the small things that are causing pain every day? Assessing this and changing this can empower staff, to continue momentum.
- Forcing function: explore how to make it difficult for people to do the wrong thing

Key Insight: The key theme that emerged is that education is never enough. Participants emphasized the need to focus on the higher leverage solutions. In addition, the person is not the problem its most often the system that is causing the problem.

Incident Analysis

- Participants were asked what they would like to share
    - With introduction and promotion of a just culture in their organization, the number of reports on medication incidents increased significantly.
    - Participant reviews incidents brought forward with the help of the unit manager to see if the incident was a process issue or an individual's lack of knowledge of the process
    - Their program looks at discharge planning from hospital to home - looks at what was prescribed, the medications that changed, etc., and checks these for discrepancies to report back to the hospital or the local pharmacist. Example: Just last week, patient recently discharged from hospital. Nursing was not involved but they noticed a discrepancy with the medications they were taking (patient was discharged with Plavix, an anti-platelet drug to prevent blood clots, but patient was still taking aspirin)
    - With this program, the goal is NOT to blame anyone but rather to prevent similar situations from happening in the future (their focus is not on blaming individuals but rather how to improve the system)
    - Participating in these webinars and promoting ISMP Canada tools have been beneficial to their practice and to the whole organization
    - ISMP Canada workshops have been effective and educational for her and has assisted her in the ability to take care of residents clinically and to assist with their management role for the organization
    - She used mapping tools from workshops to help determine what to do for improvement following an incident (their organization gives nurses and other staff 2-3 days to reflect on the situation and complete this tool/template to suggest contributing factors and strategies for improvement)
    - This approach has been helping with her analyses of incidents to identify contributing factors and create strategies to address them. Each person suggested a unique strategy to address the situation
    - She reported that they have been seeing positive changes in their organization since implementing this process
- Facilitator: What would help you make meaningful action/impact to support your current work:
- Tools related to analyzing incidents have been great for supporting their practice
- A participant asked if these tools were available in French and advised that the Canadian Incident Analysis Framework is translated and available online (Cadre canadien d'analyse des incidents). In addition, ISMP Canada has provided the templates in English (https://ismpcanada.ca/wp-content/uploads/Incident-Analysis-Templates.docx) and French (Incident-Analysis-Templates-FR.pdf)
- Requests for resources/links:
- Participants advised to send specific resource requests to LTC@ismpcanada.ca

Key Insight: Participants are actively working on effective incident analysis in their organizations. They use ISMP Canada tools, and they are talking to their colleagues about system issues and how to act together for improvement.

Measurement and Evaluation

Key discussion points:

Measurements and metrics to prove improvement is a worthy use of time and resources.

Facilitator: Safety is hard to measure i.e., how do you measure something when it's not happening. Some ideas of measurement can depend on the definition of harm used.

Measures in LTC: There is mandatory reporting to the Ministry of LTC in Ontario for selected metrics only.

The number of incidents reported is often identified for areas to improve.

One participant shared an approach of reviewing all incidents, keeping track of repeated incidents and possibly investigating it further.

Another participant shared that electronic tracking of incidents wasn't a total solution and is not perfect. They want to use electronic means because funding for human resources is limited. They are looking at internal trends in reports and compare to published external reports.

How to encourage people to report:

- One on one conversations help drive change

Key medication safety indicators:

- Med Rec
- Administration
- Falls, etc.

Med Rec indicators further explained:

- Focusing on admission med rec, transfer med rec, barcoding at administration of medication in acute care
- One participant shared that there is a difference between just doing Med Rec right now, and then doing it well at another time (is it done vs is it done well?)
- Another participant reinforced that the quality of Med Rec is very important to them.

Follow up and next steps are missing or challenging. How long did it take, cost, what is the quality and usefulness for others… the lack of data is challenging

One participant asked how many incidents are actually being reported? Need to increase reporting on errors and especially on near misses.

Another participant agreed on near misses being very important. Systems based issues are also very important to find and focus on.

The Facilitator shared that even though there is high reporting, there is still a need to decide on what's important to focus on.

Key Insight – There is no perfect measure of medication safety, but participants would love to see more reporting of near miss incidents as an indicator.

Open Dialogue

This breakout room was not selected by participants.

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:
- 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 November 2025, using a similar format and approach as the previous Network webinars.
3. Based on participant feedback, the theme and breakout room subthemes for the next webinar will be decided upon in fall 2025.

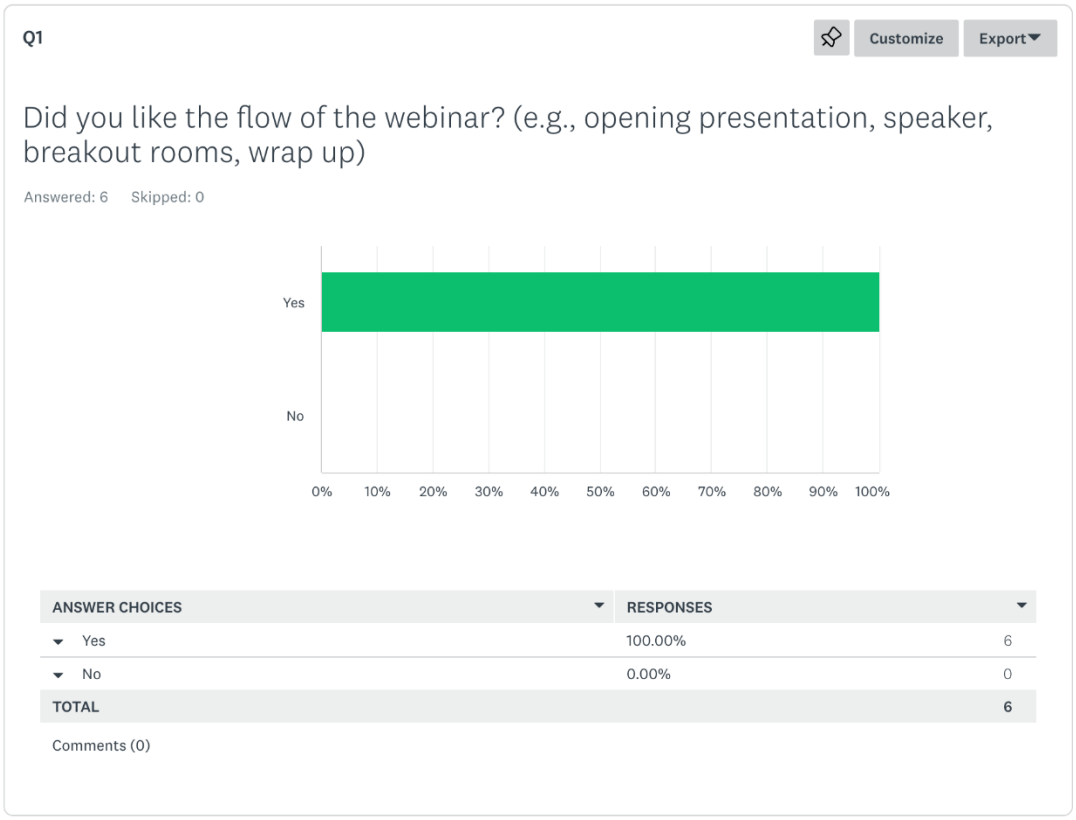
Conclusion

The recent Canadian Medication Safety Network webinar successfully met its objectives. Looking ahead, the network's greatest strength will lie in its ability to foster ongoing conversations between consumers and health care providers, ensuring their voices are heard and their priorities understood. ISMP Canada remains committed to listening and incorporating these insights into the development of future products and services. Through this collaborative approach, participants will play a vital role in shaping the future of medication safety across Canada.

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 6 people (46% of attendees) completed the survey, results are below.

Question 1



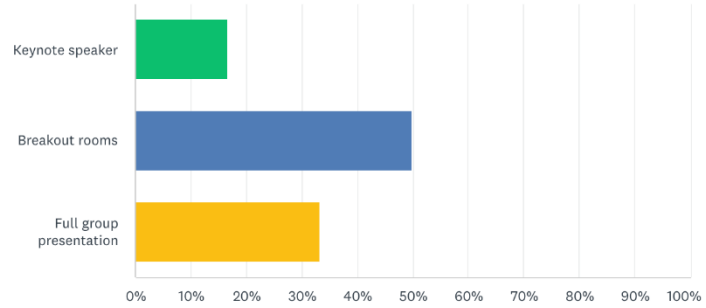
Question 2

Q2

Customize Export

Tell us your preferred section of the webinar.

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Keynote speaker	16.67%	1
Breakout rooms	50.00%	3
Full group presentation	33.33%	2
TOTAL		6

Comments (1)

Comments:

I really enjoyed all parts!

6/11/2025 12:59 PM View respondent's answers Add tags

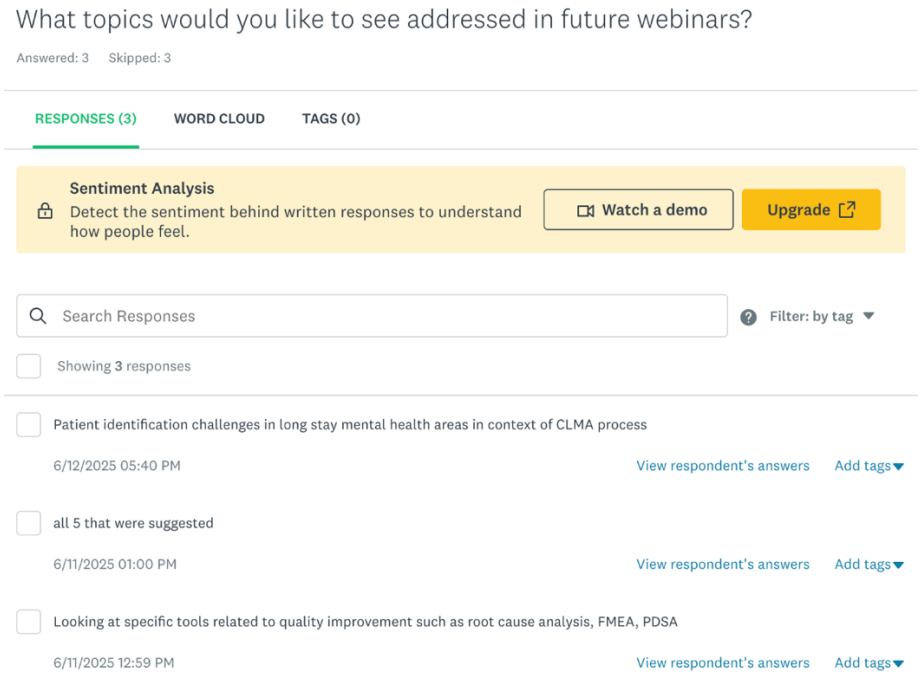
Question 3

	STRONGLY AGREE	AGREE	NEUTRAL	DISGREE	STRONGLY DISAGREE	TOTAL
The quality of the content was relevant to my interests.	50.00% 3	50.00% 3	0.00% 0	0.00% 0	0.00% 0	6
The keynote speaker was engaging.	50.00% 3	50.00% 3	0.00% 0	0.00% 0	0.00% 0	6
The time in the breakout rooms was well used.	50.00% 3	50.00% 3	0.00% 0	0.00% 0	0.00% 0	6
The conversation in the breakout room was meaningful.	50.00% 3	50.00% 3	0.00% 0	0.00% 0	0.00% 0	6

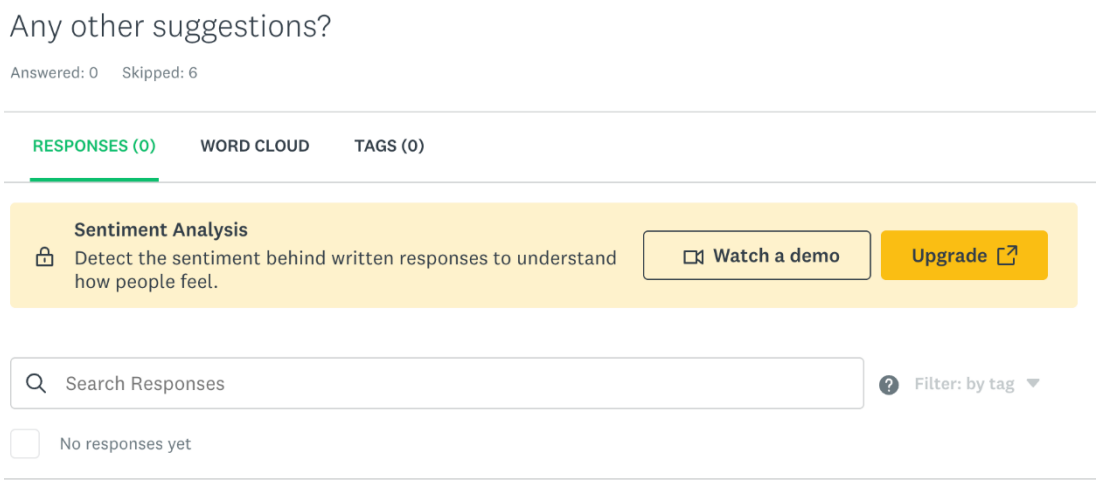
Comments (0)

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

Question 4:



Question 5:


Any other suggestions?
Answered: 0 Skipped: 6
RESPONSES (0)
WORD CLOUD
TAGS (0)
Sentiment Analysis
Detect the sentiment behind written responses to understand how people feel.
Watch a demo
Upgrade
Search Responses
Filter: by tag
No responses yet