Medication Safety Self-Assessment® for Long-Term Care

Canadian Version III
PILOT VERSION

ismp CANADA

The *Strengthening Medication Safety in LTC Initiative* is funded by the Ontario Ministry of Long-Term Care.

Views expressed in this document are those of ISMP Canada and do not necessarily reflect those of the Province.

For any questions about the Medication Safety Self-Assessment for Long-Term Care, email mssa@ismpcanada.ca

MEDICATION SAFETY SELF-ASSESSMENT FOR LONG-TERM CARE CANADIAN VERSION III, PILOT TEST VERSION

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Introduction

This update of the Medication Safety Self-Assessment® for Long Term Care (MSSA-LTC), Canadian, Version III has been undertaken as part of the *Strengthening Medication Safety in Long-Term Care* initiative, a 3-year partnership between the Institute for Safe Medication Practices Canada (ISMP Canada) and the Ontario Ministry of Long-Term Care.[1] This initiative was launched in follow-up to the recommendations from the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Home System (Gillese Inquiry).[2] One of the deliverables of the initiative is to improve and update tools used by the sector to evaluate the safety of medication management systems in LTC Homes, and thereby enhance the ability of the sector to monitor medication safety and risk. One of these tools is the MSSA-LTC.

The MSSA-LTC is designed to support the LTC sector to evaluate the safety of medication management systems by:

- Heightening awareness of the distinguishing characteristics of a safe medication system;
- Identifying vulnerabilities and opportunities for improvement related to medication system safety;
- Creating a baseline measurement of the current level of implementation of recommended strategies for medication safety; and,
- Monitoring progress over time through periodic repeated measurement.

Development and validation of the revised assessment content was supported by an expert Advisory Panel, which included residents and family representatives, an interdisciplinary group of health care providers with direct care and leadership responsibilities, and representatives from professional associations and regulatory authorities. The validation process included a pilot test, followed by cognitive interviews completed by the Accessing Centre for Expertise of the Institute of Health Policy, Management and Evaluation at the University of Toronto.

Topics and content for this revision have been derived from a variety of sources, including:

- Recommendations from the Gillese Inquiry[2]
- Feedback from current users
- ISMP Canada resources and learning from analysis (e.g., safety bulletins, MSSA programs)
- ISMP, United States, resources (e.g., newsletters, MSSA programs)
- National standards of practice and guidelines for medication management in LTC for physicians, nurses, pharmacists and pharmacy technicians
- A literature search conducted by the Canadian Agency for Drugs and Technologies in Health (CADTH) focused on: medication management in LTC, medication system technology in LTC and incident analysis in LTC

This assessment also includes content from the Medication Safety Self Assessment: Focus on “Never Events” in Long-Term Care.[3]

[1] Views expressed in this document are the views of ISMP Canada and do not necessarily reflect those of the Province.

[2] Gillese EE. Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System Report, 2019. Available from: https://longtermcareinquiry.ca/en/final-report/

[3] ISMP Canada and Canadian Patient Safety Institute. Medication Safety Self Assessment: Focus on “Never Events” in Long-Term Care, 2019 [cited 2021 Feb21]. Available from: https://mssa.ismp-canada.org/never-events-ltc.

Background

The MSSA-LTC has been widely used by the long-term care community in Canada since it was launched by ISMP Canada in 2006 and updated in 2012. To February 1st, 2021, a total of 849 facilities have submitted at least one assessment. The majority of users are long-term care Homes; however, the program has also been used by other types of organizations providing long-term care, including correctional facilities. An ISMP Canada Safety Bulletin published in 2019 describes 12 years of experience with the program.[4]

ISMP Canada is not a standard-setting organization and the assessment items in this document are not intended to represent a minimum standard of practice. Some of the practices described in the items represent innovative practices and system enhancements that are not yet widely implemented; however, their value in reducing errors is grounded in research and expert analysis of medication incidents and their causes.

Individual Homes/facilities should not expect to score highly in all areas. The process of completing the MSSA-LTC is intended to identify areas of focus for quality improvement and enhancement of safe medication practices. MSSA-LTC results can be combined with learning from review of medication incident reports to support the Home/facility's quality improvement program. MSSA findings are intended for internal use and become more useful as repeat assessments are performed to see where improvements have been achieved over time and where challenges remain. MSSA findings are also useful for de-identified analysis and learning at a system level.[5,6]

Structure of the MSSA

The self-assessment is divided into 15 sections, referred to as "Key Elements. Each Key Element section is divided into one or more sub-sections, referred to as "Core Characteristics". Each Core Characteristic section includes a number of assessment items. Teams are asked to rank the current level of implementation for each assessment item.

Sections IX to XV include content originally published in the MSSA: Focus on Never Events in Long-Term Care, 2019 with selected additional new content related to learning from the Gillese Inquiry.[2]

Privacy and Confidentiality

ISMP Canada is committed to protecting the privacy, confidentiality, and security of any information for which it is responsible. All activities related to MSSA data are conducted in compliance with ISMP Canada's privacy policy; available from: https://www.ismp-canada.org/privacy_policy.htm.

Individual Homes/facilities are able to access aggregate results for comparative purposes. Individual respondents cannot be identified from the aggregate results.

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[4] Medication Safety in Long-Term Care: Measuring Quality Improvement Over 12 Years. ISMP Canada Safety Bulletin, 2019; 19(3). Available from : https://www.ismp-canada.org/download/safetyBulletins/2019/ISMPCSB2019-i3-LTC-MSSA.pdf

[5] Medication Safety in Long-Term Care. ISMP Canada Safety Bulletin 2008 [cited 2021Feb21; 8(10). Available from: https://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2008-10MedicationSafetyinLongTermCare.pdf

[6] Medication Safety in Long-Term Care: Measuring Quality Improvement Over 12 Years. ISMP Canada Safety Bulletin, 2009 [cited 2021 Feb21]; 19(3). Available from: https://www.ismp-canada.org/download/safetyBulletins/2019/ISMPCSB2019-i3-LTC-MSSA.pdf

Aggregate data will be used by ISMP Canada for quality improvement, research and education purposes, including sharing de-identified summaries with system partners such as the Ministry of Long-Term Care in Ontario.

Advisory Panel

ISMP Canada thanks the following individuals for sharing their advice on the MSSA-LTC content and format:

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Melissa Sheldrick, Patient and Family Advisor

Other consultants
Accessing Centre for Expertise (ACE), Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health

Instructions for Completing the Self-Assessment

1. **Establish an interdisciplinary team similar to the following:**
   - Resident/family representative
   - Director of care
   - Medical Director or Physician
   - Pharmacist
   - Pharmacy technician, if applicable
   - Registered Nurse
   - Registered Practical Nurse
   - Personal support worker
   - Safety/quality improvement and/or risk management professional(s)

2. **Distribute the assessment document before the team meeting so that team members can review and consider the questions in advance.**

3. **Discuss each assessment item and select the option that represents the team's understanding of the level of implementation of the item.**

   All assessment items refer to medications prescribed, dispensed, and administered to *all* residents of the Home/facility unless otherwise noted.

   Possible responses:

   A Always – This item is fully implemented and in practice more than 90% of the time
   O Often - This item is implemented and in practice 70-90% of the time
   S Sometimes – This item is implemented and in practice 40-70% of the time
   R Rarely – This item is implemented and in practice less than 40% of the time
   N Never – This item has not been implemented in our Home/facility
   NA Not applicable – Use this option where indicated, if an assessment item does not apply to your Home/facility

   For self-assessment items with multiple components, full implementation (score of A) is appropriate only if all components are present.

   Homes may want to consider assigning an individual to record any discussion generated around each assessment item and the rationale behind the selected choice. This information, meant for internal use only, can assist the team when reviewing scores for individual items or reassessing the Home at a later date.

   For assessment items that are not applicable to your Home/facility:
   Some assessment items may not be applicable to all LTC Homes/facilities; criteria for a "not applicable" response have been provided for selected items. For example, some sites may not provide intravenous infusions, therefore, there will be no associated risks.

5. **Finalize your assessment.**
   You will be prompted to save your responses for each section before you proceed to the next section. When all responses have been entered, you will be prompted to *"Check MSSA for errors"* and then to submit your results.

Once you have submitted your results you cannot edit them. The web-based survey tool will immediately download the information into a secure database maintained solely by ISMP Canada. No data is maintained on the Internet survey form after it has been submitted. Individual results can be viewed or accessed only by the Home submitting them. **Confidentiality is assured.**

6. **Print/view your completed assessment.**
   Once your results have been submitted you will be able to print a report summarizing your results.

7. **Compare your results to the aggregate.**
   Once your results have been submitted you will immediately[7] be able to compare your results to the aggregate response. You can compare to the total aggregate or to demographically similar facilities using the filters provided.

   View/print options include:
   - Summary of results ("report card" format)
   - Graphs comparing your Home's/facility's results to the aggregate database for key elements and individual assessment items, including available filters based on demographic information submitted. (To ensure confidentiality, there must be at least 3 respondents in the aggregate to generate graphs.)

8. **Using aggregate data**
   LTC Homes/facilities can freely share their own results internally and externally to the organization as they deem appropriate; however, any comparisons to aggregate data can only be shared externally to the organization with written permission from ISMP Canada. Email mssa@ismpcanada.ca for more information.

[7] To maintain confidentiality, a minimum of 3 responses are required before aggregate data can be viewed.

Frequently Asked Questions (FAQs)

These FAQs are related to the process for completing the self-assessment. FAQs related to content are also provided within the document for selected assessment items, where applicable.

How many team meetings should we schedule?
Reports from previous users indicate it will take 2-3 hours to complete this self-assessment. Depending on your organization, you may wish to do this all at once or schedule two separate meetings. The assessment is divided into two sections, Part A: General and Part B: High-Alert Medications, creating a natural break point for a second meeting, if needed.

Do we need an interdisciplinary team to complete the self-assessment?
Yes. Because medication use is a complex, inter-disciplinary process, the value and accuracy of the assessment is significantly reduced if it is completed by a single individual or discipline involved in medication use.

Do we need senior leadership representation on our team?
Yes. Attendance by an individual from the Home's/facility's leadership team is valuable because the assessment contains many items that relate to your organization's overall commitment to resident safety. Additionally, participation in the self-assessment provides senior leadership with insight into areas of risk in the medication use system.

What if an item doesn't apply to the services offered in my Home/facility?
A "not applicable" response is available for selected assessment items.

May I make copies of the self-assessment document?
The copyright allows you to make copies of the self-assessment for internal use. You may not modify or alter the content.

The assessment is intended for use as part of ongoing quality improvement activities. Other uses, such as in education presentations external to an individual Home/facility or corporate group require written permission from ISMP Canada. Email mssa@ismpcanada.ca for more information.

My organization has a number of sites. Do I need a password for each one?
It is recommended that each site within an organization complete the assessment independently. Each site will require its own password.

How are individual items scored?
The assessment items are scored as follows:

A = 4 Always – This item is fully implemented and in practice more than 90% of the time
O = 3 Often – This item is implemented and in practice 70-90% of the time
S = 2 Sometimes – This item is implemented and in practice 40-70% of the time
R = 1 Rarely – This item is implemented and in practice less than 40% of the time
N = 0 Never – This item has not been implemented in our Home/facility
NA Not applicable – Use this option where indicated, if an assessment item does not apply to your Home/facility

Assessment Tool

Demographic Information

1. In which province or territory is your Home located: _____

2. Which category best describes the size of the community[8] served by your Home?
   - ☐ Very small population centre (less than 1000)
   - ☐ Small population centre (1,000 - 29,999)
   - ☐ Medium population centre (30,000 - 99,999)
   - ☐ Large population centre (100,000 and over).

3. Which category best describes your Home?
   - ☐ Long-Term Care Home/ Continuing Care Facility
   - ☐ Mental Health Facility
   - ☐ Correctional Services Facility
   - ☐ Other; please specify: _____

4. How many residents live in your Home?
   - ☐ Less than 50
   - ☐ 50-99
   - ☐ 100-299
   - ☐ 300-499
   - ☐ More than 500

5. How are medications provided to residents?
   - ☐ Internal pharmacy
   - ☐ Received from an affiliated hospital or healthcare system
   - ☐ Received from an outsourced provider not affiliated with the organization

6. Which medication system technologies have been implemented in your Home/facility? (Check all that apply.)
   - ☐ Automated Dispensing Cabinets
   - ☐ Bar Coding for medication selection during dispensing (pharmacy service provider)
   - ☐ Bar Coding for medication administration in the Home/facility
   - ☐ Electronic clinical decision support for prescribers
   - ☐ Electronic prescribing (computerized prescriber order entry)
   - ☐ Electronic medication administration record
   - ☐ Other; please specify: _____

7. How are medication incidents reported in your Home/facility?
   - ☐ By staff and physicians completing a paper form on site
   - ☐ By staff and physicians completing an electronic form using an on site system
   - ☐ By staff and physicians advising the pharmacist at the PSP and then a report is completed using a PSP system
   - ☐ Other; please specify: _____

[8] Statistics Canada Definitions (archived content); available from: https://www.statcan.gc.ca/eng/subjects/standard/sgc/notice/sgc-06.

8. How is your Home/facility owned?
   - ☐ For-profit
   - ☐ Municipal
   - ☐ Not-for profit
   - ☐ Other; please specify: _____

9. Is your Home part of a larger health care organization or corporate group with common governance?
   - ☐ No
   - ☐ Yes

   How many sites are there in your organization?
   - ☐ 2-5
   - ☐ 6-10
   - ☐ 11-25
   - ☐ 25-100
   - ☐ More than 100

10. Has your Home previously completed the ISMP Canada Medication Safety Self-Assessment for Long-Term Care?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

Scoring Your Self-Assessment

All assessment items refer to medications prescribed, dispensed, and administered to *all* residents of the Home/facility unless otherwise noted.

N Never – This item has not been implemented in our Home/facility

R Rarely – This item is implemented and in practice less than 40% of the time

S Sometimes – This item is implemented and in practice 40-70% of the time

O Often - This item is implemented and in practice 70-90% of the time

A Always – This item is fully implemented and in practice more than 90% of the time

NA Not applicable – Use this option where indicated, if an assessment item does not apply to your Home/ facility

For self-assessment items with multiple components, full implementation (score of A) is appropriate only if all components are present.

The assessment items are scored as follows:

N = 0 Never – This item has not been implemented in our Home/facility
R = 1 Rarely – This item is implemented and in practice less than 40% of the time
S = 2 Sometimes – This item is implemented and in practice 40-70% of the time
O = 3 Often – This item is implemented and in practice 70-90% of the time
A = 4 Always – This item is fully implemented and in practice more than 90% of the time
NA Not applicable – Use this option where indicated, if an assessment item does not apply to your Home/facility

Section A: General

I. Resident and Family Engagement and Partnership

Core Characteristic # 1:

Residents or their substitute decision makers are included as active partners in their care through education about their prescribed medications and ways to avert harm associated with medication use.

Self-Assessment Items		N	R	S	O	A	NA
1.1 NEW	Residents/family caregivers are included as active members of interdisciplinary committees with responsibility for monitoring and evaluating the safety of the medication use system in the Home/facility. (MSSA-NE-LTC # 2.12)						
1.2 REV	Residents, their family caregivers, and/or substitute decision makers are encouraged to actively participate in the decision-making process about the medications that the resident receives (for example, using resources such as *5 Questions to Ask About Your Medications;* available from: https://www.ismp-canada.org/medrec/5questions.htm). (LTC #105)						
1.3 REV	Practitioners investigate and resolve all resident /family caregiver/ substitute decision maker concerns or questions about a medication or medication regimen. (LTC #106)						
1.4 REV	At admission, and periodically thereafter (e.g., during care conferences), residents/family caregivers/substitute decision makers are educated about the importance of being familiar with their medications and how to assist their health care professionals in verifying their identity, if possible, as a check for accuracy during administration. (LTC #100)						
1.5 NEW	Prescribers and other members of the health care team regularly interact with residents, family caregivers, or substitute decision makers to determine their health priorities (i.e., What matters to you?) to support shared decision-making regarding medication therapy.						
1.6 REV	When a new medication is prescribed, an appropriate practitioner (e.g., prescriber, nurse, pharmacist) informs the resident, family caregiver, or substitute decision maker of the name and dose of the medication, the general purpose for use, expected outcomes and important side effects and obtains informed consent. (LTC #102 and 104)						

Core Characteristic # 1:

Residents or their substitute decision makers are included as active partners in their care through education about their prescribed medications and ways to avert harm associated with medication use.

Self-Assessment Items		N	R	S	O	A	NA
1.7	All medication incidents that reach the residents, regardless of the level of harm that results, are fully disclosed to residents, their families or substitute decision makers, in a timely manner. (LTC #108)						
1.8 NEW	Residents/family caregivers/substitute decision makers are given an opportunity to share their perspective as part of the information gathering and investigation steps of an incident analysis.						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 2:

Essential resident information is obtained, readily available in useful form, and considered when prescribing, dispensing, and administering medications.

Self-Assessment Items		N	R	S	O	A	NA
2.1 REV	The medication administration record contains current resident photographs to assist staff in identifying residents for medication administration. ***FAQ: How frequently should photographs be taken to be considered "current"?*** *Homes/facilities should have a standardized process to update resident photographs at least annually and whenever there is a significant change in resident appearance.*						
2.2 REV	The resident's health record includes current, consistent information relevant to medication use (e.g., allergies/ sensitivities/ intolerances, medical conditions, swallowing difficulties, etc.) that is reflected in the Pharmacy computer system database or pharmacists have access to this data in real-time. (LTC #3)						
2.3 REV	*In electronic systems,* medication allergies/ sensitivities/ intolerances and other details, such as swallowing difficulties or the need to crush medications, are listed and clearly visible on all resident-specific pages or computer screens (e.g., electronic health record, electronic prescribing screens, eMAR, pharmacy order entry systems) as a visible reminder to those prescribing, dispensing and administering medications. (LTC #4) *Select NA if your medication systems are paper only.*						
2.4 REV	*In paper systems,* medication allergies/ sensitivities/ intolerances and other details, such as swallowing difficulties or the need to crush medications, are accurately listed and clearly visible on all pages (e.g., prescriber order sheets, Medication Administration Records) as a visible reminder to those prescribing and administering medications. (LTC #6) *Select NA if your medication systems are electronic only,*						

Notes:

II. Care Team

Core Characteristic # 3:

The interdisciplinary team works collaboratively to support safe resident care.

Self-Assessment Items		N	R	S	O	A	NA
Prescribers							
3.1 REV	Physicians and nurse practitioners are available, consistent with their agreement with the Home/facility and professional standards, to assess the needs of residents, prescribe and regularly review all medications as required by provincial/ territorial regulations and practice standards. (LTC #67)						
Pharmacists							
3.2 NEW	The pharmacy services contract outlines expectations for services to be provided by clinical pharmacist(s) and, where applicable, pharmacy technician(s), at the Home/facility (e.g., number of dedicated hours/month).						
3.3 NEW	Site visits by the clinical pharmacist(s) are scheduled to occur at times that nurses, physicians, nurse practitioners, residents and family members can discuss and resolve medication therapy issues.						
3.4 REV	Pharmacists work collaboratively with the interdisciplinary team to optimize therapeutic outcomes associated with medication use, including reviewing resident health records and new medication orders, providing input into the selection of medications and dosage forms, and monitoring of effects. (LTC #21)						
3.5 NEW	Residents with swallowing difficulties, dietary modifications or enteral feeding are clearly identified, and clinical pharmacists work with nurses and prescribers to optimize medication regimens for these individuals.						
3.6 REV	A pharmacist is on-call 24/7 to respond to drug therapy/ drug information questions. (LTC #72)						
Nurses							
3.7 NEW	Nurses work to their full scope of practice; i.e., use their clinical knowledge and experience to support optimal therapeutic outcomes for residents.						

Core Characteristic # 3:

The interdisciplinary team works collaboratively to support safe resident care.

Self-Assessment Items		N	R	S	O	A	NA
3.8 NEW	Contracts with agencies providing nursing services to the Home/facility require that the contracting agency have a roster of nurses who have been oriented to the Home/facility and the Home/facility maintains a similar list. *Reference: Recommendation # 13 from the MLTC Public Inquiry, 2019 [cited 2021 Feb22]; available from: https://longtermcareinquiry.ca/en/final-report/*						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 4:

The complement of practitioners matches the clinical workload without compromising resident safety.

Self-Assessment Items		N	R	S	O	A	NA
4.1 REV	Management and direct care staff indicate that regular staffing patterns are adequate to provide safe resident care, including plans for team member absences, both planned (e.g., vacation) and unplanned (e.g., illnesses). (LTC # 87)						

Notes:

Core Characteristic # 5:

Standardized processes are in place to ensure sufficient orientation to the medication use system, competence evaluation and ongoing education to support appropriate knowledge and skills related to safe medication practices.

Self-Assessment Items		N	R	S	O	A	NA
Orientation							
5.1	All newly-hired practitioners complete a formal orientation that includes competence evaluation before participating independently in the medication use process (e.g., medication procurement, prescribing/order entry systems, dispensing, administration, monitoring of outcomes). (LTC #89)						
5.2	The length of time for orienting new practitioners can be extended based on ongoing assessment of individual needs. (LTC #92)						
5.3 REV	During orientation, information is provided about processes related to the pharmacy services provider, including the medication order and delivery process, required documentation, availability of medication information resources, telephone numbers of the pharmacy, and how to access the clinical pharmacist. (LTC # 91)						
5.4 NEW	During orientation, information is shared about current medication safety initiatives in the Home/facility.						
Continuing Education							
5.5 REV	Practitioners are educated about human factors, system-based safety, and the principles of error reduction (e.g., standardization, process constraints, redundancy for critical functions and the hierarchy of effectiveness). (LTC #133) ***FAQ: What is the hierarchy of effectiveness?*** *The hierarchy of effectiveness identifies higher and lower leverage actions for safety. See: Ontario Critical Incident Learning Bulletin: Designing Effective Recommendations; available from: https://www.ismp-canada.org/download/ocil/ISMPCONCIL2013-4_EffectiveRecommendations.pdf.*						
5.6 REV	Practitioners receive ongoing information about medication incidents and high-risk situations occurring within the Home/facility, relevant incidents occurring in other Homes/ facilities (e.g., published in ISMP Canada Safety Bulletins), and strategies implemented to prevent such incidents. (LTC #95)						

Core Characteristic # 5:

Standardized processes are in place to ensure sufficient orientation to the medication use system, competence evaluation and ongoing education to support appropriate knowledge and skills related to safe medication practices.

Self-Assessment Items		N	R	S	O	A	NA
5.7 REV	Education is provided about new medications, particularly those with special handling instructions (e.g., investigational drugs) including provision of printed or electronic information from approved sources. (LTC #94)						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility
R **Rarely –** This item is implemented and in practice less than 40% of the time
S **Sometimes –** This item is implemented and in practice 40-70% of the time
O **Often –** This item is implemented and in practice 70-90% of the time
A **Always –** This item is fully implemented and in practice more than 90% of the time
NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

III. Communication of Medication Information

Core Characteristic # 6:

Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.

Self-Assessment Items		N	R	S	O	A	NA
Prescribing							
6.1 REV	An up-to-date list of prohibited, dangerous abbreviations, symbols and dose designations (unacceptable methods of expressing doses) is established, and available to all practitioners (e.g., posted in medication rooms) to support clear communication of medication information or orders including handwritten or preprinted orders, medication						

Core Characteristic # 6: Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	administration records, medication labels and in electronic formats. (LTC #33) ***FAQ: Is there a list of dangerous abbreviations, symbols and dose designations that should not be used?*** *ISMP Canada's Do Not Use List of Dangerous Abbreviations, Symbols, and Dose Designations is available from: https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf.*						
6.2	Medication orders are signed by the prescriber and include the resident's full name, date, medication name, strength/dose, quantity (narcotics), frequency, route of administration, and, where required, length of treatment, consistent with legal requirements for community-based prescribing. (LTC #31)						
6.3 REV	Verbal orders from prescribers that are on site in the facility are used only in true emergencies (e.g., where the prescriber cannot leave the bedside or during sterile procedures where ungloving would be impractical) and the verbal order is repeated back to the prescriber for verification prior to administration, including spelling back look-alike/sound-alike drug names. (LTC #35)						
6.4 REV	Telephone orders from prescribers are used only in the following circumstances: i) When the prescriber is not on site and has enough resident-specific information to safely order medications; ii) When the prescriber is on site but not able to come to the care unit to write the order in a timely manner to meet the resident's needs; or iii) When an order requires clarification and can be safely handled by telephone. (LTC #36)						
6.5	The nurse, pharmacist or pharmacy technician receiving a telephone order from a prescriber immediately writes/ electronically enters it into the resident's health record/ computerized order entry system, and reads it back to the prescriber for verification, including spelling out look-alike, sound-alike drug names. (LTC #37)						

Core Characteristic # 6: Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
6.6 NEW	Where a telephone order is received by the pharmacy service provider, a standardized process is in place to communicate the order to the Home/facility for documentation in the health record.						
6.7 REV	Verbal and telephone orders documented in the resident's health record are reviewed and countersigned by the prescriber, according to Home/facility policy and/or regulatory requirements. (LTC #38) ***FAQ: Prescribers may not come into the Home/facility for several days after a telephone order has been given. The Home/facility policy requires signing within 72 hours – how do I rank this question?*** *If prescribers do not consistently come into the Home/facility and sign orders, or fax back signed copies of orders, consistent with the Home/facility policy, the response should be Sometimes or Rarely.*						
Admission Assessment							
6.8 REV	Information available to the clinical team supports a comprehensive pre-admission assessment for all residents, including past medical history, current medications (including non-prescription items, natural health products and substance use [e.g., alcohol, cannabis, tobacco]), allergies, resident's language preference, mental status, ambulatory status, current weight, swallowing ability, family and/or substitute decision maker contact information. (LTC #12) ***FAQ: What it the information we receive is not current; how do we answer this question?*** *The objective is to have as much current information as possible so that medications can be safely prescribed, dispensed and administered. If information received is often not accurate and complete at the time of admission, the appropriate score would be Sometimes or Rarely.*						
6.9 REV	A Best Possible Medication History (BPMH) is completed, using a standardized process, for every resident upon admission or re-admission. (LTC #13) ***FAQ: What is a best possible medication history (BPMH)?*** *A BPMH includes: Prescription and non-prescription medications, vitamins, herbal products and other alternative therapies. How to best develop the BPMH depends on whether the resident is coming from home, hospital or another setting. It is recommended that more than one source of information be consulted, whenever possible, to validate the BPMH. See Medication Reconciliation in Long-Term Care: Getting Started*						

Core Characteristic # 6: Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	Kit, 2017 [cited 2021 Feb22]. Available from : https://www.ismp-canada.org/download/MedRec/MedRec-LTC-GSK-EN.pdf,.						
6.10 REV	The Best Possible Medication History includes accurate information on the last doses of medications administered at the transferring site or at home, the discontinuation date where applicable (e.g., where the transferring site's protocol defines length of use) and contact information from the transferring site or the community pharmacy previously serving the resident. (LTC #14)						
6.11 NEW	A pharmacist completes a Medication Reconciliation for all new admissions within 2 business days following admission to compare the admission orders with the Best Possible Medication History and resolves any identified discrepancies with the prescriber. (added to LTC # 13) ***FAQ: Can a BPMH and Medication Reconciliation be completed before admission?*** *Yes, the BPMH and Medication Reconciliation can be completed before admission and this can be helpful in addressing discrepancies before the resident arrives at the Home/facility. If this occurs, a process is needed to check for any changes to medications that may occur before the resident is admitted to the Home/facility.*						
6.12 REV	At admission/readmission to the Home/facility prescribers write or electronically enter complete orders for all medication therapy. (Orders to "resume the same medications" or to "take medications from home" are not accepted.) (LTC #34)						
Pharmacy Communication							
6.13 REV	On admission, each document transmitted to the pharmacy service provider, including admission orders, includes the following clearly visible and legible information: • Date and time of order • Home/facility and care location, including room number • Resident's surname, first name and initial • Date of birth • Health card number • Prescriber name • Medication allergies/intolerances						

Core Characteristic # 6: Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	(LTC # 10)						
6.14 REV	Following admission, information submitted to the pharmacy service provider with medication orders is sufficient to identify the resident and ensure differentiation between residents with the same first and last name (i.e., at minimum: surname, first name and initial, health card number, Home/facility). (LTC #11)						
6.15 REV	When a dispensing delay may result from the need for pharmacist intervention prior to dispensing a medication (e.g., an unclear or potentially harmful medication order), the Home/facility is immediately informed so that the nurses who provide care to the resident are aware of the concern and do not look for alternate ways to access the medication for administration. (LTC #130)						
Medication Administration							
6.16 REV	Computer-generated paper or electronic medication administration records, that share a common database with the pharmacy system, are used to guide and document medication administration. (LTC #39) ***FAQ: How should we respond to this question if we use handwritten MARs?*** *If your site uses handwritten MARs, you would answer this question as Never, because this item has not been implemented.*						
6.17 REV	Medication administration records (eMARs/cMARs/paper MARs) are immediately accessible and used for reference at each step of medication selection, verification and administration to confirm that the resident identity, medication and dose are correct (i.e., the MAR is available at the bedside or medication administration location).						
6.18 NEW	Two unique identifiers (e.g., name, date of birth, current photograph) are verified prior to medication administration.						
6.19 NEW	Documentation of medication administration occurs immediately following the resident receiving the medication (i.e., the medication administration record is available in the location where medications are administered and the nurse documents administration before going on to another task). (Split from LTC #40)						

Core Characteristic # 6:

Methods of communicating medication orders and other drug information are standardized to minimize the risk of error.

Self-Assessment Items		N	R	S	O	A	NA
6.20 NEW	Medications that cannot be crushed are clearly identified in medication administration records and on prescription labels to support correct administration of these items.						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 7:

Essential drug information is readily available in useful form and is considered when prescribing, dispensing, administering and monitoring medications.

Self-Assessment Items		N	R	S	O	A	NA
7.1 REV	Up-to-date, user-friendly drug information resources are readily available for reference by care team members (e.g., electronic access on all computers, or current editions of hard copy references in each medication room/nursing station). (LTC #17)						
7.2 REV	Any hard copy drug information references, including commercially available charts and guidelines used in the Home/facility, are checked annually and all outdated reference materials are removed from use and replaced as necessary. (LTC #18) ***FAQ: When are references considered outdated?***						

Core Characteristic # 7:

Essential drug information is readily available in useful form and is considered when prescribing, dispensing, administering and monitoring medications.

Self-Assessment Items		N	R	S	O	A	NA
	Reference materials are considered outdated after one year of publication or when the next edition is available, or the content is no longer relevant to the practice setting.						
7.3 REV	Medication order sets, protocols, checklists and clinical guidelines that will be used in the Home/facility are approved by the Professional Advisory Committee or equivalent, with a structured process for review (e.g., annual) to ensure continued appropriateness. (Split from LTC #20)						
7.4 NEW	Access information for the local Poison Information Centre is prominently posted in each medication room, close to telephones, and is easily available from computers used for medication administration. (split from LTC #17 and #91)						
7.5 NEW	Policies and procedures related to the medication system are readily available to care team members (e.g., electronic access or current hard copy in each medication room). (Split from LTC #17)						

Notes:

IV. Medication Monitoring

Core Characteristic # 8:

The interdisciplinary team has access to information required to support monitoring of medication therapy outcomes and works collaboratively to achieve therapeutic goals.

Self-Assessment Items		N	R	S	O	A	NA
8.1 REV	There is a standardized approach to ensuring periodic evaluation of residents' health parameters, appropriate to the goals of care, to support monitoring of medication therapy, including regular weights, vital signs, and laboratory testing (e.g., HbA1C, INR, creatinine, drug levels, etc). (LTC #15)						
8.2 REV	All health care practitioners involved in the medication use process can easily and electronically access laboratory values while working in their respective clinical locations, whether on-site or at a remote location. (LTC #1) ***FAQ: What does "access to laboratory values while working in their respective locations" mean?*** *The work site for physicians, nurses and pharmacists should not limit the practitioner's access to needed laboratory value results while they perform their responsibilities for caring for a specific resident. This generally translates into having secure access to electronic information (i.e., an electronic resident health record) whether from a remote office or on-site at the Home/facility.*						
8.3 REV	Prescribers are notified of high alert laboratory test results through a critical value notification system. (LTC #16)						
8.4 REV	Pharmacists and/or prescribers ensure dose adjustments for medications that may be toxic in residents with kidney or liver impairment. (LTC #2)						
8.5	All medication and treatment orders, whether routine or "as needed", include the clinical indication to support monitoring of resident drug therapy outcomes. (LTC #32)						
8.6 REV	All medication orders prescribed during the operating hours of the pharmacy service provider are entered into a computerized resident profile and screened electronically against the resident's current clinical profile for allergies/intolerances, contraindications, interactions (including drug/drug, drug/food and drug/disease), and appropriateness of doses *before* medications are dispensed and administered. (Exception: emergency lifesaving situations) (LTC #27)						

Core Characteristic # 8:

The interdisciplinary team has access to information required to support monitoring of medication therapy outcomes and works collaboratively to achieve therapeutic goals.

Self-Assessment Items		N	R	S	O	A	NA
8.7 NEW	The on-call physician or nurse practitioner contacted about a change in resident condition is provided with information about the resident's current medical conditions, medications, and medication allergies/intolerances to support appropriate prescribing in urgent situations.						
8.8 a NEW	For medications prescribed when the pharmacy service provider is closed, an on-call pharmacist remotely accesses the patient's medication profile to and screens the new prescription for medication allergies, drug interactions and therapeutic appropriateness before the medication is accessed from the emergency supply and administered to a resident. (Exception: emergency lifesaving situations)						
OR							
8.8 b NEW	For medications prescribed when the pharmacy service provider is closed, the Home/facility sends the prescription to a designated back-up pharmacy, with a copy of the resident's current medication administration record to support evaluation of therapeutic appropriateness by the dispensing pharmacist.						
8.9 NEW	The Home/facility documents severe or unresponsive hypoglycemia as a medication incident, with appropriate follow-up to determine the underlying cause. *References:* • *Recommendation # 84 from the MLTC Public Inquiry; available from: https://longtermcareinquiry.ca/en/final-report/* • *Ontario Ministry of Long-Term Care Directive, Feb 2020 [cited 2021 Feb22]. Available from: http://www.health.gov.on.ca/en/public/programs/ltc/ministers_directive.aspx*						
8.10 NEW	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 non-preventable). (MSSA-NE-LTC # 2.15) *References:* • *Recommendation # 82 from the MLTC Public Inquiry; available from: https://longtermcareinquiry.ca/en/final-report/* • *Ontario Ministry of Long-Term Care Directive, Feb 2020 [cited 2021 Feb22]. Available from: http://www.health.gov.on.ca/en/public/programs/ltc/ministers_directive.aspx*						

Core Characteristic # 8:

The interdisciplinary team has access to information required to support monitoring of medication therapy outcomes and works collaboratively to achieve therapeutic goals.

Self-Assessment Items		N	R	S	O	A	NA
8.11 NEW	An established committee (e.g., Professional Advisory Committee, Quality/Safety Committee) has established a list of "trigger" or "rescue" medications that includes antidotes and reversal agents (e.g., diphenhydramine and naloxone) which may indicate an adverse drug event has occurred (preventable and non-preventable) and monitors the use of these medications. *Reference: Recommendation # 83 from the MLTC Public Inquiry; available from: https://longtermcareinquiry.ca/en/final-report/* ***What is a "trigger" medication?*** *The Institute for Healthcare Improvement has developed a series of tools that identify flags that indicate possible patient safety incidents. These flags are referred to as triggers. An example would be a patient receiving warfarin who required administration of Vitamin K to treat a bleed. The order for Vitamin K would be a trigger to review the chart for possible missed INR testing, or overlooked results.* (LTC #118) *For more information on trigger tools see: http://www.ihi.org/resources/Pages/Tools/IntrotoTriggerToolsforIdentifyingAEs.aspx.*						
8.12 NEW	Each resident's medication regimen is reviewed by an interdisciplinary team at established intervals (e.g., quarterly or as required by provincial/ territorial legislation/regulation with the goal of identifying and, where possible, deprescribing potentially inappropriate medications (e.g., antipsychotics and benzodiazepines in the elderly).						
8.13 NEW	The interdisciplinary care team is aware of and uses evidence-based guidance frameworks and tools for deprescribing to optimize medication prescribing and therapeutic outcomes. *References: Beer's List, STOPP, STOPPFrail*						
8.14 NEW	The possibility of a medication error or adverse drug reaction is considered when a resident presents with new concerning signs and symptoms. *Reference: Unexpected Hypoglycemia: Consider Medication Error in the Differential Diagnosis. ISMP Canada Safety Bulletin, 2007 [cited 2021 Feb 22]; 7(1). Available from: https://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2007-01Hypoglycemia.pdf*						
8.15 REV	Conflicts surrounding the safety of a medication order are resolved through a defined, clear and effective path. (LTC #42)						

Core Characteristic # 8: The interdisciplinary team has access to information required to support monitoring of medication therapy outcomes and works collaboratively to achieve therapeutic goals.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	FAQ: What is meant by "conflicts surrounding the safety of a medication order?" *Sometimes a prescriber writes an order that pharmacist or nurse or is not comfortable dispensing or administering based on their understanding of the clinical situation. Typically, these situations can be resolved by the individual pharmacist or nurse and the prescriber; however, in some cases the prescriber may disagree and insist the order be implemented. If the nurse or pharmacist do not feel their concerns have been addressed and they feel the order presents a possible risk to a resident, there should be a clear path to follow to request additional review; e.g., escalate to the Director of Care, Pharmacy Supervisor or Medical Director, as applicable.*						

V. Medication Storage and Handling

Core Characteristic # 9: Strategies are undertaken to minimize the possibility of errors with drug products that have similar or confusing manufacturer labelling/packaging or drug names that look or sound alike.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
9.1	Products with look-alike drug names or packaging (e.g., insulin pen cartridges) are segregated from each other, or other means are used (e.g., auxiliary labels, warning labels on storage bins) to minimize the risk of incorrect selection. (LTC #70)						
9.2 NEW	Unit dose packaging (e.g., bubble, single or multi-drug strip packaging) provided by the pharmacy service provider includes a physical description of the medication to assist nurses in verifying that the correct medication has been dispensed. *Select NA if medications for your Home/facility are not dispensed in unit dose packaging.*						
Notes:							

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 10:

Well-designed, readable labels that clearly identify medications are present on all containers, and medications remain labelled up to the point of actual administration.

Self-Assessment Items		N	R	S	O	A	NA
10.1 REV	Pharmacy computer systems produce clear and legible labels free of dangerous abbreviations and non-essential information, to support understanding by those administering medications. (LTC #45)						
10.2 REV	Oral solid medications (i.e., tablets/capsules) for individual residents are dispensed in labelled, ready-to-use single doses (e.g., bubble, single or multi-drug strip packaging). (LTC #54) (Exceptions: medications intended for short-term use [e.g., antibiotics]; medications with special packaging requirements [e.g., oral disintegrating tablets].)						
10.3 REV	All medications provided in a unit-of-use container (e.g., eyedrops, inhalers) or a time-limited prescription filled in a vial (e.g., antibiotics) are labelled with a prescription number, the resident's name, date, medication name, strength, form, dose, manufacturer, quantity, directions for use, prescriber's name, and the identity of the dispensing pharmacy, as required by regulatory/professional standards. (LTC #48 + #54)						
10.4 REV	When more than one strength of medication is required to make up the prescribed dose of medication, the pharmacy provides distinctive labels or packaging alerts to assist nurses to ensure the correct dose is administered. (LTC #56)						
10.5 REV	All medications remain in the manufacturer's or the pharmacy's packaging up to the point of actual drug administration to the resident (i.e., are not pre-poured), to support a final check of the medication against the Medication Administration Record. (LTC #55)						

Core Characteristic # 10:

Well-designed, readable labels that clearly identify medications are present on all containers, and medications remain labelled up to the point of actual administration.

Self-Assessment Items		N	R	S	O	A	NA
10.6 REV	Nurses can match the medication name (e.g., generic or brand name) on the label of resident-specific medications dispensed from the pharmacy with the corresponding medication name on the Medication Administration Record. (LTC #132)						
10.7 REV	All medication containers that must be transported from the point of preparation to the resident (e.g., injections prepared in the medication room) are labelled, at minimum, with the drug's name and dose. (LTC #47)						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 11:

Medication concentrations, doses, and administration times are standardized whenever possible.

Self-Assessment Items		N	R	S	O	A	NA
11.1 REV	Standard times for scheduled drug administration have been established and are consistently used unless medication properties require an altered schedule (e.g., medications that should be taken on an empty stomach). (LTC #58)						
11.2 REV	Dosing windows have been established and are consistently used to help nurses safely administer most medications at established standard times, even if the initial dose was administered at a nonstandard time. (LTC # 59)						
11.3 NEW	In special care situations, such as dementia care units, nurses are supported to adjust medication administration						

Core Characteristic # 11:

Medication concentrations, doses, and administration times are standardized whenever possible.

Self-Assessment Items		N	R	S	O	A	NA
	times to meet residents' needs (e.g., flexible timing of once daily medications).						

Notes:

Core Characteristic #12:

There are established procedures to manage the use of resident's own medications and self-administration of medications.

Self-Assessment Items		N	R	S	O	A	NA
12.1	Medications brought into the Home/facility by residents or family members are not administered to the resident until an authorized prescriber has approved their use and a qualified practitioner has verified the identity of the medication(s) and the proper instructions for administration. (LTC #50) ***FAQ: What is a "qualified practitioner"?*** *A qualified practitioner is a pharmacist or other practitioner with the skills and knowledge to verify medication identity when a pharmacist is not available.*						
12.2	Where a prescriber, in consultation with the care team, has ordered self-administration of medications, including those not supplied by the pharmacy service provider (e.g., natural health products, traditional medicines, cannabis) by a resident, a documented process is in place to ensure the following: • Assessment of the resident for both cognitive and physical capability to self-administer medications, with periodic re-evaluation (e.g., quarterly); • Safe, secure storage to prevent access by other residents; • Documentation of doses taken, if required; • Appropriate assessment of outcomes; and • Resupply of medications.						

Core Characteristic #12:

There are established procedures to manage the use of resident's own medications and self-administration of medications.

Self-Assessment Items		N	R	S	O	A	NA
	(LTC #60)						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 13:

Medications are delivered to care units in a safe and secure manner and are available for administration within a time frame that meets essential resident needs.

Self-Assessment Items		N	R	S	O	A	NA
13.1 REV	Medications are delivered from the pharmacy to the Home/facility or care unit under the direct control of authorized pharmacy personnel and are handed off to the Home's/facility's authorized nursing staff, with a documented accountability trail. (LTC #61)						
13.2 REV	Time frames established between the Home/facility and the pharmacy service provider for dispensing of newly prescribed medications are appropriate to meet resident care needs. (LTC #66)						
13.3 NEW	The Home/facility is notified by the pharmacy service provider if there will be a delay in the expected delivery time and a contingency process exists for time-critical medications.						
13.4 REV	The provision of medication samples directly to the Home/facility by physicians, nurse practitioners, nursing staff and pharmaceutical vendors is prohibited, and this policy is clearly communicated. In rare circumstances, if drug						

Core Characteristic # 13:

Medications are delivered to care units in a safe and secure manner and are available for administration within a time frame that meets essential resident needs.

Self-Assessment Items		N	R	S	O	A	NA
	samples are required, the drug is prescribed via standard procedures, dispensed through the pharmacy (including electronic allergy/ interaction checking and appropriate labelling and packaging for resident-specific use), with administration documented on the Medication Administration Record. (LTC #68) ***FAQ: Our prescribers sometimes provide samples to residents to try a new medication and save the resident or family money during the trial process. Since the prescriber knows the other medications the resident is taking, isn't this OK?*** *No, your score would be Never, as you have not implemented a policy prohibiting this. The provision of sample medications directly to residents is unsafe for several reasons: i) the prescriber may not be fully aware of potential drug interactions; ii) all medications administered within the Home/facility should be documented on the MAR unless the resident has been authorized to self-manage their medications; and iii) storage conditions prior to the samples being brought to the Home/facility are unknown.*						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 14:

Medications available as wardstock in the Home/facility are limited and securely stored.

Self-Assessment Items		N	R	S	O	A	NA
14.1 REV	A limited emergency/after-hours stock of medications has been established for urgently needed items (e.g., glucagon, naloxone) and times when medication is not readily available from the pharmacy service provider (e.g., antibiotics required on evenings/weekends). (LTC #71)						
14.2 NEW	An established committee (e.g., Professional Advisory Committee or Quality/Safety Committee) reviews the usage of medications in the emergency stock at least annually and makes modifications based on best practice information on safe use.						
14.3 REV	The selection of non-prescription medications stocked by the Home/facility for general use is approved by an established committee (e.g., Professional Advisory Committee, Quality/Safety Committee) and usage is reviewed at least annually, with adjustments made based on best practice evidence. (LTC #69) *Select NA if your Home/facility does not maintain any non-resident specific stock of non-prescription medications.* ***FAQ: Why would non-prescription items not be dispensed specifically for individual residents?*** *In some jurisdictions, non-prescription medications are supplied through a provincial stock program (e.g., Ontario Government Pharmacy) and the Home/facility is responsible for ordering and managing this inventory.*						
14.4 REV	Audits of medication storage areas in the Home/facility are conducted and documented at defined intervals by a designated pharmacist, pharmacy technician or nursing staff member to ensure that only approved medications are stocked, quantities are within agreed-upon limits, discontinued or expired medications are removed or safely disposed, and that the storage area is configured to minimize the risk of selecting the incorrect product. (LTC #73)						
14.5 NEW	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. *Reference: Recommendation # 30 from the MLTC Public Inquiry; available from: https://longtermcareinquiry.ca/en/final-report/*						

Core Characteristic # 14: Medications available as wardstock in the Home/facility are limited and securely stored.						
Self-Assessment Items	**N**	**R**	**S**	**O**	**A**	**NA**
Notes:						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 15: Cold chain procedures are in place to ensure appropriate storage of medications requiring refrigeration.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
15.1 REV	Medications and vaccines are stored in designated refrigerators that are not used to store food. (LTC #85)						
15.2 REV	A standardized process is in place to monitor and document minimum and maximum temperatures for medication/ vaccine refrigerators at least daily (or in accordance with regulatory requirements/guidelines) and a notification process is in place to manage variances. (split from LTC #85) ***FAQ: What is the recommended temperature range for storing medications and vaccines requiring refrigeration?*** *The recommended temperature range for storing medications and vaccines requiring refrigeration is 2° to 8°C.*						

Core Characteristic # 15: Cold chain procedures are in place to ensure appropriate storage of medications requiring refrigeration.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
15.3 NEW	Refrigerators used to store medications are connected to the Home/facility's emergency power system.						
Notes:							

Core Characteristic # 16: Hazardous chemicals are safely sequestered from residents and are not accessible in drug preparation areas.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
16.1	There are no hazardous chemicals or cleaning compounds stored in the medication rooms or other medication storage/preparation areas. (LTC #74)						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility
R **Rarely –** This item is implemented and in practice less than 40% of the time
S **Sometimes –** This item is implemented and in practice 40-70% of the time
O **Often –** This item is implemented and in practice 70-90% of the time
A **Always –** This item is fully implemented and in practice more than 90% of the time
NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 17:

Processes are in place to ensure secure storage and appropriate disposal of discontinued and expired medications.

Self-Assessment Items		N	R	S	O	A	NA
17.1 REV	To prevent accidental administration of a discontinued medication, a standardized process exists to remove these items from resident supplies and this removal is documented on the Medication Administration Record as part of the medication order change process. (LTC #63)						
17.2 REV	Discontinued medications are placed in an appropriately secured area or container until removal by pharmacy or authorized destruction occurs (following approved procedures). (LTC #64)						
17.3 REV	Medications are not accessed from supplies of discontinued items and then used for other residents. (Split from LTC #64)						
17.4 REV	Written policies and procedures are in place for medication destruction, consistent with applicable legislation and guidelines, such as federal/provincial/territorial legislation (including the Controlled Drugs and Substances Act, environmental guidelines, long-term care regulations, hazardous waste guidelines). (LTC #65)						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

VI. Medication System Technology

Core Characteristic # 18: Medication system technologies are implemented in accordance with a medication safety plan and optimized for safety.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
18.1 NEW	The Home/facility follows a detailed, sequenced plan for adoption and implementation of medication system technologies.						
18.2 NEW	Information technology personnel, with specialty training in clinical informatics, who are knowledgeable about medication systems technologies in use in the home/facility, are readily available for assistance in the development, application, and troubleshooting of these systems. (MSSA-Hosp 2016, #13.12)						
18.3 NEW	Staff have been trained in and follow detailed downtime procedures when medication technologies are not available.						
18.4 NEW	Data and reports available through medication system technologies (e.g., barcode scanning technology rates, automated dispensing cabinet [ADC] overrides) are reviewed at pre-determined intervals and identified concerns are investigated and addressed. (MSSA-NE-LTC # 2.16) ***Select NA*** *if no medication system technology is in use in the Home (i.e., no reports are available for review).*						
Electronic Health Record							
18.5 NEW	An integrated electronic health record updates, stores and shares information such as clinical notes, lab results, current medication profile, diagnostic imaging and other key clinical reports, and is accessible by all members of the interdisciplinary care team.						
Electronic Prescribing Systems							
18.6 NEW	Prescribers enter medication orders into a computer system with integrated clinical decision support that is directly interfaced with the pharmacy computer system and other systems for medication management (e.g., laboratory).						
18.7 REV	The electronic prescribing system performs medication dose range checks and alerts prescribers about doses outside the usual range for the intended recipient. (LTC # 22)						

Core Characteristic # 18: Medication system technologies are implemented in accordance with a medication safety plan and optimized for safety.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	Select NA if your Home/facility does not have an electronic prescribing system that is integrated with the electronic health record.						
18.8 NEW	The electronic prescribing system requires prescribers to enter an explanation upon overriding a serious alert (e.g., exceeding a maximum dose for a high alert medication, a serious drug interaction, an allergy). *Select NA if your Home/facility does not have a electronic prescribing system that is integrated with the electronic health record.*						
18.9 REV	The electronic prescribing system allows prescribers to add customized alerts specific to client needs. (LTC #25) *Select NA if your Home/facility does not have a electronic prescribing system that is integrated with the electronic health record.*						
18.10 NEW	The electronic prescribing system receives drug information updates from a database vendor at least quarterly. (adapted from LTC #26) *Select NA if your Home/facility does not have a electronic prescribing system that is integrated with the electronic health record.*						
Pharmacy Computer System							
18.11 NEW	Medication orders are only entered into the pharmacy computer system *after* the resident's allergies have been correctly entered and coded (i.e., allergy information is a required field).						
18.12	The pharmacy computer system performs medication dose range checks and alerts pharmacy team members about doses outside the expected range for the intended recipient. (LTC #23)						
18.13 NEW	The pharmacy computer system requires practitioners to enter an explanation upon overriding a serious alert (e.g., exceeding a maximum dose for a high alert medication, a serious drug interaction, an allergy).						
18.14 REV	The pharmacy computer system allows pharmacists to add customized alerts specific to resident needs. (LTC #24)						

Core Characteristic # 18: Medication system technologies are implemented in accordance with a medication safety plan and optimized for safety.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
18.15 REV	The pharmacy computer system receives drug information updates from a database vendor at least quarterly. (LTC #26)						
18.16	The pharmacy computer system maintains current and past resident medication profiles according to regulatory requirements. (LTC #28)						
Medication Administration Records							
18.17 NEW	An electronic Medication Administration Record (eMAR) that shares a common database with the pharmacy computer system, is updated in real time 24/7 as new medication orders are received.						
Automated Dispensing Cabinets							
18.18 NEW	The number, size and placement of automated dispensing cabinets is determined based on the intended use (e.g., all medications or selected medications only) and layout of resident care areas, giving consideration to proximity of supplies required to support the medication administration process (e.g., sinks, syringes, auxiliary supplies). (MSSA-Hosp 2016 # 11.22) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.19 NEW	In Homes/facilities with automated dispensing cabinets, refrigerated medications are accessed through an integrated, locked refrigeration unit. (MSSA-Hosp 2016 # 11.27) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.20 NEW	High-alert medications are stored in single product drawers in automated dispensing cabinets, and in single use containers. (MSSA-Hosp 2016 # 11.26) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.21 NEW	Automated dispensing cabinets are “profiled”, meaning that medications must be accessed or recorded for a specific resident.						

Core Characteristic # 18: Medication system technologies are implemented in accordance with a medication safety plan and optimized for safety.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	Select NA if automated dispensing cabinets are not in use in your Home/facility.						
18.22 NEW	First doses of high-alert medications are removed from an automated dispensing cabinet *after* a pharmacist reviews the order for safety. (Exception: emergency life-saving situations.) (MSSA-Hosp # 9.2) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.23 NEW	Medications are retrieved from automated dispensing cabinets for one resident at a time, immediately before planned administration of the item. (MSSA-Hosp 2016 # 11.25) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.24 NEW	Use of the override function for automated dispensing cabinets is restricted to system downtime periods or emergency situations. (MSSA-Hosp 2016 # 11.28) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
18.25 NEW	The pharmacy service provider audits and reports on the use of the override function for automated dispensing cabinets (e.g., types of medications retrieved on override, time of day, day of week, care area location) and process changes are implemented based on audit findings. (MSSA-Hosp 2016 # 11.29) *Select NA if automated dispensing cabinets are not in use in your Home/facility.*						
Bar Coding							
18.26	The pharmacy service provider uses machine readable coding (e.g., bar coding) or other electronic method to verify drug selection during dispensing. (LTC #49)						

Core Characteristic # 18:

Medication system technologies are implemented in accordance with a medication safety plan and optimized for safety.

Self-Assessment Items		N	R	S	O	A	NA
18.27 NEW	Machine-readable coding (e.g., bar coding) is used to verify each item being loaded when filling automated dispensing cabinets (ADCs*).* *Select Never if bar coding is not available.* *Select NA if automated dispensing cabinets are not in use in the Home/facility.*						
18.28 REV	Machine readable coding (e.g., bar coding) or some other failsafe method (e.g., biometric identification) that uses at least two unique resident identifiers (e.g., name and birth date, name and health record number) is used to verify resident identity during drug administration. (LTC #9)						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 19:

The potential for human error is mitigated through careful procurement, maintenance, use, and standardization of medication devices.

Self-Assessment Items		N	R	S	O	A	NA
19.1 REV	Practitioners are educated about the use of medication devices, associated protocols/guidelines and best practices, and competence with their use is verified before they operate the device (e.g., insulin pens, insulin pumps, glucose monitoring devices, infusion pumps, inhalation delivery devices, enteral feeds, oxygen, peritoneal dialysis, etc.). (LTC #75)						
19.2 REV	The distal ends of all tubing are clearly labelled for residents who are receiving multiple solutions via various routes of administration (e.g., labelling the distal end of bladder irrigation, intravenous, enteral tubing properly identifies relevant access sites). (LTC #76) *Select NA if infusions or irrigations are never administered in the Home/ facility.*						
19.3 NEW	Failsafe tubing connectors are used whenever available (e.g., ENfit connectors for enteral feeding). *Select NA if enteral feeds are not administered in your Home/facility.*						
19.4 REV	The types of medication administration devices (e.g., parenteral infusion pumps, enteral feed pumps) used in the Home/facility is limited (ideally to one type for each function) to optimize competence with their use. (LTC #78) *Select NA if infusion devices/pumps are never used to administer medications to residents.*						
19.5	All electronic infusion control devices for parenteral or enteral use undergo inspection and testing (including volumetric testing of rate accuracy) at least annually. (LTC #79) *Select NA if infusion devices/pumps are never used to administer medications to residents.*						
19.6 NEW	A proactive risk assessment process is undertaken to identify and address the potential for errors with all new medication delivery devices and all such purchases are aligned with the Home/facility's medication safety plan. ***FAQ: What kind of proactive risk assessment process is required?*** Failure mode and effects analysis (FMEA) and review of relevant literature are appropriate proactive risk assessment processes. It is important to document and address the potential for error with new devices before a decision is made to purchase and use the device.						

Core Characteristic # 19:						
The potential for human error is mitigated through careful procurement, maintenance, use, and standardization of medication devices.						
Self-Assessment Items	**N**	**R**	**S**	**O**	**A**	**NA**
Notes:						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

VII. Work Environment

Core Characteristic # 20:						
Medication orders are prescribed, transcribed, prepared, and administered in a physical environment that offers adequate space and lighting and allows practitioners to remain focused on medication use tasks.						
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
20.1 REV	Lighting is adequate to clearly read labels and other important drug information in medication storage, preparation, and administration areas within the Home/facilt and task lighting (e.g., flashlights) is available to view labels at the resident's bedside as needed. (LTC #80) ***FAQ: What is considered adequate lighting?*** *100 foot-candles is suggested as the appropriate light level to ensure readability of critical information in care areas. Practically, this will be a*						

Core Characteristic # 20:

Medication orders are prescribed, transcribed, prepared, and administered in a physical environment that offers adequate space and lighting and allows practitioners to remain focused on medication use tasks.

Self-Assessment Items		N	R	S	O	A	NA
	subjective assessment based on the experience of the nurses on your team.						
20.2	Areas in the Home/facility where medications are prescribed, transcribed and/or entered into computer systems are isolated and relatively free of distractions, interruptions (e.g., phone calls) and noise. (LTC #84) ***FAQ: What is an appropriate noise level for areas where critical tasks are being performed?*** 50 decibels is suggested as an appropriate ambient noise level in areas where critical tasks are being performed.						
20.3 REV	Designated workspaces where medications are prepared are orderly and free of clutter. (LTC #81)						
20.4 REV	Alternate means of communicating non-urgent information between team members (e.g., note pads/mini white boards on medication carts) are utilized to minimize interruption/ distraction of nurses during medication administration. (LTC #86)						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

VIII. Quality Improvement and Risk Management

Core Characteristic # 21:

A just and trusting culture within a system-based approach to error reduction is in place and supported by the Home's/facility's leadership team.

Self-Assessment Items		N	R	S	O	A	NA
21.1	Specific medication safety objectives are included in the Home's/facility's strategic plan, and reflected in standard operating policies and practices, directly communicated to all staff, and acknowledged in a positive manner when achieved ("celebrating successes"). (LTC #115)						
21.2 REV	An established interdisciplinary committee (e.g., Professional Advisory Committee, Quality/Safety Committee) reviews medication incident information to identify system-based contributing factors, determines appropriate intervention(s) for resolution of medication safety and practice-related issues, and monitors the effectiveness of interventions. (LTC #99)						
21.3 REV	An established interdisciplinary committee (e.g., Professional Advisory Committee, Quality/Safety Committee) routinely monitors the safety literature (e.g., ISMP Canada Safety Bulletins, Coroner/Medical Examiner reports) for recommendations and evidence-based practices, including technology, that should be considered for local implementation. (LTC #43 and #121)						
21.4 REV	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. (LTC #116)						
21.5 REV	Error rates are not determined or calculated from practitioner incident reports and are not used for internal (unit-to-unit) and/or external comparisons. (LTC #111) ***FAQ: What is meant by error rate?*** *Many organizations attempt to calculate an error rate (e.g., using "the number of voluntary reported incidents as the numerator, and a denominator such as total doses dispensed) to compare the "rate" of errors in an organization or unit- to-unit. Such numbers have little meaning or relevance. See http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2002-08ErrorRates.pdf* *If your Home/facility is part of a corporate group where numbers of incident reports are compared from Home to Home, your answer to this question would be Never.*						

Core Characteristic # 21:

A just and trusting culture within a system-based approach to error reduction is in place and supported by the Home's/facility's leadership team.

Self-Assessment Items		N	R	S	O	A	NA
21.6 NEW	Practitioners' job descriptions, performance evaluations, and the medical staff by-laws include specific accountability standards for resident/medication safety (e.g., willingness to speak up about safety issues, change practices to enhance safety, ask for help when needed, enhance teamwork, follow the safety literature) and accountability standards do not include the absence of errors or a numerical error threshold. *Reference: ISMP Canada MSSA for Hospitals, Cdn V. III, 2016, Item 17.5* ***FAQ: How should we address situations where staff repeatedly make mistakes? We track the number of incident reports for each staff member and have a policy for performance review above a certain number in a year. How should we score this item?*** *You would score this item as Never.* *The intent of this item is to focus on system or latent failures that contribute to medication incident occurrence, rather than on the individuals involved. Linking incident reports to disciplinary action (or performance) will discourage reporting. If, through examination of a medication incident, it is found to have occurred as a result of inappropriate, malicious, or illegal behaviour, or if there is drug diversion, breach of confidentiality, or other misconduct, then alternate means of handling the issue, such as progressive discipline, or police involvement, are warranted. Staff performance gaps will likely involve a number of areas and be identified by means other than medication incident reporting. The UK NHS Just Culture Guide was designed to assist managers to respond to safety incidents; see: https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf*						
21.7 REV	The organizational 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 that results, including no harm. (LTC #109) *See the UK NHS Just Culture Guide, designed to assist managers to respond to safety incidents; see: https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf*						
21.8 REV	All care team members report and openly discuss incidents and have the opportunity to identify system vulnerabilities and opportunities for improvements. (split from LTC #107)						

Core Characteristic # 21:

A just and trusting culture within a system-based approach to error reduction is in place and supported by the Home's/facility's leadership team.

Self-Assessment Items		N	R	S	O	A	NA
21.9	When incidents occur, communication and educational efforts are widespread among all practitioners who may make a similar error, rather than remedial action(s) directed at only those practitioners who were involved in the incident. (LTC #98)						
21.10 REV	Error prevention strategies focus on system design enhancements that prevent harmful errors and encourage safe behavioural choices, rather than focusing on the behaviour of individual practitioners. (LTC #107)						
21.11 REV	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). (LTC #113)						
21.12 REV	There is a standardized process to conduct routine audits to assure medication administration procedures are followed, that monitoring of medication therapy outcomes is documented and there is follow up with practitioners if expected standards are not met. (LTC #93)						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 22:

Practitioners are encouraged to identify and report incidents, and interdisciplinary teams regularly analyze incidents that have occurred within the Home/facility and in other Homes/facilities for the purpose of redesigning systems to best support safe practitioner performance.

Self-Assessment Items		N	R	S	O	A	NA
22.1	Practitioners are educated on the need for, and importance of, incident and near miss reporting. (LTC #117)						
22.2 REV	Physicians, nurses and pharmacists receive training on how to respond to medication incidents, including reporting and documentation processes, disclosure procedures and planning for ongoing communication with residents and families following an incident. (LTC #97)						
22.3 REV	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. (LTC #120)						
22.4 NEW	The structured framework used for incident analysis includes screening for possible intentional harm. *Reference: Recommendation # 79 from the MLTC Public Inquiry 2019, [cited 2021 Feb22; available from: https://longtermcareinquiry.ca/en/final-report/*						
22.5 REV	An established interdisciplinary committee (such as the Professional Advisory Committee or Quality/Safety) ensures system improvements or redesign strategies recommended following an incident analysis are implemented. (LTC #122)						
22.6 NEW	An established interdisciplinary committee (e.g., Professional Advisory Committee, Quality/Safety Committee) establishes objective and quantitative indicators and measurement processes to support monitoring of the safety of the medication use system (e.g., number of harm events identified through random chart review using trigger tools, number of residents transferred to hospital each quarter for medication-related reasons). *Reference: MSSA for Hospitals, Cdn V III, 2016, Item 18.13* ***What is a trigger tool?*** *The Institute for Healthcare Improvement has developed a series of tools that identify flags that indicate possible patient safety incidents. This flags are referred to as triggers. An example would be a patient receiving*						

Core Characteristic # 22:

Practitioners are encouraged to identify and report incidents, and interdisciplinary teams regularly analyze incidents that have occurred within the Home/facility and in other Homes/facilities for the purpose of redesigning systems to best support safe practitioner performance.

Self-Assessment Items		N	R	S	O	A	NA
	warfarin who required administration of Vitamin K to treat a bleed. The order for Vitamin K would be a trigger to review the chart for possible missed INR testing, or overlooked results. *For more information on trigger tools see:* *http://www.ihi.org/resources/Pages/Tools/IntrotoTriggerToolsforIdentifyingAEs.aspx*						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Core Characteristic # 23:

Proven infection control practices and safe handling practices are followed when storing, preparing, administering and disposing of medications, including hazardous medications.

Self-Assessment Items		N	R	S	O	A	NA
23.1	When oral solid dosage forms (capsules, tablets) are handled, staff members use gloves or follow other appropriate infection control handling practices to avoid direct contact between the product and skin surfaces. (LTC #126)						
23.2	Practitioners use appropriate hand hygiene procedures prior to preparing or administering any injectable product (IM, SC, IV push, IV admixture, SC cassette/bag, etc.) (LTC #127)						
23.3 REV	Use of multi-dose vials of injectable medications and diluents is avoided to the extent possible and, in normal circumstances such containers are used for one resident only. (LTC #128) ***Why is the use of multi-dose containers not recommended?*** *Multiple punctures into a container increases the likelihood of contamination of the product, despite inclusion of a preservative. Multiple punctures also increase the risk of rubber particles in the withdrawn solution. Use of the same container for multiple residents also increases the risk of cross-contamination.*						
23.4 REV	Topical preparations such as eyedrops, creams, etc are used for one resident only (i.e., not shared). (LTC #129) ***FAQ: Can topical products be used for more than one person if they are not dispensed for a specific resident (e.g., wardstock items)?*** No. Regardless of the source or type of product (i.e., non-prescription stock items as well as those dispensed from the pharmacy service) all medications should be labelled and used for only one resident.						

Notes:

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

Section B: High-Alert Medications

IX. General Strategies for Safety with High-Alert Medications

Core Characteristic # 24:

Practitioners are aware of risks associated with high-alert medications and additional safeguards have been implemented for these medications.

Self-Assessment Items		N	R	S	O	A	NA
24.1 NEW	Internal reports of identified risks (including near misses), errors, and adverse reactions associated with high-alert medications are regularly reviewed by an established committee (e.g., Professional Advisory Committee, Quality/Safety Committee) and actions taken to address identified vulnerabilities. (MSSA-NE-LTC # 2.14)						
24.2 a REV	Selected high-alert medications (as defined by the Home/facility; e.g., opioids, insulin) are independently double-checked by another practitioner, and this check is documented in the health record, *before* administration. (LTC # 124; MSSA-NE-LTC # 2.9)						
****OR****							
24.2 b NEW	Machine-readable coding (e.g., bar coding) is used prior to medication administration to identify **both** the resident and the medication/dose. (MSSA-NE-LTC # 2.9)						
24.3 NEW	TALLman lettering, when used to differentiate high-alert medications, follows the conventions recommended by ISMP Canada. (MSSA-NE-LTC # 2.7) ***Select Never*** *if TALLman lettering is not used in your Home.*						

X. Anticoagulants

Core Characteristic # 25:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of anticoagulants (blood thinners).

Scope: Unless otherwise stated, these items apply to oral agents (warfarin, direct oral anticoagulants [e.g., dabigatran, apixaban, rivaroxaban]), and those administered subcutaneously (unfractionated heparin, low molecular weight heparins [e.g., dalteparin, enoxaparin]).

	Self-Assessment Items	N	R	S	O	A	NA
Prescribing							
25.1	A standard, reliable process is in place to screen residents for recent anticoagulant use before invasive procedures, and, if therapy must be discontinued, protocols or guidelines define when anticoagulants should be stopped and restarted, and when alternative agents to bridge the resident should be considered. ***FAQ; What does the term "bridge" mean in this item?*** *If a specific anticoagulant such as warfarin must be discontinued before an invasive procedure, the resident may require an alternative agent such as heparin or low molecular weight heparin in the interim. The alternative agent is often referred to as a "bridge" until the long-term anticoagulant can be resumed. The Home/facility should develop protocols that define when bridge therapy will be prescribed. Often the decision is based on the resident's diagnosis or type of procedure that will be performed.*						
25.2	Standardized protocols/order sets are used to direct the reversal of anticoagulation, when required (e.g., providing guidance for dosing of vitamin K for patients on warfarin with an elevated INR).						
Monitoring							
25.3	When new residents (or residents returning from an inpatient stay) are receiving anticoagulant treatment, a practitioner verifies the indication for ongoing anticoagulation, reassessment date if applicable, and ensures laboratory testing is ordered if required.						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

XI. Insulin

Core Characteristic # 26:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of insulin.

Scope: Unless otherwise stated, these items apply to all concentrations of insulin prescribed, prepared, dispensed, and/or administered by the subcutaneous route, using a vial and syringe, pen, or continuous subcutaneous insulin infusion device (insulin pump).

Self-Assessment Items		N	R	S	O	A	NA
Prescribing							
26.1	The names for insulin products in computer order entry systems match order sets, protocols, medication administration records (paper and electronic), automated dispensing cabinet screens, infusion pump screens, medication labels, and any other format used to communicate medication information in the Home/facility.						
26.2	Standard order sets that promote best practice (e.g., use of scheduled basal and bolus insulin doses, and appropriate correction doses) are used for all residents receiving subcutaneous insulin.						
26.3	Combination insulins are expressed using the full brand name and dose expression on the same line (e.g., NovoLOG Mix 70/30, not just NovoLOG Mix) in handwritten orders, computer order entry systems, order sets, protocols, medication administration records (paper and electronic), automated dispensing cabinet screens, pharmacy labels, and any other format used to communicate medication information in the Home/facility.						

Core Characteristic # 27:

Strategies have been implemented to address risks associated with the use of concentrated insulins (e.g., U-200, U-300, U-500).

Self-Assessment Items		N	R	S	O	A	NA
Prescribing							
27.1	Concentrated insulin products (e.g., U-200, U-300, U-500) are clearly identified in computer order entry systems, order sets, protocols/guidelines, medication administration records (paper and electronic), automated dispensing cabinet screens, drug						

Core Characteristic # 27: Strategies have been implemented to address risks associated with the use of concentrated insulins (e.g., U-200, U-300, U-500).							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
	storage bins, pharmacy labels, and any other format used to communicate medication information in the Home/facility. *Select NA if concentrated insulins are not used in your Home/facility.*						
Administration							
27.2	Concentrated insulins (U-200, U-300, U-500) not given via a pen device, are administered with syringes specific to their strengths (i.e., U-100 insulin syringes and tuberculin syringes are not used). *Select NA if concentrated insulins are not used in your Home/facility.*						

Core Characteristic # 28: Strategies have been implemented to address risks associated with insulin pens.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
Dispensing							
28.1	Insulin pens are dispensed and labelled by the pharmacy for individual residents OR stocked in a profiled automated dispensing cabinet.						
28.2 **NEW**	Insulin pens are labelled on the barrel of the insulin pen, not on the cap, to reduce the likelihood of mix-ups.						
28.3 **NEW**	The Home/facility works with the pharmacy service provider to limit the supply of insulin available in the Home/facility to meet immediate needs of residents and avoid over stocking of this medication. *Reference: Recommendation # 10 from the MLTC Public Inquiry, 2019 [cited 2021 Feb22]; available from: https://longtermcareinquiry.ca/en/final-report/*						
Care Team							
Orientation and Continuing Education							

Core Characteristic # 28: Strategies have been implemented to address risks associated with insulin pens.							
Self-Assessment Items		**N**	**R**	**S**	**O**	**A**	**NA**
28.4	During initial orientation and annually thereafter, all nurses and other health care providers who may administer insulin are educated about the proper use of insulin pens for a single resident and the dangers of sharing pens among multiple residents, even if the needle is changed in between residents.						
28.5 NEW	Insulin cartridges/pens are securely disposed in accordance with an approved protocol. *Reference: Recommendation # 74 from the MLTC Public Inquiry, 2019 [cited 2021 Feb22]; available from: https://longtermcareinquiry.ca/en/final-report/*						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility
R **Rarely –** This item is implemented and in practice less than 40% of the time
S **Sometimes –** This item is implemented and in practice 40-70% of the time
O **Often –** This item is implemented and in practice 70-90% of the time
A **Always –** This item is fully implemented and in practice more than 90% of the time
NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

XII. Methotrexate for Non-Oncologic Use

Core Characteristic # 29:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of methotrexate for non-oncologic indications (e.g., rheumatoid arthritis).

Scope: Unless otherwise stated, these items apply to methotrexate administered by the oral, IM, or subcutaneous, route and used to treat non-oncologic conditions, such as rheumatoid arthritis, psoriasis, certain connective tissue or muscle inflammatory diseases, Crohn's disease, and multiple sclerosis. (Methotrexate used for an oncologic indication is excluded.)

Self-Assessment Items		N	R	S	O	A	NA
Prescribing and Dispensing							
29.1	Computer order entry systems (pharmacy and computerized prescriber order entry [CPOE]) have been programmed to default to a *weekly* rather than *daily* dosage regimen for oral, intramuscular and subcutaneous methotrexate and the day of administration (e.g., Wednesday) is specified.						
Monitoring							
29.2 NEW	All orders for methotrexate are flagged for review by the clinical pharmacist for the Home/facility to ensure correct dosing. *Reference: Zarowitz BJ, Erwin WG, Ferris M, Losben N, Proud T. Methotrexate safety improvement in nursing home residents. J Am Med Dir Assoc. 2012;13(1):69-74.*						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

XIII. Opioids

Core Characteristic # 30:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of opioids.

Scope:

Unless otherwise stated, these items apply to opioids (including in combination with other analgesics that are administered by the following routes: buccal, intramuscular, nasal, oral, subcutaneous, sublingual, transdermal.

	Self-Assessment Items	N	R	S	O	A	NA
	Prescribing						
	Therapeutic Review of Orders						
30.1 NEW	Pharmacists routinely calculate morphine milligram equivalents for all high-potency opioids (e.g., fentanyl, hydromorphone) and communicate with prescribers when doses ordered are outside the recommended therapeutic range for the intended recipient.						
30.2	A process (e.g., alert requesting confirmation during order entry in electronic prescribing and pharmacy systems) is in place to verify that the resident is opioid-tolerant before dispensing (or releasing from an automated dispensing cabinet [ADC]) long-acting opioids that are indicated only for such residents (e.g., fentanyl patches).						
	Storage						
30.3	Immediate-release and extended-release oral formulations of the same opioid are stored separately in resident care areas where non-resident specific stock is available. *Select NA if opioids are only dispensed in resident-specific packaging.*						
30.4	Morphine and HYDROmorphone are not stored right next to each other in resident care areas where non-resident specific stock is available. *Select NA if opioids are only dispensed in resident-specific packaging.*						
30.5	High dose/high concentration formats of opioids are available only if prescribed for individual residents (i.e., not stocked in regular unit narcotic/controlled drug supplies or emergency drug boxes). Specific products not to be stocked: i) Fentanyl ampoules or vials with total dose greater than 100 mcg per container; ii) HYDROmorphone ampoules or vials with total dose greater than 2 mg; and iii) Morphine ampoules or vials with total dose greater than 15 mg.						

Core Characteristic # 30:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of opioids.

Scope:

Unless otherwise stated, these items apply to opioids (including in combination with other analgesics that are administered by the following routes: buccal, intramuscular, nasal, oral, subcutaneous, sublingual, transdermal.

Self-Assessment Items		N	R	S	O	A	NA
	FAQ: How should situations requiring high dose/high concentration opioids be managed (e.g., end of life care)? *If these medications are required, they should be labelled for individual residents and removed from the care area as soon as they are no longer required for that resident.*						
Administration							
30.6	The date, time, and anatomical location of an opioid transdermal patch applied to a resident is documented on the resident's medication administration record.						
30.7	Practitioners remove any previously applied transdermal opioid patches prior to the application of a new patch and document the patch removal on the resident's medication administration record.						
30.8	A policy/procedure on the proper disposal of opioid patches exists and is followed (e.g., narcotic disposal system containers, containers that deactivate residual drug) and these items are not disposed with regular garbage.						
Monitoring							
30.9	The Home/facility uses a validated, standardized sedation scale (e.g., Richmond Agitation Sedation Scale, Pasero Opioid-Induced Sedation Scale ([POSS],) to guide the assessment and early detection of unintended advancing sedation during opioid therapy.						
30.10	When naloxone is used, residents are monitored for signs of re-sedation and respiratory depression for at least 90 minutes after administration of the reversal agent (and longer if an extended-release dosage form was given) in accordance with an established protocol.						

XIV. Oral Anti-Cancer Drugs (Chemotherapy)

Core Characteristic # 31:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of **oral** anti-cancer drugs.

Scope: Unless otherwise stated, these items apply to oral medications used to treat cancer, including hormonal agents. The health risks associated with exposure to individual OACDs are typically assessed based on their potential for carcinogenicity, teratogenicity, genotoxicity, reproductive toxicity or organ toxicity.

Self-Assessment Items		N	R	S	O	A	NA
Prescribing							
31.1 REV	Written or faxed orders are required for oral anti-cancer drugs; verbal/telephone are accepted only to hold or discontinue treatment.						
31.2	Orders for oral anti-cancer drugs to be taken or given on specific days are written explicitly including the specific dates medications are to be given (e.g., written as “Day 1, 2, 3,” not “Days 1-3”, noting the dates or indicating the start date and noting it as “Day 1”).						
31.3	For intermittent treatment with oral anti-cancer drugs, the quantity prescribed and dispensed (e.g., number of tablets/capsules) for residents is the exact quantity required for a single cycle of treatment. *For example, capecitabine is available in 500 mg tablets. If one cycle of treatment is ordered for capecitabine 1,250 mg/m2 [BSA = 1.6 m2] twice a day for 2 weeks, then the order would note 2,000 mg twice a day for 2 weeks with 112 tablets prescribed and dispensed to the Home.*						
Dispensing and Administration							
31.4	Oral anti-cancer drugs are identified as such on the medication administration record and the medication label and handled in accordance with applicable guidelines and best practices by pharmacy and nursing personnel, including use of personal protective equipment.						
31.5	All oral anti-cancer drugs are provided in a ready-to-use form that requires no further preparation or manipulation by the practitioner who will be administering it (i.e., provided in the exact dose required).						

XV. Parenteral Infusions

Core Characteristic # 32:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of continuous and intermittent intravenous and subcutaneous infusions of medications, including opioids.

Self-Assessment Items		N	R	S	O	A	NA
Prescribing							
32.1	Standardized concentrations have been established for continuous subcutaneous infusions of opioids. *Select NA if your Home does not provide continuous subcutaneous infusions of opioids.*						
32.2	Order sets for intravenous and subcutaneous infusions express concentrations and hourly doses in a manner and sequence that matches the entries on medication administration records (paper/electronic), pharmacy labels and infusion pump programming requirements. *Select NA if parenteral infusions are never administered in the Home/ facility.*						
Dispensing							
32.3	Medications for intravenous and subcutaneous infusion are prepared in the pharmacy and provided in a ready-to-use format that requires no further preparation or manipulation (i.e., infusions are not prepared by nurses in care areas). *Select NA if parenteral infusions are never administered in your Home/facility.*						
32.4 REV	Medications for intravenous infusion are labelled with, at minimum, the base solution and the name, total amount or concentration of each additive in the container. (LTC #52) *Select NA if parenteral infusions are never administered in the Home/ facility.*						
32.5	When changes are ordered for resident-specific premixed intravenous or subcutaneous infusions, a new supply is obtained from the pharmacy service provider (i.e., the amount of drug in a premixed IV solution is not "topped-up" if there is a dose increase). (LTC #57) *Select NA if parenteral infusions are never administered in your Home/ facility.*						

Core Characteristic # 32:

Strategies have been implemented to address risks associated with prescribing, dispensing, administering and monitoring of continuous and intermittent intravenous and subcutaneous infusions of medications, including opioids.

Self-Assessment Items		N	R	S	O	A	NA
32.6	Labels affixed to cassettes/minibags for ambulatory infusion pumps clearly identify the medication name and concentration, the flow rate, and other information required to program the ambulatory infusion pump. (LTC #53) *Select NA if ambulatory infusion pumps are never used in your Home/facility.*						
Administration							
32.7	There is an independent double check of parenteral solutions prior to administration. (LTC # 77) *Select NA if parenteral infusions are never administered in your Home/facility.*						
Monitoring							
32.8	Monitoring criteria have been established and implemented for residents receiving continuous infusions of opioids or other medications used as part of palliative or end-of-life care, including palliative sedation (e.g., monitoring vital signs, level of consciousness, use of pulse oximetry). (LTC 2006 # 7; removed in 2012 revision)						

Scoring Your Self-Assessment

N **Never –** This item has not been implemented in our Home/facility

R **Rarely –** This item is implemented and in practice less than 40% of the time

S **Sometimes –** This item is implemented and in practice 40-70% of the time

O **Often –** This item is implemented and in practice 70-90% of the time

A **Always –** This item is fully implemented and in practice more than 90% of the time

NA **Not applicable** – Use this option where indicated, if an assessment item does not apply to your Home/ facility

XVI. Evaluation

Core Characteristic # 33:

The following brief survey will assist ISMP Canada and CPSI to evaluate this self-assessment program.

After completion of the evaluation, you will be able to finalize and submit your results and compare them to the aggregate response.

Self-Assessment Items		A	B	C	D	E	NA
33.1	How many people were there in the team completing the assessment? A – 1 B – 2-4 C – 5-7 D – 8-10 E – more than 10						
33.2	Which disciplines/provider groups were involved in completing the assessment? A – Pharmacy only B – Nursing only C – Medicine only D – Nursing and Pharmacy E – Nursing, Pharmacy and Medicine						
33.3	How long did it take your team to complete the assessment? A – less than 1 hour B – 1-2 hours C – 2-3 hours D – 3-4 hours E – more than 4 hours						
33.4	Do you plan to take any action following completion of the assessment? A – No B – Maybe C - Yes						
33.5	Do you plan to incorporate this assessment into ongoing quality improvement activities for your practice setting? A – No B – Not sure C – Yes, at least every 3 years D – Yes, at least every 2 years E – Yes, every year						

Core Characteristic # 33:

The following brief survey will assist ISMP Canada and CPSI to evaluate this self-assessment program.

After completion of the evaluation, you will be able to finalize and submit your results and compare them to the aggregate response.

Self-Assessment Items		A	B	C	D	E	NA
33.6	Please rank the learning and insights gained from this program relative to the time invested: A – not worth it B – repeat of previous knowledge C – useful D – excellent E – invaluable						
33.7	Would you recommend this assessment program to a colleague in another organization? A – no B – unlikely C – maybe D – probably E – definitely						

XVII. DELETED ITEMS

The following items from the Medication Safety Self-Assessment for Long-Term Care, Canadian Version II, 2012 have been deleted.	
5	The pharmacy computer system automatically screens and detects drugs to which patients are allergic/sensitive/intolerant and provides a clear warning to staff during order entry. (Addressed in new 8.6)
8	Monitoring criteria have been established and results are documented in the resident`s health record for those who receive high alert/ high risk medications (e.g., insulin, digoxin, lithium, warfarin or other anticoagulants) or specialized procedures pertaining to drug administration, (e.g., palliative care, use of G-tube, PCA pump, etc.).
19	Current protocols, guidelines, dosing scales, monitoring information for high-alert drugs (e.g., hypoglycemic agents, insulin, narcotic analgesics, cytotoxic agents, etc.) are readily accessible to physicians, pharmacists, and nurses, and used when indicated.
20	All internally developed drug information tools (e.g., pocket references, drug information cards, drug education material, etc.) undergo a formal approval process before use that includes, at a minimum, review by a pharmacist and those who will be using the tool, and continued relevance is assessed.
29	The formulary that guides drug prescribing for residents (e.g., provincial, national or payee formulary) is accessible in the Home/facility for reference by prescribers and other health care providers involved in the medication use process.
30	There is a system in place to alert prescribers that a new or repeat medication authorization is required, to ensure the uninterrupted availability of drugs under special coverage (e.g., provincial coverage, tuberculosis drugs, investigational drugs, limited use drugs, methadone and opioids, etc.).
39	A: In Homes/facilities without CPOE, computer-generated MARs share a common database with the pharmacy system and are used for medication administration. OR B: in Homes/facilities with CPOE systems, the CPOE system shares a common database with the pharmacy system and is used to generate eMARs for medication administration.
41	Integrated automated medication system technologies are available for each stage of the medication use process to increase the accuracy and safety of medication ordering, dispensing, and administration (and improve efficiencies, such as minimizing duplication of same work [e.g., order entry] by different practitioners).
43	Recommendations in external safety bulletins (e.g., ISMP Canada Safety Bulletins, Coroner/Medical Examiner reports) are considered by the committee responsible for medication management (e.g., Professional Advisory Committee, Quality/Safety) and, where relevant, action is taken to help prevent local errors. (New 9.1)

The following items from the Medication Safety Self-Assessment for Long-Term Care, Canadian Version II, 2012 have been deleted.	
44	Auxiliary warnings or other label enhancements (e.g., TALLman lettering) are placed on packages and storage bins of medications with problematic names, packages, and labels to highlight look-alike drug name pairs, and/or other safeguards are considered to decrease the likelihood of selection errors (e.g., segregated or differentiated storage containers).
51	Labels affixed to commercially available IV infusion containers are positioned to support visibility of the manufacturer's label.
62	The timing of medication deliveries from the pharmacy is mutually agreed upon to ensure secure transfer of medications to the Home/facility, and nurses are notified whenever drugs arrive at the Home/facility or care unit (regular deliveries and after hours).
82	There is adequate space for storage of medications and associated supplies in care areas and medication stock rooms where applicable.
83	Medications are stored in a manner consistent with the manufacturers' recommendations. (e.g., refrigerated, protected from light, etc.).
88	Plans for new or expanded clinical programs (e.g., changes to admission criteria, adding respite care beds, etc.) within the Home/facility are well communicated to all affected practitioners, and appropriate consideration of resources is addressed prior to implementation, so that the additional work volume will be met without compromising resident safety.
90	During orientation, illustrative examples of errors occurring locally and/or published errors (e.g., in ISMP Canada Safety Bulletins) are shared with new practitioners along with system-based strategies that have been implemented to reduce the risk of similar errors.
96	Practitioners are provided with the necessary support and time to attend internal and external educational programs related to safe medication management processes.
103	During medication administration, nurses routinely inform residents/family caregivers/ substitute decision makers of the name, the dose, and purpose of the medication.
109	No disciplinary action is taken against practitioner who make an error. Administrative action may be warranted in incidents related to performance management; e.g., chemical dependence, malicious, illegal or inappropriate behaviour that results in an incident, drug diversion, breach of confidentiality, or other misconduct.
110	Practitioners do not accumulate demerits or points for causing a medication incident, but are given the opportunity to identify system issues and participate in professional practice updates. (replaced with related item from MSSA for Hospitals)
112	The administrative team provides positive feedback to individuals and units that report incidents and works with them to implement preventative strategies.

The following items from the Medication Safety Self-Assessment for Long-Term Care, Canadian Version II, 2012 have been deleted.	
123	Practitioners are provided with regular feedback about reported incidents, hazardous situations, and incident reduction strategies that are being implemented. (duplicate of 5.6; LTC #95)
131	The Home/facility has identified a list of high-alert medications in use in the Home and established strategies to ensure the safe use of these medications (e.g., independent double checks, segregated storage, auxiliary labelling).
132	The order of information on the pharmacy medication label follows the same sequence as the information in the Medication Administration Record. (New 10.7) partial – item split from LTC # 132)

The following items originally included in the MSSA: Focus on "Never Events" in Long-Term Care, have been deleted for this version.	
30.3	Immediate-release and extended-release oral formulations of the same opioid are stored separately in the pharmacy.
30.5	Morphine and HYDROmorphone are not stored right next to each other in the pharmacy.

Glossary

Adverse Drug Event (ADE)

An injury from a medicine or lack of an intended medicine - includes adverse drug reactions and harm from medication incidents.[9]

Adverse Reaction

Adverse reactions[10] are undesirable effects to health products. Health products include medications, medical devices and natural health products. Medications include both prescription and non-prescription pharmaceuticals; biologically-derived products such as vaccines, serums, and blood derived products; cells, tissues and organs; disinfectants; and radiopharmaceuticals.

Reactions may occur under normal use conditions of the product. Reactions may be evident within minutes or years after exposure to the product and may range from minor reactions like a skin rash to serious and life-threatening events such as a heart attack or liver damage.

At-Risk Behaviour

An intentional act that increases risk where risk is not recognized or is mistakenly believed to be justified.[11]

Automated Dispensing Cabinet

A drug storage device or cabinet that electronically dispenses medications in a controlled fashion and tracks medication use.[12]

Barcode Scanning Technology

The use of optical machine-readable representation of data found in barcodes on medication packages. The process involves the use of a barcode scanner, an electrical device that can read and output printed barcodes to a computer.

Behavioural Choice

Intentional acts that are undertaken by the free exercise of one's judgement - unlike human error, which is unintentional, behavioural choice represents the purposeful behaviour we intentionally employ while engaging in our day-to-day activities.[7]

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[9] Adapted from Bates DW, Spell N, Cullen DJ, Burdick E, Laird N, Petersen LA, Small SD, Sweitzer BJ and Leape LL, "The Costs of Adverse Drug Events in Hospitalized Patients. Adverse Drug Events Prevention Study Group," Journal of the American Medical Association 277, 4 (January 22, 1997): pp. 307–11.

[10] https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-information.html; accessed February 10, 2021.

[11] ISMP Medication Safety Self Assessment for Hospitals. 2011. Available from: http://www.ismp.org/selfassessments/Hospital/2011/full.pdf

[12] ISMP Medication Safety Self-Assessment for Automated Dispensing Cabinets. 2009. Available from: http://www.ismp.org/selfassessments/ADC/Login.asp

Best Possible Medication History (BPMH)

A history created using 1) a systematic process of interviewing the resident/family, and 2) a review of at least one other reliable source of information to obtain and verify all of a resident's medication use (prescribed and non-prescribed).[13] Complete documentation includes medication name, dosage, route and frequency. The BPMH is more comprehensive than a routine primary medication history, which may not include multiple sources of information.

The BPMH is a 'snapshot' of the resident's actual medication use, which may be different from what is contained in their records. This is why the resident's/family caregiver's involvement is vital.

Care Area

Recognizing the differences in organizations of various types of long-term care facilities, "care area" is generic terminology that can be interpreted and applied by the Home/facility, specific to its organization, where medications are stored or administered (e.g., locations or physical units, groupings by medical conditions/diagnoses, etc.).

Computerized Medication Order Entry System

Refers to any computer system into which medication orders are entered, including pharmacy computer systems and computerized prescriber order entry systems.

Computerized Prescriber Order Entry (CPOE)

Refers to an electronic or computerized system into which an authorized prescriber directly enters medical orders, including medication orders. CPOE systems ideally also offer clinical decision support.

Concentrated Insulin

Any insulin with a concentration greater than 100 units/mL, including U-200, U-300, and U-500 insulin.

Critical Incident

An incident resulting in serious harm (loss of life, limb, or vital organ) to the resident, or the significant risk thereof. Incidents are considered critical when there is an evident need for immediate investigation and response. The investigation is designed to identify contributing factors and the response includes actions to reduce the likelihood of recurrence.[14]

In Ontario, critical incidents are defined as medication incidents or adverse drug reactions that result in a resident being taken to hospital.[15]

Culture of Safety

The underlying beliefs and values of an organization as they relate to safety as a priority.[16]

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[13] Adapted from https://www.ismp-canada.org/medrec/; accessed February 10, 2021.

[14] Davies J, Hebert P and Hoffman C, Canadian Patient Safety Dictionary (Ottawa: Royal College of Physicians and Surgeons of Canada, 2003).

[15] Long-Term Care Homes Act, 2007, S.O. 2007 [cited 2021 Feb22], c. 8. O. Reg. 79/10: GENERAL, Section 107. Available from: https://www.ontario.ca/laws/regulation/100079#BK131

[16] ISMP Canada, HSO, CPSI, 2019. ISMP Canada Definitions webpage: https://www.ismp-canada.org/definitions.htm

Cycle of Chemotherapy

A dose of chemotherapy that is repeated at regular intervals. Several chemotherapy cycles may make up a total treatment protocol. For example, the CHOP chemotherapy protocol may consist of one cycle given every 3 weeks, with a total of six cycles for the course of therapy.

Dangerous Abbreviations, Symbols and Dose Designations

Abbreviations, symbols and dose designations that have been identified as easily misinterpreted or involved in medication incidents leading to harm and should be avoided in medication-related communications.[17]

Documented Plan

An established process that is available in written or electronic form and readily accessible to all team members.

Dosing Window

When a first dose is administered at a nonstandard time, nurses need an agreed-upon method of converting subsequent doses to the standardized schedule. Many facilities have guidelines for this purpose. These “dosing windows” or “staggered dosing times” provide a matrix for determining the safest time to administer the second dose according to when the first dose was administered. Patients usually are back on a standard dosing schedule by the third dose.[18]

Electronic Prescribing (e-prescribing)

The secure electronic creation and transmission of a prescription between an authorized prescriber and a patient’s pharmacy of choice, using clinical electronic medical record (EMR) and pharmacy management software.[19]

Electronic Health Record (EHR)

The systems that make up the secure and private lifetime record of a person's health and health care history. These systems store and share such information as lab results, medication profiles, key clinical reports (e.g., hospital discharge summaries), diagnostic images (e.g., X-rays), and immunization history. The information is available electronically to authorized health care providers.[20]

Emergency Lifesaving Situation

A time when health care team members must act immediately to administer medications to mitigate imminent resident harm; e.g., administration of glucagon for severe hypoglycemia.

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[17] ISMP Canada’s Do Not Use list of dangerous abbreviations, symbols and dose designations. Available from: http://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

[18] Cohen M, editor. Medication errors. 2nd ed. Washington, DC: American Pharmaceutical Association; 1999.

[19] Electronic Prescribing in Primary Care: Effects on Medication Safety, ISMP Canada Safety Bulletin 2018; 18(10). Available from: https://www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-i10-ePrescribing.pdf

[20] Canada Health Infoway. Understanding EHRs, EMRs and PHRs. Available from: https://www.infoway-inforoute.ca/en/solutions/digital-health-foundation/understanding-ehrs-emrs-and-phrs

Failure Mode and Effects Analysis (FMEA)

A proactive safety technique that helps to identify process and product problems before they occur. It is one of several types of proactive risk assessment that can be used in healthcare settings.[21]

Family Caregiver

Family members and other significant people (as identified by the care recipient) who provide care and assistance to individuals living with a physical, mental or cognitive condition.[22,23]

Similar term: informal caregiver

Harm

A temporary or permanent impairment in body functions or structures. It includes mental, physical, sensory functions and pain.[24]

Hazardous Chemical

A substance that may be toxic to residents or staff if not handled correctly. Typically, these items are subject to Workplace Hazardous Materials Information System (WHMIS).[25]

High-Alert Medications

Drugs that bear a heightened risk of causing significant resident harm when they are used in error.[26]

Human Error

Inadvertently doing other than what was intended (e.g., a mental slip, lapse, or mistake). Human errors are unintentional acts, not behavioural choices.

Implemented

Accomplished or achieved in practice, not just policy.

Incident Analysis

A structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer and share learning.[27]

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[21] FMEA (definition), ISMP Canada website: http://www.ismp-canada.org/fmea.htm

[22] Family caregiver (definition). Canadian Caregiver Coalition 2014; quoted in Mobilizing Action Integrated Action Plan: A Canada that recognizes, respects and supports the integral role of family caregivers in society. Updated August 2015: Available from: https://www.carerscanada.ca/wp-content/uploads/2015/09/Moblizing-Action-Plan-Report_21.pdf

[23] Family (Informal) Caregiver (definition). Family Caregiver Alliance website: https://www.caregiver.org/definitions-0

[24] Developed by the collaborating parties of the Canadian Medication Incident Reporting and Prevention System. 2005. ISMP Canada Definitions webpage: https://www.ismp-canada.org/definitions.htm

[25] WHMIS 2015 - New Hazardous Products Regulations Requirements [cited 2021 Feb22]. Available from: https://www.canada.ca/en/health-canada/services/environmental-workplace-health/occupational-health-safety/workplace-hazardous-materials-information-system/whmis-2015/labelling-chemicals-workplace-chemicals/new-hazardous-products-regulations-requirements.html

[26] ISMP's List of High-Alert Medications in Long-Term Care Settings; available from: https://www.ismp.org/sites/default/files/attachments/2017-11/LTC-High-Alert-List.pdf

[27] Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012. Incident Analysis Collaborating Parties are Canadian Patient Safety Institute (CPSI), Institute for Safe Medication

Similar term: root cause analysis

Independent Double Check

A process in which a second practitioner conducts a verification. Such verification can be performed in the presence or absence of the first practitioner. In either case, the most critical aspect is to maximize the independence of the double check by ensuring that the first practitioner does not communicate what he or she *expects* the second practitioner to see, which would create bias and reduce the visibility of an error. An automated check, e.g., bar coding is an acceptable independent double check; however, consideration must be given to the parameters that can be checked electronically before human checks are eliminated.[28]

Intentional Act

A situation in which a health care provider deliberately acts in a manner where the likely outcome is known; in a resident safety context, this refers to actions taken where the potential for harm is known.

Just Culture

A safety-supportive model of shared accountability where healthcare institutions are accountable for the systems they design, for supporting the safe behavioural choices of patients, visitors and staff, and for responding to staff behaviours in a fair and just manner. In turn, staff members are accountable for the quality of their behavioural choices (human error is not a behavioural choice) and for reporting their errors and system vulnerabilities.[29]

Machine-Readable Coding

Any encoded identifying mark (e.g., bar code) representing data that can be read with a computerized reading device, such as a scanner or imager.[14]

Maximum Dose

The dose of a medication that represents the upper limit that is normally found in the literature or in manufacturer recommendations.[30] Maximum doses may vary according to age, weight, diagnosis, or comorbidity.

Medication Administration Record (MAR)

A form that records the medications ordered for the resident (regularly scheduled and "as needed") and their administration. Medication administration records are usually generated through the pharmacy information system.

Practices Canada, Saskatchewan Health, Patients for Patient Safety Canada (a patient-led program of CPSI), Paula Beard, Carolyn E. Hoffman and Micheline Ste-Marie. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF

[28] Institute for Safe Medication Practices Canada © January 2005. Adapted with permission from: Institute for Safe Medication Practices (US). The virtues of independent double checks – they really are worth your time! ISMP Safety Alert. 2003 March 6;8(5):1.

[29] 2011 ISMP Medication Safety Self Assessment for Hospitals; available from: http://www.ismp.org/selfassessments/Hospital/2011/full.pdf

[30] Adapted from the 2012 ISMP International Medication Safety Self Assessment® for Oncology; available from: https://mssa.ismp-canada.org/data/oncology/mssa_oncology.pdf

Computerized Medication Administration Record (cMAR)

A paper MAR generated from the pharmacy computer system. Staff manually document on this form the doses of medication administered. Staff may also need to make manual changes to the form to reflect recent medication order modifications.

Electronic Medication Administration Record (eMAR)

An electronic record of medication use that is maintained digitally on a computer system. An eMAR indicates medications to be administered on a computer screen and doses are recorded through data entry.

Medication Device

Equipment such as infusion pumps, inhalers, implantable pumps, syringes, pen devices that contain medication (e.g., epinephrine, insulin), tubing, robotics, and other related devices that are used for medication preparation, dispensing, and administration.[31]

Medication Incident

Any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of a healthcare professional or resident. Medication incidents may be related to professional practice, drug products, procedures, and systems, and include prescribing, order communication, product labelling/ packaging/ nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.[32]

Simplified Definition: A mistake with medication, or a problem that could cause a mistake with medication.[33]

Medication Reconciliation

A formal process in which healthcare providers work together with patients [residents], families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.[34] Medication reconciliation requires a systematic and comprehensive review of all the medications a patient [resident] is taking (known as a best possible medication history [BPMH]) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the resident.

Medication Safety

Freedom from preventable harm with medication use.[35]

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[31] 2011 ISMP Medication Safety Self Assessment for Hospitals; available from: http://www.ismp.org/selfassessments/Hospital/2011/full.pdf

[32] Adapted with permission from the National Coordinating Council for Medication Error Reporting and Prevention, What Is Medication Error? Developed by the collaborating parties1 of the Canadian Medication Incident Reporting and Prevention System. © 2001. ISMP Canada Definitions webpage: https://www.ismp-canada.org/definitions.htm

[33] ISMP Canada, 2010. ISMP Canada Definitions webpage: https://www.ismp-canada.org/definitions.htm

[34] https://www.ismp-canada.org/medrec/; accessed February 10, 2021.

[35] ISMP Canada, 2007. ISMP Canada Definitions webpage: https://www.ismp-canada.org/definitions.htm

Near Miss or Close Call

An event that could have resulted in unwanted consequences, but did not because, either by chance or through timely intervention, the event did not reach the patient.[36]

Similar Terms: Near Hit or Good Catch

Never Event

An event known to cause severe harm to a resident, or with the potential to do so, and is preventable through known strategies by the health care professional team or organization. [37, 38]

No Harm Event

An incident occurs that reaches the resident, but results in no injury. Harm is avoided by chance or because of mitigating actions.[39]

Opioid-naïve

Individuals who have not previously been taking opioids on a routine basis in a dose sufficient to produce tolerance (see "opioid-tolerant resident").

Opioid tolerant

Individuals receiving, for 1 week or longer, at least: 60 mg oral morphine/day; 25 mcg transdermal fentanyl/hour; 30 mg oral oxycodone/day; 8 mg oral hydromorphone/day; 60 mg oral hydrocodone/day; or an equianalgesic dose of another opioid.[40]

Oral Anti-Cancer Drug (OACD)

A drug that is used to treat cancer (or other indications) and includes some hormonal agents. The health risks associated with exposure to individual OACDs are typically assessed based on their potential for carcinogenicity, teratogenicity, genotoxicity, reproductive toxicity or organ toxicity.[41]

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[36] Davies J, Hebert P and Hoffman C, Canadian Patient Safety Dictionary (Ottawa: Royal College of Physicians and Surgeons of Canada, 2003).

[37] Never Events for Hospital Care in Canada. Health Quality Ontario and the Canadian Patient Safety Institute. September 2015. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/NeverEvents/Documents/Never%20Events%20for%20Hospital%20Care%20in%20Canada.pdf

[38] Morrison C. Pharmacists called on to create "never event" list for pharmacy. PharmJ 4 MAR 2014. Available from : https://www.pharmaceutical-journal.com/news-and-analysis/pharmacists-called-on-to-create-never-event-list-for-pharmacy/11135384.article?firstPass=false

[39] Davies J, Hebert P and Hoffman C, Canadian Patient Safety Dictionary (Ottawa: Royal College of Physicians and Surgeons of Canada, 2003).

[40] Institute for Safe Medication Practices. Medication Safety Self Assessment® for High-Alert Medications, 2018. https://www.ismp.org/assessments/high-alert-medications

[41] Vu K, Emberly P, Brown E, et al. Recommendations for the safe use and handling of oral anticancer drugs in community pharmacy: A pan-Canadian consensus guideline. Canadian Pharmacists Journal / Revue des Pharmaciens du Canada, vol. 151, 4: pp. 240-253. First published May 16, 2018. Abstract available from: http://journals.sagepub.com/doi/abs/10.1177/1715163518767942.

Pharmacy Practice Management System

The information management systems used by pharmacy professionals[42] (i.e., pharmacy computer/software systems).

Practitioner

A licensed healthcare professional, who is authorized within the Home/facility to prescribe, dispense, or administer medications (e.g., physician, pharmacist, pharmacy technician, nurse, nurse practitioner respiratory therapist).

Prescriber

A licensed health care professional with authority to prescribe medications (e.g., physician, nurse practitioner).

Professional Advisory Committee

An interdisciplinary committee that convenes on a scheduled basis, or when necessary, to review the safety, use, efficacy, and monitoring of medications that will be available for use in the Home/facility. The committee also sets policies and procedures regarding the safety of the entire medication use process.

Regularly Scheduled Medication

May also be referred to as “routine”, “maintenance”, “scheduled”.

Safety

Freedom from accidental injuries.[43]

Secure Storage Area

A designated, restricted access area that meets national and provincial/territorial regulatory requirements for storage of targeted substances such as opioids and benzodiazepines; for example, a separately locked area in a medication room or cart, or a safe in a pharmacy.

Substitute Decision Maker

A person authorized to make health and personal care decisions on behalf of a resident who is unable to do so. [44]

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[42] NAPRA. Pharmacy Practice Management Systems: Requirements to Support NAPRA’s “Model Standards of Practice for Canadian Pharmacists”. Available from: https://napra.ca/sites/default/files/documents/NAPRA_Pharmacy_Practice_Management_Systems_November2013_b.pdf

[43] Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human: Building a safer health system. Washington, DC, National Academy Press, 1999.

[44] Speak Up Ontario. What is a substitute decision maker? [Internet] [cited 2021 Feb21]. Available from: https://www.speakupontario.ca/resource/the-substitute-decision-maker-hirearchy/.

System

A set of interdependent elements (people, processes, equipment) that interact to achieve a common aim.[45]

TALLman Lettering

TALLman lettering is a method used to assist in the differentiation of look-alike/sound-alike drug names through the application of UPPER-CASE lettering to certain sections of drug names.

Transition of Care[46]

The movement of a patient from one level or area of care to another (e.g., moving from an intensive care unit to a general hospital unit; transferring from a hospital to a nursing home; moving from home or rehabilitation to long-term care).

Unit-of-Use

A supply of medication that is intended for several doses of therapy, for a single patient (e.g., an inhaler, a tube of ointment or a 100 mL bottle of cough syrup).[47]

[45] World Alliance for Patient Safety. WHO draft guidelines for adverse event reporting and learning systems. Geneva (Switzerland): World Health Organization; 2005.

[46] 2012 ISMP International Medication Safety Self Assessment® for Oncology; available from: https://mssa.ismp-canada.org/data/oncology/mssa_oncology.pdf

[47] Davies J, Hebert P and Hoffman C, Canadian Patient Safety Dictionary (Ottawa: Royal College of Physicians and Surgeons of Canada, 2003).

References

Selected Supporting References (to be added)