

## WHO World Patient Safety Day 2022 Event

### EHMA & IAPO Webinar: Medication Without Harm: Fostering Medication Safety in Hospitals

#### Summary Report

**Speakers:** **Dr András Süle**, President, European Association of Hospital Pharmacists (EAHP)  
**Mr Kawaldip Sehmi**, CEO, International Alliance of Patient Organisations (IAPO)  
**Ms Muriel Schneider**, Program Director, Global Self-Care Federation  
**Prof. Sandra Buttigieg**, President, European Health Management Association (EHMA), Consultant in Public Health Medicine and Chair of the Patient Safety and Quality Improvement Team at Mater Dei Hospital in Malta.

**Facilitator:** **Ms Anett Ruszanov**, Programme and Policy Director, EHMA

#### Background

This year's World Patient Safety Day, observed on 17<sup>th</sup> September, raised global awareness about **patient safety** and called for **solidarity** and united action by all countries and international partners to **reduce harm to patients** from Medication Errors. WHO's Global Safety Challenge was launched in 2017 with the ambitious objective of reducing severe avoidable medication-related harm by 50% by 2022. The guidelines have 4 domains, 3 action areas and 16 sub-domains as shown in Figure 1 below.



Figure 1. Strategic Framework of Global Safety Challenge

The webinar was co-organised by the European Health Management Association (EHMA) and the International Alliance of Patient 'Organisations (IAPO).

## Objectives

This webinar aimed to raise awareness of the **benefits of medication safety for all healthcare stakeholders in hospital environments**. It discussed the **advantages** of effective medication management and what **strategies**, and **tools** are required to reduce medication-related harm in hospitals in the key action areas of polypharmacy, high-risk situations, and transitions of care identified by the WHO as high-risk areas for the occurrence of a medication error.

## Unusual suspects of medication error

In the European region, patient harm from medications may exceed the risk from counterfeit medications, and to some extent medication shortages according to **Dr Sule**. Medication errors can occur in 50% of intravenous administration cases and above 40% during nursing ward dispensations. Medication safety and medication harm are amongst the most **under-researched, under-diagnosed** and **under-appreciated sources of risk** in health care professionals 'everyday practice. Contributors to patient harm from medication include medication logistics, preparation, compounding, dispensing and administration of medicine to patients. Lesser-known factors or the "unusual suspects" giving rise to a medication error include professional **miscommunication** and **mishandling of patient data** (both electronic and paper-based). These 'suspects 'arise in the daily **fragmented** practices in **health care delivery** between different settings of care, especially during transitions between different levels of healthcare systems. Medication management pathways in hospitals are delicately balanced, change constantly and are sensitive to time, location, and geopolitics. Errors caused by activities in the pathway have been hiding in plain sight for years, if not decades. The highest risk to patients from medication harm occurs during **transitions of care** including from hospital to community setting. To ensure seamless, error-free, care transitions patients and professionals must have access to individuals' medication therapeutic information, ideally already during the pre-hospitalisation period and after patient discharge. Quality management studies on medication-related errors place medication harm occurrences in the 'never 'category, however, they are not a never occurrence. Solutions including **technology**, the addition of **pharmacological expertise in the medication management process**, and systems to measure the problem's scale are available. Measurable **real-world data** and **real-world evidence** can be used to inform policy decisions on how best to reduce patient harm from medication errors in hospitals, so errors truly become a 'never 'occurrence.

## Patients' active participation

Patients should be better included and **empowered** in the medication process enabling to enable them to protect and advocate for their safety said **Mr Kawaladip Sehmi**. Patients need to be included in all patient safety matters. Patients and carers have a **right**, a **duty** and a **responsibility** to know all information about a medicine. Patients should be **active participants, remain vigilant** and **report** any issues which may result in harm from medication. This includes the impact a new medication may have on other medications and on **quality of life**. Easy access to medication therapeutic information can be facilitated by the implementation of **electronic records**. Electronic material can be adapted to the patient's needs ensuring that regardless of age, gender, culture, ability or background patients can access facts on their medication. Patients were encouraged to **participate in discussions with professionals** during medication reviews, to ask whether a medication **is still needed**, and why it is required. Inclusive stakeholder discussions to ensure compliance with guidelines for ending a medication were recommended. Patients were encouraged to create, and access, **strong peer groups** to access information and **participate in medication-related debates**.

## Health literacy and patient empowerment

Health literacy and patient empowerment can support better health decisions and prevent medication errors in self-care contexts advised **Ms Muriel Schneider**. **Self-care** products include non-prescription **medication, food supplements** and **medical devices**. Self-care is a daily, habitual ritual including decisions about our hygiene routines to self-administrating medication. Self-care can enhance patients 'quality of life and support healthcare sustainability and needs to be embedded in the healthcare system. Health literacy is a key enabler for self-care, patient empowerment and equity and affects a person's capacity to engage in self-care to protect and improve

their health. **Digital tools**, such as electronic Product Information (ePI) can enhance health literacy. Paper product information leaflets are currently used in combination with ePI. In the longer term, it is recommended that only **ePI** be used as it can provide up-to-date, adaptable (e.g. text size can be altered, videos and language translations incorporated) and trusted information to patients thus reducing harm from medication errors. Digital tools can address patients' unmet needs and empower patients to be more involved in healthcare decisions.

### Strategies and tools for implementation

**Prof Sandra Buttigieg** told the audience that 1.5 million preventable adverse drug events occur annually and every 1 in 150 patients admitted to a hospital dies from an adverse event in the U.S. In Europe, there is high variability across member states in the risk of suffering a medication error in acute care settings. Medication administration errors account for up to one-third of adverse events for children and nurses are more likely to be implicated when an error is not intercepted. A study by the European Collaborative Action on Medication Errors and Traceability (ECAMET), of which EHMA is a member, showed that in Europe, not all hospitals have digital tools to safely prescribe, dispense and prepare medication. Research from across Europe shows the impact of errors on health systems and that these errors are preventable. Healthcare managers can refer to the [WHO's strategic framework for patient safety from medication harm](#) to support reductions in medication errors and draw on their leadership, governance, and management skills to **encourage shared responsibility between healthcare professionals and patients** to reduce harm from medication. **Cultures of safety in hospitals** needed to be created to promote harm reduction to patients from medication. Introducing **digital tools** including medication barcode administration and **electronic Medication Administration Record (eMAR)** can reduce medication error rates by two-thirds as demonstrated by some hospitals. To tackle the problem of medication errors in hospitals implementing automated medicine cabinets, smart pumps and fully connected digital systems is required. Moreover, metrics systems based on an independent, audit, approach should be installed. **Real-world data** is required to provide more detailed information on what happens, where and what the roots of error are. Medication errors are a wicked problem that requires **collaboration amongst multiple stakeholders** to effectively tackle them.

### Take away messages

- **Invest** in digital tools, research, and real-world evidence collection to tackle the roots of medication errors.
- **Create** and foster cultures of safety in hospitals.
- **Initiate** more dialogue and collaboration between stakeholders who are likely to be involved in a medication error.
- **Fix** measurable indicators and results; **report** and analyse results to pave the way towards further improvements for patients.