Medication Without Harm 2022





Concept Note:

The third Global Patient Safety Challenge has been initiated by WHO with the focus on Medication Safety. It is based on the patient safety philosophy that was previously developed by WHO, according to which errors are unavoidable and largely caused by weak health systems; the challenge is to reduce their occurrence and implications. The Challenge was formally launched in March 2017, at the Second Global Ministerial Patient Safety Summit in Bonn, Germany on 29 March 2017.

"The aim of the Global Patient Safety Challenge on Medication Safety is to strengthen medication safety by improving the health systems that minimize medication-related harm by %50, globally in the next 5 years. "The third WHO Global Patient Safety Challenge: Medication Without Harm will propose solutions to address many of the obstacles the world faces today to ensure the safety of medication practices. WHO's goal is to achieve widespread engagement and commitment of WHO Member States and professional bodies around the world to reducing the harm associated with medication".

Importance of Medication Safety as a Priority That Needs Urgent Action:

When compared to patients in high-income countries, patients in low-income countries lose twice as many years of life adjusted for disability as those in high-income countries. Every year, a significant number of patients are harmed or die because of unsafe health care, resulting in a high public health burden worldwide, most of this harm is preventable. Adverse events are now estimated to be the 14th leading cause of morbidity and mortality in the world. It is estimated that over half of all medicines are prescribed, dispensed, or sold inappropriately, with many of these leading to preventable harm. Therefore, ensuring safe medication use and having the processes in place to improve medication safety should be considered of central importance to countries working towards achieving UnitedHealthcare.1





Definition of key concepts:

Medication Errors: Is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.»2

Medication Safety: is defined as freedom from preventable harm with medication use (ISMP Canada, 2007). 3

Introduction:

In health care systems throughout the world, unsafe medication practices and medication errors are the primary sources of avoidable harm. Low-and middle-income countries experience this harm at variable levels and in different ways—the annual cost of medication errors is estimated to be 42 billion US dollars worldwide4. The Saudi Patient Safety Center (SPSC)- WHOcc on Patient Safety Policies and Strategies working with experts, partners, and WHO-EMRO to deliver training activity series to support the WHO Global Patient Safety initiatives with a focus on Low- and Middle-Income Countries (LMICs), and one of the five strategic activities assigned to SPSC-WHOcc is Medication Without Harm, in alignment with the 3rd WHO Global Patient Safety Challenge.



Aim:

In alignment with the 3rd WHO Global Patient Safety Challenge Medication without Harm, this working activity aims to educate healthcare professionals about the importance of medication reconciliation in reducing medication-related harm.





The need for building capacities on Medication Safety:

Ensuring medication safety is one of the critical challenges, as the countries and stakeholders need to prioritize raising awareness and have a vital role in driving change management through introducing improvement strategies, tools, resources, and skills necessary for Medication Safety at Polypharmacy, high alert situations, transition of care, reporting and learning, medication reconciliation, and other areas.

Overall Learning objectives:

- To recognize the importance of medication safety as a Patient Safety priority that faces health systems across the globe, especially in LMIC.
- To outline the key steps in developing improvement strategies for Medication Safety.
- To identify the appropriate resources and skills needed for Medication Safety.
- Best practices in relation to initiatives, rules, and regulations from KSA.



Target Audience:

- Pharmacist
- Physicians
- Nurses



Topic:

Role of Pharmacist>s in enhancing Medication Safety

Objectives:

- Identify pharmacists' roles and contributions toward medication safety.
- Outline the need to improve safety culture in pharmacies.
- To outline the importance of engaging patients and families for medication safety.
- sRecommendations to LMIC in emphasizing on the pharmacist's role in medication safety.

Topic:

Medication Safety in High-Alert Situations

Objectives:

- To define High Alerts situations.
- To outlines the main factors contributing to high-alert situations
- To outline the key strategies to reduce avoidable harm associated with highrisk situations.
- Outline the necessity to enhance safety management in high-alert situations.
- Recommendations to accelerate implementation of medication safety in high alert situations at LMIC.



Topic:

Improving Medication discrepancies during transitions of care

Objectives:

- To define transition of care.
- To highlight risks and contributing factors for medication error during transition of care.
- To outline strategies to prevent medications errors during transitions of care.
- To outline the importance of engaging patients and families.
- To provide tips in planning and implementation
- To share with LMIC challenges and lessons learned for improving transition of care issues.

Topic:

Medication Safety: Polypharmacy

Objectives:

- Define what is meant by polypharmacy.
- Discuss the risks and contributing factor associated with polypharmacy.
- To outline the importance of engaging patients and families.
- To outline effective strategies of Medication Safety targeting Polypharmacy issues.
- To identify the appropriate resources that can be used by LMIC to enhance polypharmacy issues.





Topic:

LASA: Prevention Strategies

Objectives:

- Define what is meant by a look alike, sound alike (LASA).
- Outline LASA risks and associated errors.
- Describe potential strategies to prevent LASA associated errors.
- Recommendations to LMIC to enhance LASA associated errors.

Topic:

Technology and Medication Safety

Objectives:

- To describe technologies trends undertaken in a pharmacy-related setting.
- To outline how dose technology affect medication safety?
- To highlight benefits of utilizing technology enhance medication safety at LMIC.



Medication Reconciliation Patient-Centered Approach (TOT)

PROGRAM DESCRIPTION:

This course is done under the SPSC-WHOcc activities in alignment with the third WHO global patient safety challenge. One of the most critical activities that healthcare providers can perform to improve the safety and quality during transition of care is medication reconciliation. This program summarizes the essential steps to conduct medication reconciliation in a healthcare setting with hands-on experience in taking medication history and patient chart review utilizing the WHO-High5 -standard operating protocol and international Patient Safety and quality standards.

Objectives:

- To describe the importance of Medication Reconciliation process.
- To present the principles and strategies to spread and measure the improvements Medication Reconciliation
- To recognize the Physician, pharmacist, and Nurses' role in this process.



Target Audience:

- Pharmacist
- Physician
- Nurse



The curriculum consists of four modules as follows:

- Module 1: [Medication reconciliation: the 3 w's: what, why and when?]
- Module 2: [Medication Reconciliation: Who's job, is it?]
- Module 3: [Implementing Medication Reconciliation Strategies]
- Module 4: [Medication Reconciliation: Staff Training & Competency Program for Healthcare Professionals]

Reference:

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- ISMP Canada Definitions of Terms. Accessed August 2022,23. https://www.ismp-canada.org/definitions.htm
- 4. WHO launches global effort to halve medication-related errors in 5 years. Accessed August 2022, 24. https://www.who.int/news/item/29-03-2017-who-launchesglobal-effort-to-halve-medication-related-errors-in-5-years

For more information:

Email: whocc@spsc.gov.sa

Website: Click here



