Saskatchewan Health Authority

Newsletter

Medication Safety

November 2024
Department of Pharmacy

INTRODUCTION TO THE MEDICATION SAFETY NEWSLETTER

WELCOME

Welcome to the SHA Pharmacy Medication Safety Newsletter!

The Medication Safety Team is excited to connect with you through these newsletters and bring relevant and essential information. Our mission and vision is to empower individuals with the knowledge and tools needed to manage and administer medications safely and effectively, while fostering a culture of safety in our healthcare settings. We hope that these resources and readings will be valuable and helpful to your practice. Thank you for being a part of our commitment to improving medication safety!

NEWSLETTER GOALS

- Educate on safe medication practices and increase safety literacy
- Update on new safety guidelines, best practices and provide practical tips and tools
- Raise awareness of medication risks and examine common safety challenges
- Promote open communication and advocate for patient-centered care and Just Culture
- Highlight resources and offer support

WHO WE ARE

The SHA Medication Safety Team is composed of experts from various healthcare fields, education and experience. We are authoritative resources on organizational medication safety-related evidence, information and knowledge.

The team works across professional silos, hierarchy, and former regions to engage in medication safety efforts and investigates medication error reporting data to develop and ensure efforts result in tangible improvements in the medication-use system.

Together, we strive to create a safer healthcare environment for you by staying ahead of emerging risks, implementing best practices, and providing valuable educational and relevant resources.

We are here to support you in your journey toward safe and effective medication management. If you ever have questions or concerns, don’t hesitate to reach out—we’re always here to help!

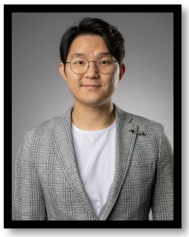
MEET THE MEDICATION SAFETY TEAM

Angela Butuk - Medication Safety Officer, BSN, RN RNFA

Has been the MSO in Saskatoon for 14 years, an experience that has been rewarding and positive. Previous clinical experiences include OR (across North America), clinical nurse educator, outpatient clinics and procedural roles. Always interested in patient safety but never understood safety science until moving into this role of MSO. In addition to Human Factors and System Safety, keenly interested in Just Culture with Just Culture Certification, as well as ISMP Medication Safety Intensive training. Currently a member of the national advisory committee for NSIR. Saskatoon is home, has two children and many, many pets. Travel, reading and gardening are her hobbies.

Terrence (Terry) Davidson - Medication Safety Resource Pharmacist, BSP

Obtained his BSP in 2001 and spent several years in retail before transitioning to hospital pharmacy in 2007, with a focus on adult medicine and psychiatry. His passion for safety grew while working as acting senior and assisting with the implementation of SMART pumps. Currently, supports the pharmacy department, collaborates closely with the MSO, and assists Patient Safety and Risk Management. Originally from Leader, Saskatchewan, he's married to Marla and has a 16-year-old daughter, Emma. He has a variety of hobbies, particularly enjoying watching Emma compete in dance and baton twirling, and spending time outdoors.



John Yoo - Medication Safety Pharmacist, BSP, BSChem.

Experienced in clinical consulting pharmacy work in an outreach and appointment-based model of practice, with unique patient demographics, including long term care, community group homes, nursing homes, convalescent care. Passionately interested in optimizing systems, finding efficiencies and effectiveness, leading and empowering others to succeed. Intrigued with advancing medication safety and healthcare through technology and innovations. Continuous involvement in committee, leadership and team-oriented roles. Outside of work, he enjoys hockey (go Stars!), golf, playing piano, and spending time with his wife and 2 girls.

Corey Herod - Medication Safety and Clinical Quality Manager, BSP

A pharmacist for 24 years and his journey has taken him through the pharmaceutical industry, retail pharmacy, and in 2006, found his passion in hospital pharmacy, particularly in cardiology. In 2009, he worked on the Regina BDM pharmacy application, which opened his eyes to the technological side of hospital pharmacy. Now, as the Medication Safety and Clinical Quality Manager, he's incredibly proud of the team's dedication to creating a safer medication use system. Outside of work, he enjoys photography, technology, biking, snowboarding, PC/console gaming. As well, if you're into board games, he'd love to chat about his collection!

Doug Sellinger - Clinical Quality, Safety & Logistics Director, BSP, MALT, FCSHP

Started his leadership journey shortly after the publication of "To Err is Human: Building a Safer Health System" and was assigned to lead work on ensuring and improving a safer medication-use system in Regina. Medication safety has been part of his work-life for most of the past 25 years and is pleased to be leading the team, as they continuously look for ways to improve the patient and family-centered medication system throughout SHA in collaboration with other key stakeholders. As time permits, he enjoys distance running and has completed numerous marathon or ultra-marathon races including one of the Abbott World Major Marathons.

Provincial Pharmacy Rounds—Medication Safety

"When the Antidote Causes Harm - Preventing Errors with Intravenous Acetylcysteine"

November 20th @ 12:00-13:00. Presented by ISMP Canada and HIROC
Zoom Link: https://us02web.zoom.us/j/82429747966
(Meeting ID: 824 2974 7966)

PYXIS Product Advisory

Becton Dickinson (BD) Canada reports 4 instances of Pyxis MedStation™ ES or Pyxis CII Safe systems opening the wrong Smart CUBIE pocket or position in error during a normal dispense workflow. Opening of the wrong Smart CUBIE creates a potential opportunity for incorrect drug loading or administration to patient. Users are reminded to verify the drug name on package removed with the patient's Medication Administration Record (MAR) prior to administering medications.

Recommended actions:

- If available, use bar code verification to load and vend medications from Pyxis MedStation™ and Pyxis CII Safe.
- Verify medication and dose delivered by Smart CUBIE is the same as requested.
- Verify medication and dose to the Patient's MAR, following best practises prior to administering.
- Notify pharmacy if you detect this error on a MedStation or CII Safe in your area.

ECRI's Top 10 Patient Safety Concerns for 2024

ECRI's Top 10 Patient Safety Concerns 2024 identifies imminent safety challenges for patients and staff that we believe require maximum focus for the coming year; more importantly, it offers actionable recommendations to remedy these challenges.

Drawing on ECRI and ISMP's evidence-based research, data, and expert insights, this report sheds light on issues that leaders should evaluate within their own institutions as potential opportunities to reduce preventable harm. Some of the concerns represent emerging risks, some are well known but still unresolved, but all of them pertain to areas where organizations can make meaningful change.

The Top 10 Patient Safety Concerns 2024 is a guide for a systems approach to adopting proactive strategies and solutions to mitigate risks, improve healthcare outcomes, and ultimately, enhance the well-being of patients and the healthcare workforce.

The List for 2024

1. Challenges Transitioning Newly Trained Clinicians from Education into Practice
2. Workarounds with Barcode Medication Administration Systems
3. Barriers to Access Maternal and Perinatal Care
4. Unintended Consequences of Technology Adoption
5. Decline in Physical and Emotional Well-Being of Healthcare Workers
6. Complexity of Preventing Diagnostic Error
7. Providing Equitable Care for People with Physical and Intellectual Disabilities
8. Delay in Care Resulting from Drug, Supply, and Equipment Shortages
9. Misuse of Parenteral Syringes to Administer Oral Liquid Medications
10. Ongoing Challenges with Preventing Patient Falls

CLICK HERE TO DOWNLOAD THE REPORT

Vanessa's Law — Unsafe Drugs Act

WHAT IS VANESSA'S LAW?

Vanessa's Law is the Protecting Canadians from Unsafe Drugs Act, which received royal assent in 2014. Vanessa's law introduces amendments to the Food and Drugs Act that give Health Canada more power to protect Canadians from unsafe products. These amendments include the requirement for hospitals to report all serious adverse drug reactions (ADR) and medical device incidents (MDI) to Health Canada within 30 days of the event being documented within the hospital.

WHY IS IT CALLED "VANESSA'S LAW"?

The law is named after Vanessa Young, who died of cardiac arrhythmia at the age of fifteen after being prescribed Prepulsid (Cisapride) for a stomach disorder. At that time, the United States Food & Drug Administration (US FDA) had advised against prescribing the medication to patients that had conditions similar to Vanessa's and Health Canada was in the process of reviewing the drug but had few adverse reaction reports compared with the US FDA. After Vanessa died, a campaign for increased regulation of therapeutic products led to greater powers for Health Canada to request safety data about drugs and medical devices from hospitals.

DID YOU KNOW?

Biocides will be added to the reporting requirements coming into effect on May 2025.

"A biocide is a drug that's manufactured, sold or represented for use in destroying or inactivating micro-organisms, or in reducing or controlling their number, on a non-living and non-liquid surface. In other words, biocides are surface disinfectants and surface sanitizers.

Biocides do not include products for use as follows: in air or water, on contact lenses, on invasive or indirectly invasive medical devices, or exclusively on the surface of food.

Like drugs under the FDR, biocides authorized under the new regulations will be issued a drug identification number (DIN).

WHO SHOULD REPORT ADRS AND MDIS?

All health care professionals should report serious adverse drug reactions (ADR) and medical device incidents (MDI), including physicians and other prescribers, nurses, technicians, and pharmacists. If you are the first person to discover an ADR or MDI, you are the one who should report it. The person who discovers the ADR or MDI is best positioned to give the most accurate account of what happened.

HOW TO REPORT

There are two fillable and electronic forms: one for reporting serious adverse drug reactions (ADR) and one for reporting medical device incidents (MDI). Please use as much information as you can or have access to, to fill in these reports. Someone may follow up with you for more information on your report. After completion, hit "submit" and the report will be reviewed and submitted to Health Canada.

Medication Safety Newsletter Team

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