# WHO World Patient Safety Day 2023 Event
# *EHMA, EUPSF, and EAHP* Webinar: Engaging Patients for Patient Safety: Educating and Reporting Medication Harm in Hospitals
# Summary Report

Speakers: Ms Elisabeth Garcia Hernandez, mother of Ane Sanz Garcia
Dr José Luis Cobos Serrano, Board Member, International Council of Nurses, Vice-President Spanish General Council of Nursing
Prof Dr Lasse Lehtonen, EHMA Scientific Advisory Committee Member, Helsinki University Hospital, Finland
Prof. Reinhard Strametz, Chair Patient Safety Head of Wiesbaden Institute for Healthcare Economics and Patient Safety (WiHelP), Affiliate Member, European Patient Safety Foundation
Ms Anna Prokupkova, Advisor on Health and Environment Policy, The Greens and the European Free Alliance Parliamentary Group,

Moderator: Dr András Süle, President, European Association of Hospital Pharmacists (EAHP)

## Background

This year's World Patient Safety Day, observed annually on 17th September, raised awareness on the importance of all stakeholders engaging with patients to improve medication safety in hospitals. It discussed the importance of ensuring that patients are informed about medication safety and know how to report an unintended medication error when it occurs. Patient and family engagement is one of the main strategies to eliminate avoidable harm in healthcare and **'Engaging Patients for Patient Safety'** was the defining theme for World Patient Safety Day 2023.

This webinar was co-organised by the European Health Management Association (EHMA), European Association of Hospital Pharmacists (EAHP) and the European Patient Safety Foundation (EUPSF).

## Objectives

This webinar raised awareness of the **importance of all stakeholders engaging with patients to improve medication safety in hospitals**. It discussed the importance of ensuring that **patients are informed about medication safety** and **know how to report an unintended medication error** when it occurs. In addition, it explored how healthcare professionals, including health managers, and policymakers can use **reports** to **improve medication management practices** and **prevent harm from medication errors**.

**Raise awareness of patient safety through strong collaborations and alliances** Healthcare services should not aim to only cure and treat patients but seek to do so with high quality standards and ensuring a no-blame culture. Emphasising the importance of patient safety within health systems, the **European Health Management Association (EHMA), European Association of Hospital Pharmacists (EAHP) and the European Patient Safety Foundation (EUPSF)** are determined to collaborate with organisations to raise awareness and address patient safety issues advised **Dr András Süle**. **80 million people in Europe** report experiencing a serious medication error during hospitalisation. This emphasises the need for healthcare professionals, patients, and the public to work together to create a resilient healthcare environment free from medication errors.

## Patient testimonial

This testimonial was shared by **Elisabeth Garcia Hernandez**, Ane Sanz's mother, who died 3 years ago due to a medication error that led to her untimely death. On commemorating this year's 2023 World Patient Safety Day, Ane's family hopes that this testimony will drive change as well as corrective measures to prevent similar harm to other patients and improve patient care in hospitals.

Ane was born prematurely, at 24 weeks in December 2019. Ane was placed in an incubator at the neonatal unit following her birth. On January 3rd, she began to experience a change in her general condition. Her health deteriorated and she began to experience a worsening in her condition. On January 4th, Ane's medical team decided to give her paracetamol and informed her parents of the possible harm paracetamol could cause. Indeed, her health worsened. Her kidneys stopped functioning and she developed sepsis. During this time, Ane had mistakenly been administered a powerful anaesthetic, propofol, instead of smoflipid, a lipid supplement. Miraculously, her kidneys started functioning again on the 6th of January but the prolonged administration of propofol over three days caused irreversible brain damage, leading to her death on the 8th of January. Two to three weeks after Ane's death, the hospital informed Ane's family that it had launched an internal investigation of the medication error. A few months later with the help of a lawyer, Ane's family launched an administrative complaint. The motivation for the complaint was and remains that corrective measures, procedures and/or protocols be implemented to prevent avoidable harm. Ane's family remains deeply grateful for the treatment, professionalism, and compassion with which Ane was treated during her hospitalisation. However, safety mechanisms failed and caused irreparable damage. Recently, after having another baby, had Elisabeth not been vigilant, she could have been given an expired medicine. Elisabeth concluded by telling the audience that nothing will give them back their daughter. However, she and her husband would be comforted to know that Ane's death helped implement safety measures to prevent harm from medication errors to other patients.

**Overcoming barriers to reporting medication harm** Medication processes are complex and often involve multiple professionals and stages from prescription to administration. Even in well-intentioned and professional healthcare settings, human errors can occur. **Dr José Luis Cobos** emphasised the need for robust safeguards and redundancies to prevent such errors. Sharing a tragic incident involving a nurse's error that led to a child's death, he underlined the complexity of factors contributing to medication errors. These factors include insufficient training, similar administration routes, complex medication processes, lack of patient engagement or understanding, similar medication appearance and time constraints. **Hospitals need to implement systems for reporting medication harm and errors**. These systems should **advocate for open communication of errors** including reporting mistakes even those that do not result in immediate harm to patients. Open communication of errors, however, should not lead to punitive measures but rather be leveraged as a learning opportunity, incorporating **positive corrective actions** and continuous training. **Digital tools** can be adopted to improve and ensure robustness in the prescription processes by detecting errors. **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 their medicine. Healthcare professionals were therefore encouraged to actively involve patients in their medication process to enhance safety. Likewise, **manufacturers were encouraged to differentiate medication packaging, labelling, shapes, and colours** of different drugs to avoid confusion by healthcare professionals.

**Leveraging healthcare managers' leadership and governance roles for patient empowerment** Since 2011, all hospitals in Finland are obliged to have a patient safety plan. At Helsinki University Hospital (HUS), the plan includes voluntary safety incident reporting. Safety incidents can be reported by both healthcare professionals and patients. Ultimately, patient safety measures are implemented based on

incident reporting data. To address drug safety issues, Helsinki University Hospital started systematically conducting medication reconciliation and medication reviews, hiring hospital pharmacists to assist busy departments to identify and monitor high-alert medications, such as opiates, anticoagulants, and insulins, and increase expertise in the administration of these medicines. This electronic medication management system has helped reduce administration and dispensing errors. **Prof Dr Lasse Lehtonen** emphasised the importance of **creating standards of practice and expectations for a safety culture** within healthcare units and **urged healthcare managers to collect data** on safety incidents and **foster a no-blame culture** to encourage reporting. In addition, healthcare managers should **ensure patient involvement** in their treatment decisions, **basing safety actions on evidence**, **testing safety systems** before implementation, **allocating adequate resources**, and setting and revising standards to improve hospital safety cultures.

**The importance of patient engagement and education in medication safety** In the context of medication errors, **Prof. Dr. Reinhard Strametz** said that educating patients about existing systems to prevent such errors within hospitals is paramount. By providing patients with insights into medication processes, from prescription to administration, they are empowered to become active partners in their own care and act as a last line of defence against errors as demonstrated by Reason's Swiss cheese model. Patient education on reporting medication errors promotes transparency by helping patients overcome hesitancy or fear of communicating errors. Patient reports help identify root causes of errors, address systemic issues, and provide a human perspective, reminding us of the real-life consequences of errors beyond clinical parameters. A recent OECD report on The Economics of Medication Safety estimates that **1 in 10 hospitalisations** in OECD countries may be caused by a medication-related event. **One in five inpatients** experience medication-related harms during hospitalisation. Together, costs from avoidable admissions due to medication-related events and added length of stay due to preventable hospital-acquired medication-related harm total over USD $54 billion in OECD countries. This is equivalent to 11% of total pharmaceutical spending across those 31 OECD countries. **Prof. Dr. Reinhard Strametz** recommended additional strategies to reduce harm from medication errors including **implementing technological advancements**, **fostering multi-professional collaboration, providing continuous training, implementing robust medication reconciliation processes,** and **introducing digital engagement tools**.

**Leveraging EU Pharmaceutical legislation reforms to promote patient safety** Patient and healthcare professional engagement in decision-making processes, along with the importance of proper education and training for their meaningful participation in legislation reform discussions are encouraged. **Ms Anna Prokůpková** emphasised the importance of policymakers engaging with patients, caregivers and different patient safety advocacy groups in healthcare legislation discussions to incorporate their perspectives into reforms.

At the European level, challenges of addressing healthcare issues exist however the role of member states in healthcare matters remains critical. **Ms Anna Prokůpková** stressed the significance of focusing on the right tools and timing to have the most significant impact. Health and digital data literacy can enhance patient safety. Ongoing legislative efforts, such as the European Health Data Space (EHDS), aim to empower patients to have control over their healthcare data. Information sharing and the need for a balance between digital and paper-based information can contribute to patient safety.

The pharmaceutical directive and regulation puts an emphasis on pharmacovigilance which aims to put in place a robust system at industry and member state level. Through the EudraVigilance database, the European Medicines Agency monitors data on adverse effects and raises safety concerns. The issue of an overburdened healthcare system with a shortage of professionals is still a critical challenge. Active

engagement with legislators and input to improve ongoing initiatives and legislation was encouraged underlining the importance of knowing how and when to leverage legislation and policymaking as a tool for change.

## Discussion

This year's theme for Patient Safety Day 2023 'Engaging Patients for Patient Safety' aligned with the concept of endorsing **person-centered care**. This approach, **Prof Sandra C. Buttigieg, President of EHMA,** said views patients as active members of the healthcare team with their own capabilities and resources, making **a paradigm shift from traditional patient-centered care** where patients are seen as passive recipients of care. The approach also emphasises the importance of documenting the patient's perspective and the value of patients and caregivers, like Elisabeth, who actively contribute to their care.

According to **Mr Denis Herbaux**, **a European Patient safety strategy focusing on medication-related errors and healthcare-related harm would be highly beneficial. Mr Denis Herbaux, CEO, Platform for the Continuous Improvement of Quality and Care and Patient Safety (PAQS), Belgium,** emphasised that patient safety is not just about medications, but also about addressing adverse events globally and improving safety culture and the quality of care. **Ms Anna Prokůpková** suggested focusing on amending existing legislation to concretely address the desired outcome by enhancing this legislation with specific language and requirements to ensure practical implementation at the national level.

## Take away messages

- **Establish** a patient-provider partnership that empowers patients to actively participate in their care, make decisions and speak up if they notice issues.
- **Create and foster** psychologically safe environments within standards of practice and expectations for all healthcare professionals to openly communicate medication errors irrespective of their profession and grade.
- **Collect data and implement digital tools** for patient safety. Digitalisation is an important competence for health managers to leverage and make use of, to support reporting of medication errors.
- **Engage** patients in legislation reforms at the European level to provide guidance and support to countries that currently lack their own patient safety strategies, facilitating both strategy development and implementation.
- **Ensure** actions for enhancing patient safety are **evidence-based**, valuing both patient and professional expertise for practical effectiveness.