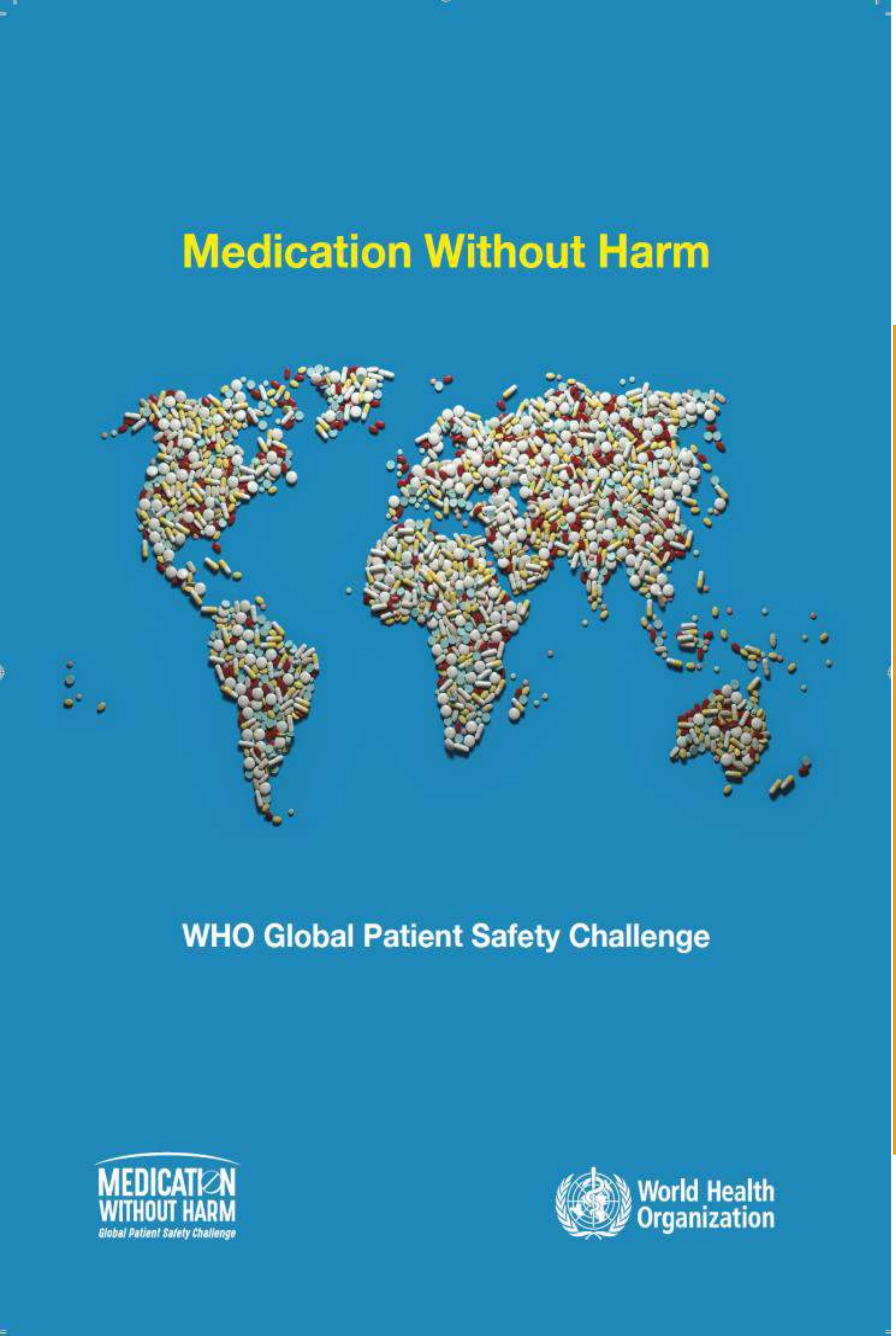

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

Introduction to the WHO Global Patient Safety Challenge: *Medication Without Harm*

Sir Liam Donaldson
WHO Envoy for Patient Safety

08 February 2022

First story of medication-related harm

Department of Health

External Inquiry into the adverse incident that occurred at Queen's Medical Centre, Nottingham, 4th January 2001

by

Professor Brian Toft
BA (Hons) Dip Com Sci (Cantab) PhD
MInstD FIRM FIIRSM FIOSH Hon FICDDS

The seeds of destruction

Pre-filled syringe containing Vincristine illustrating the warning written in blue text


Everything ok?

Vincristine: The trail continues

Check for updates

JOURNAL OF ONCOLOGY PHARMACY PRACTICE

Original Article

J Oncol Pharm Practice
0(0) 1–9
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Safe vincristine use in Switzerland: Still a long way to go?

Lea D Brühwiler[1] and **David LB Schwappach**[1,2]

Abstract

Background: Different international organizations recommend safety measures for the use of vincristine to prevent wrong route administrations. A central recommendation is to use infusion bags instead of syringes to prevent confusion with intrathecal chemotherapy. This study aimed to investigate the implementation of safety measures for vincristine and intrathecal chemotherapies in Switzerland.
Method: We conducted a written survey among hospital pharmacies of all general care and pediatric hospitals in Switzerland (n = 102). A responsible person of each hospital pharmacy was invited by email to participate in the online survey in May 2018.
Results: Of 66 responding hospitals (response rate 65%), 27 have a hospital pharmacy preparing parenteral chemotherapy. All of these hospitals prepared vincristine in 2017, while 21 also prepared intrathecal chemotherapy. Of these 21, 16 hospitals prepared vincristine as syringes, with small volume syringes being the most widely distributed dosage form. A switch from syringes to infusion bags was discussed in seven hospitals, and discussions led to plans for switch in two. The most prevalent safety measures were labeling for vincristine and special delivery for intrathecal drugs. Of hospitals preparing both vincristine syringes and intrathecal chemotherapy, four reported to have no safety measures implemented neither for vincristine nor for intrathecal chemotherapy.
Conclusion: International recommendations are not widely implemented in Swiss hospitals. Syringes are still in use and other safety measures are sparsely disseminated. Thus, Swiss vincristine patients are still at an increased risk for wrong route application. Recommendations have to be further disseminated and implementation could be enhanced.

Keywords

Vincristine, spinal injections, medication errors, patient safety, surveys and questionnaires

Date received: 11 December 2018; accepted: 12 February 2019

Introduction

Over 100 cases of inadvertent intrathecal instead of intravenous administration of vincristine have been reported worldwide since vincristine is in use, with a fatal outcome in the vast majority of patients.[1–5] Invariably patients die or suffer considerable morbidity. The reasons why these errors happened are not always known. In a literature review, Gilbar et al. identified the following possible reasons:

> [...] mistaking vincristine for intended intrathecal medication, mislabeling of syringes, i.v. and intrathecal drugs brought into treatment area at the same time, inexperienced medical staff, patient not treated in a specialist unit, treatment given out of normal hours, administration order not checked and an incomplete warning label.[3]

Different organizations such as the World Health Organization (WHO),[2] the Institute for Safe Medication Practices (ISMP),[6] the International

[1]Swiss Patient Safety Foundation, Zurich, Switzerland
[2]Institute of Social and Preventive Medicine (ISPM), Faculty of Medicine, University of Bern, Switzerland

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Second story of medication-related harm

HSIB

WWW.HSIB.ORG.UK

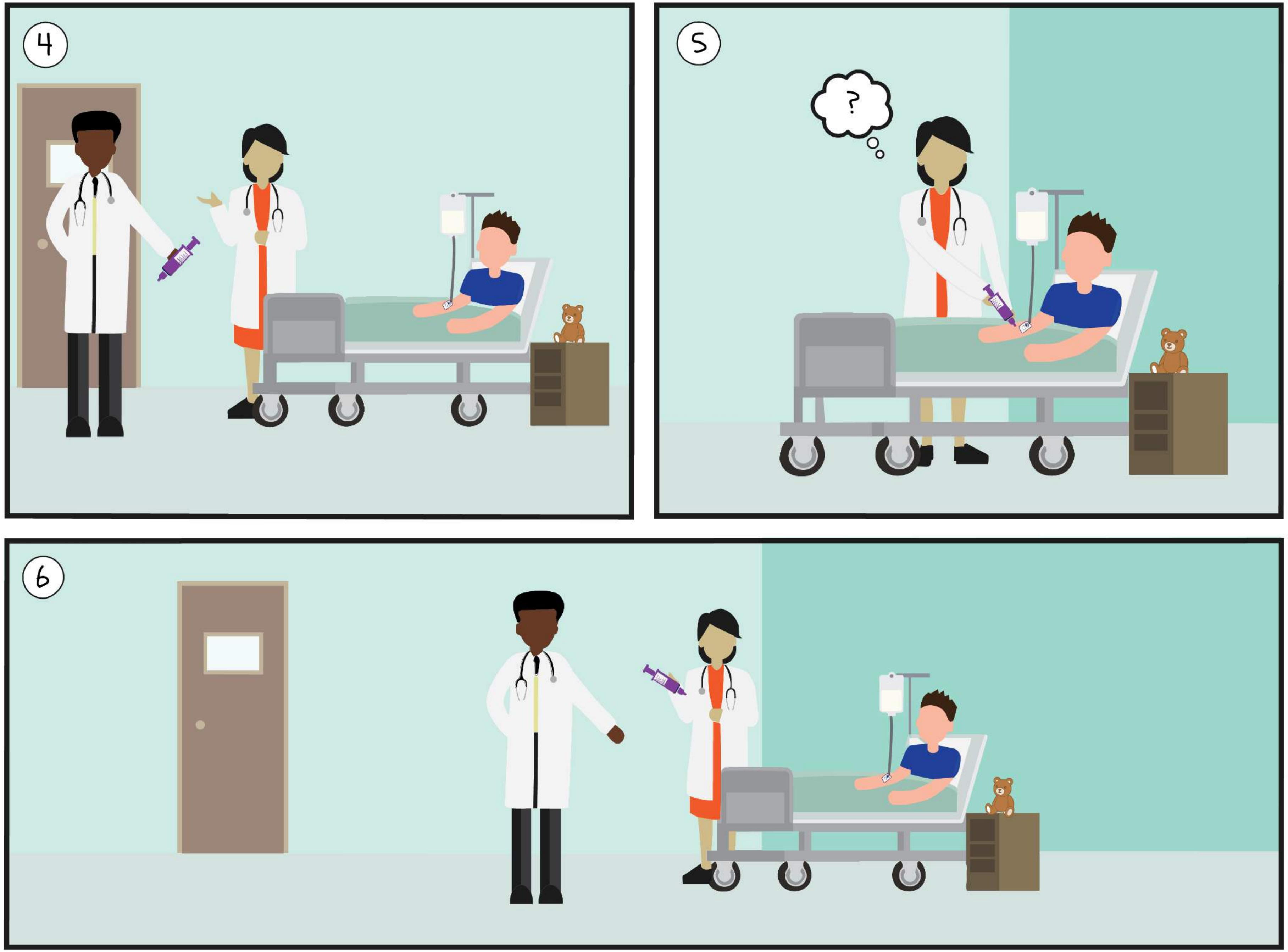
INADVERTENT ADMINISTRATION OF AN ORAL LIQUID MEDICINE INTO A VEIN

I2017/009

Independent report by the
Healthcare Safety Investigation Branch

April 2019 Edition


1
2
IV
Midazolam
3
CHECKLIST
I only know
the oral kind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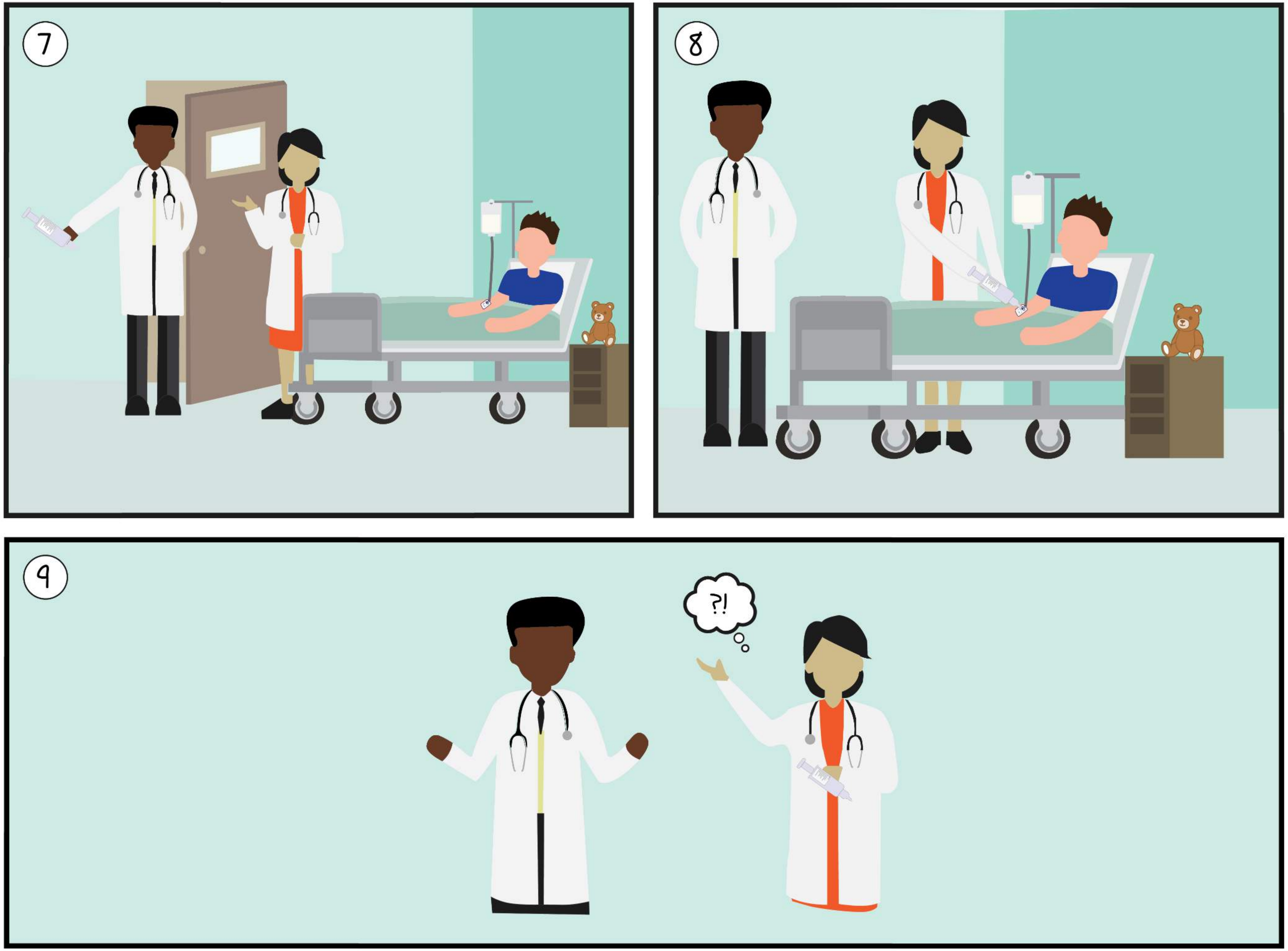
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?!

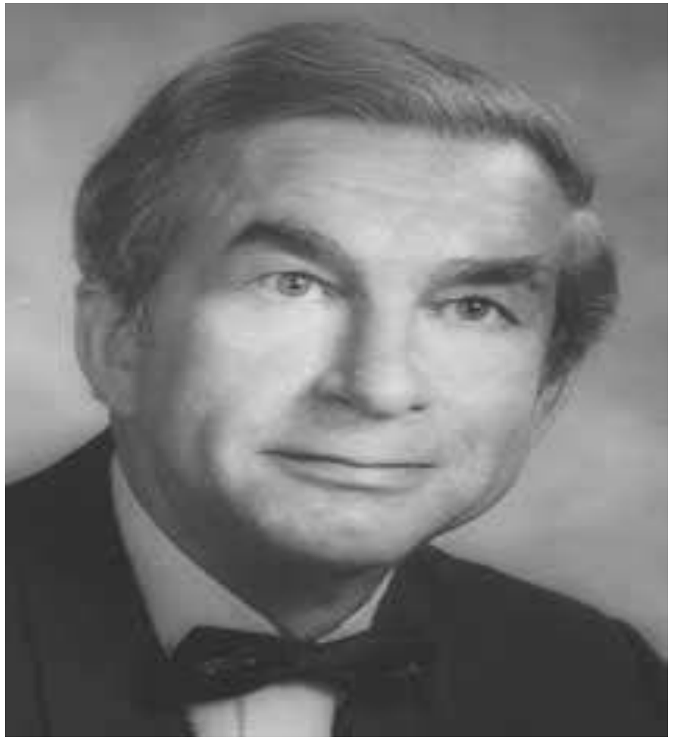

FOR ENTERAL FEEDING/MED ONLY
1 2 3 4 5 6 7 8 9 10ml


31 incidents of oral medication being given intravenously in NHS in two years (2016/18)

What can be learned from the two stories?

Seven sources of medication errors in 1961

- Medicine omitted
- Given to wrong patient
- Wrong dose
- Unintended extra dose
- Wrong route
- At wrong time
- Wrong drug entirely



ALPHONSE CHAPANIS
(1917-2002)

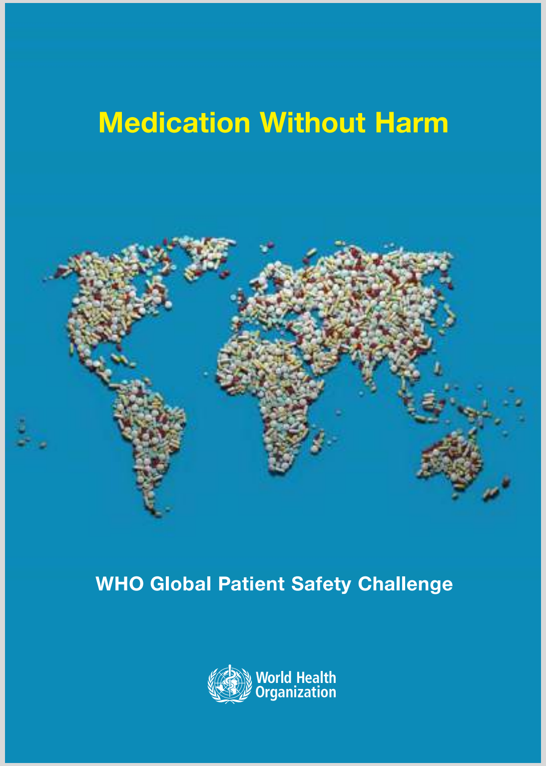
Safety failings can have devasting consequences

- Patients can die
- Patients can be injured physically and psychologically
- Families can be destroyed
- The confidence of clinical teams can be undermined
- The reputation of a service can be lost
- Costs can be high

The Third Global Patient Safety Challenge

Medication without harm

Patient Safety Challenges



Planning and Designing the 3rd WHO Global Patient Safety Challenge

Medication Without Harm (2016)

Expert Consultations and Working group meetings

Goal of the *Challenge*

Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally

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Global Patient Safety Challenge

Objectives of the *Challenge*

- **RAISE** awareness of the problems of unsafe medication practices and medication errors, and *the Challenge* as a vehicle to address this issue
- **DEVELOP** guidance/materials/technologies/tools to support the setting up of safer medication use systems for reducing errors
- **BUILD** capacities of health systems to reduce the risk of medication-related harm
- **EMPOWER** patients/families to become actively engaged in decisions, ask questions, spot errors, manage their medications
- **ENGAGE & SEEK COMMITMENT** of key stakeholders /partners/industry to raise awareness of medication-related harm and support implementation of *the Challenge*

WHO Global Patient Safety Challenge

Medication Without Harm

Global Launch, 29 March 2017

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Global Patient Safety Challenge

Shaping the *Challenge*: the Strategic Framework

Patients	Medicines
Health professionals	Systems

Domain 1: Health care Professionals

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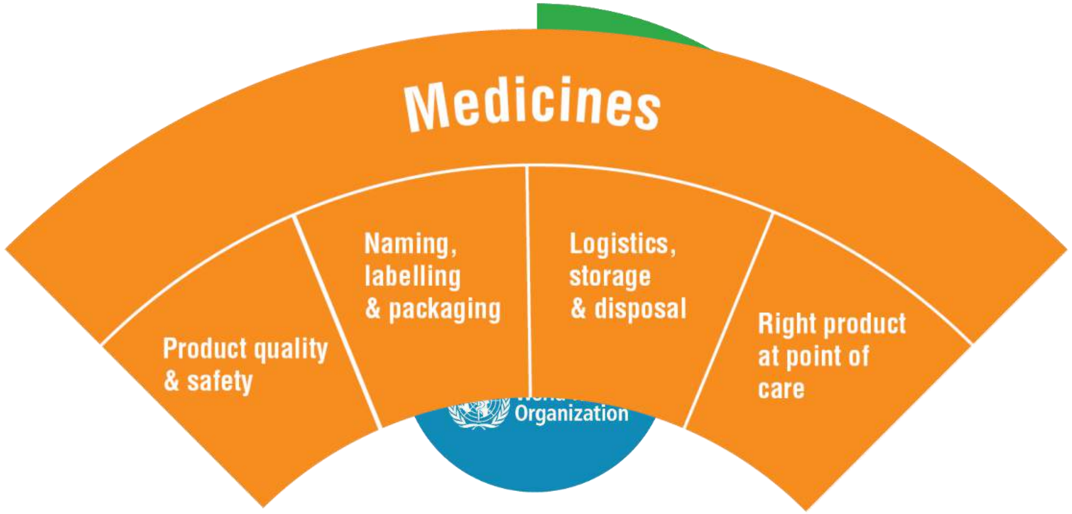
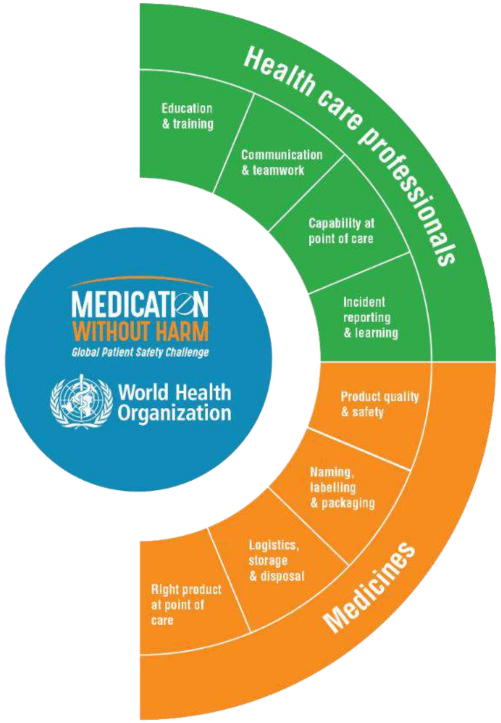
Domain 2: Medicines




Health care professionals
Education & training
Communication & teamwork
Capability at point of care
Incident reporting & learning
Medicines
Product quality & safety
Naming, labelling & packaging
Logistics, storage & disposal
Right product at point of care
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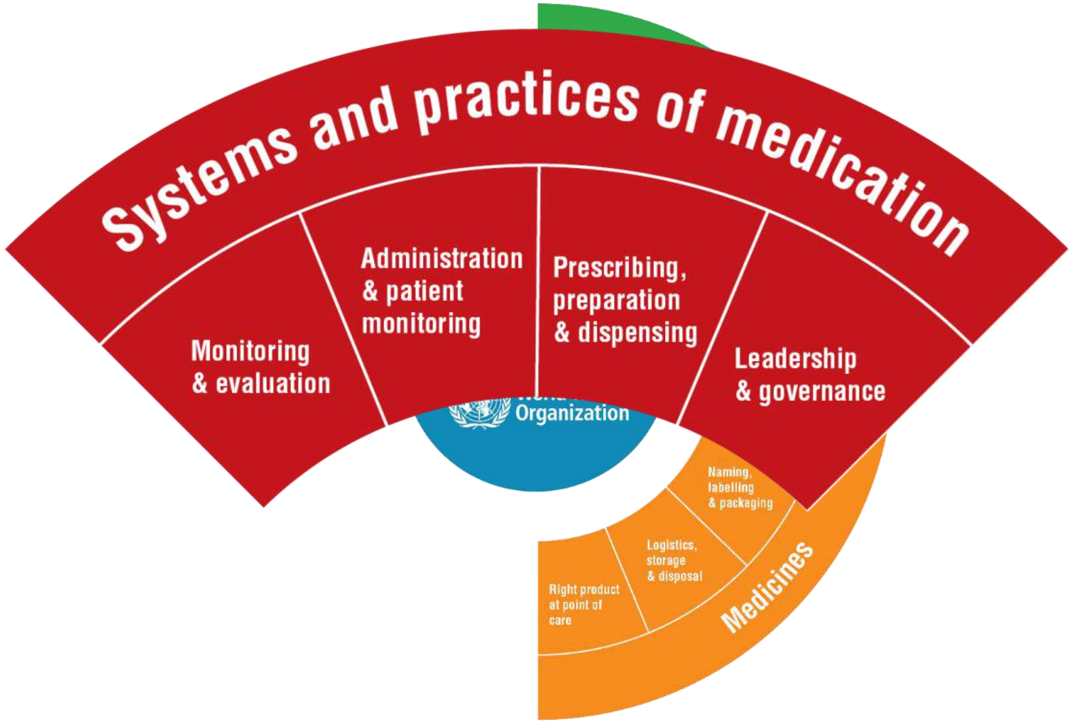
Domain 3: Systems and Practices of Medication




Health care professionals
Education & training
Communication & teamwork
Capability at point of care
Incident reporting & learning
Medicines
Product quality & safety
Naming, labelling & packaging
Logistics, storage & disposal
Right product at point of care
Systems and practices of medication
Leadership & governance
Prescribing, preparation & dispensing
Administration & patient monitoring
Monitoring & evaluation
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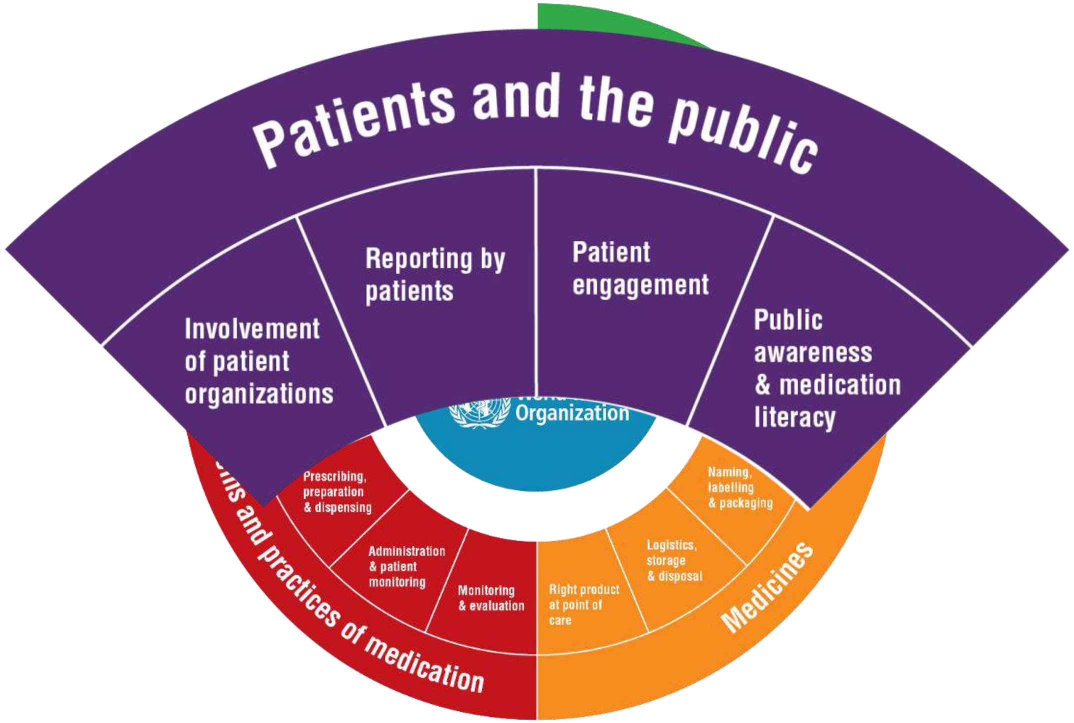
Domain 4: Patients and the Public



The 4 Domains of the Strategic Framework

Key Actions Areas

- High-risk situations
- Polypharmacy
- Transitions of Care

Expert Consultation: Global action to support implementation 2017, Geneva

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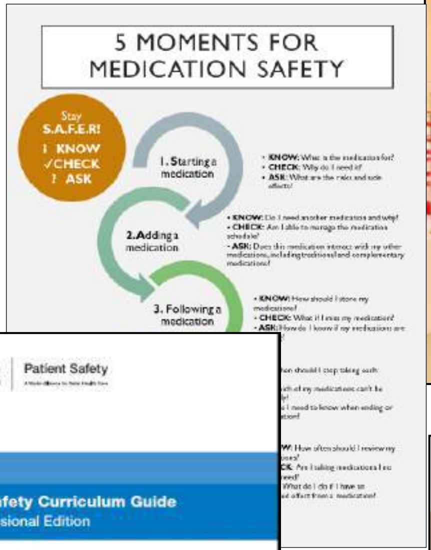
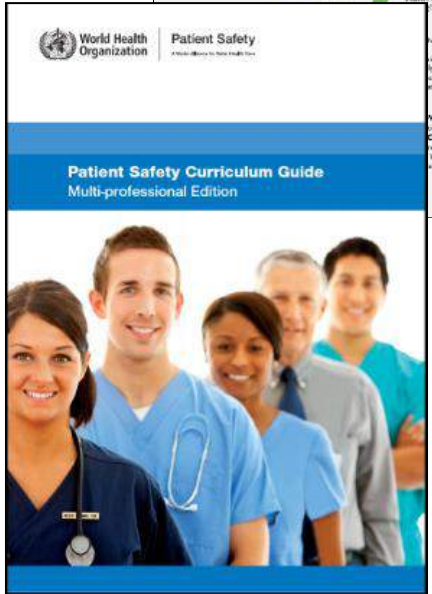
- **Education and training** in medication safety
- Evaluation tools and methodologies for **measuring** progress and impact of the *Challenge*
- **Patient Engagement Tool**: "5 Moments for Medication Safety"
- **Research priorities** in medication safety





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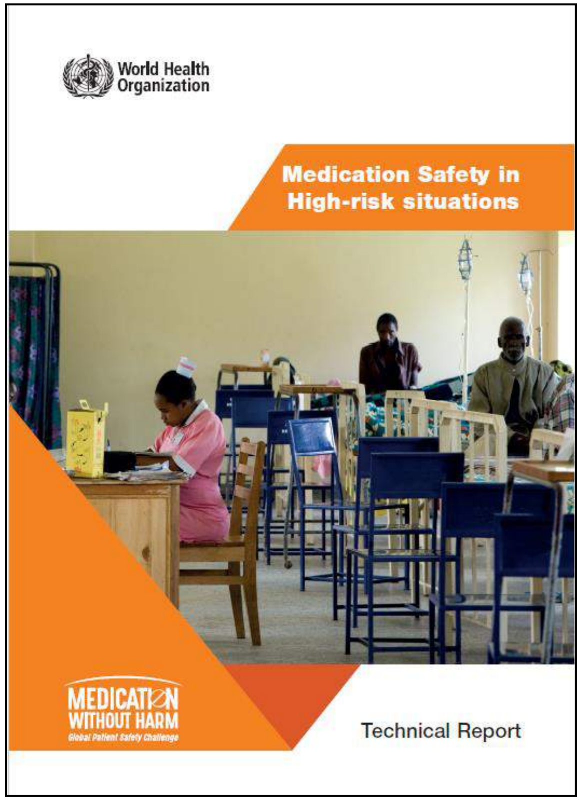
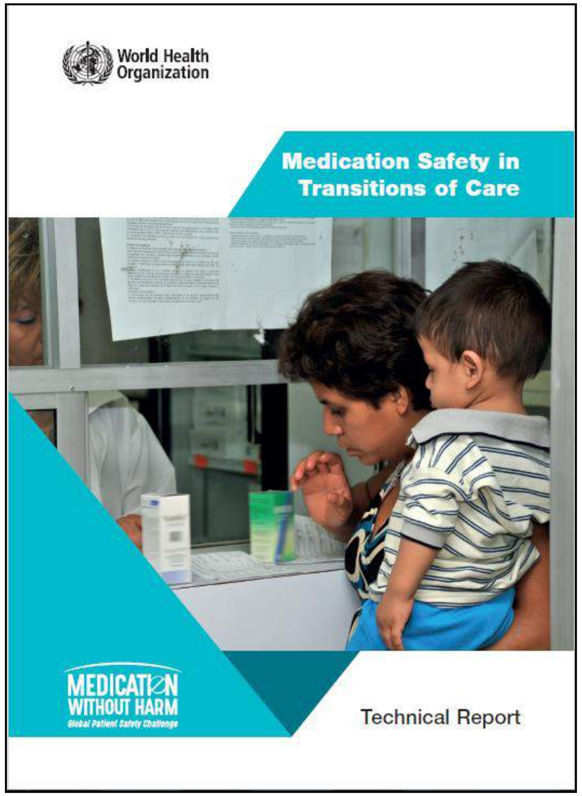
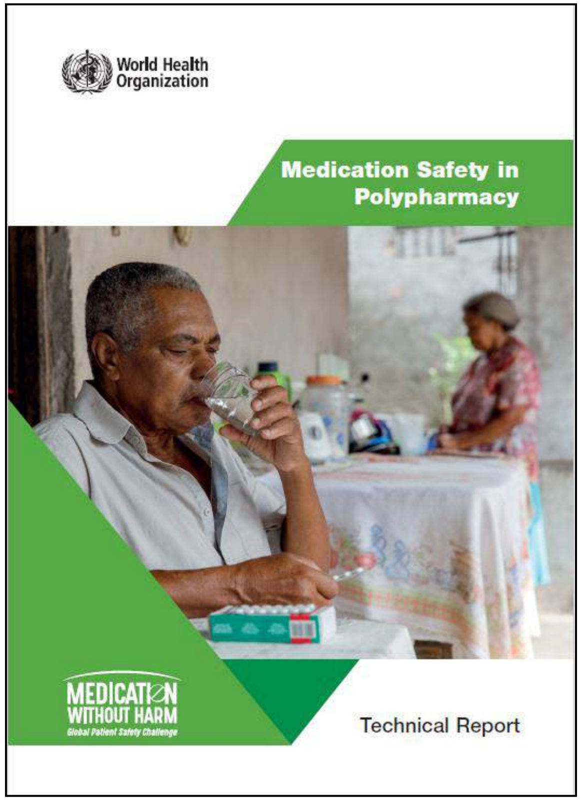
Early Priority Action – Technical reports







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Key Action Areas: National

Early priority actions

Ask countries and key stakeholders to make strong commitments, prioritize and take early action, and effectively manage three key areas to protect patients from harm, namely:

- high-risk situations
- polypharmacy
- transitions of care

Developmental programmes

Ask countries to convene experts, health professionals and leaders, stakeholders and patients to design targeted programmes of change

Take action to improve safety in each of the four domains of the Challenge framework:

- patients and the public
- medicines
- health care professionals
- systems and practices of medication

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The success of the *Challenge* depends on…

- High prioritization of medication safety within health care systems
- Achieving widespread buy-in by stakeholders
- A shift to the mainstream of care provision activities
- Taking concrete actions to prevent harm
- Creating a social movement with involvement of all stakeholders

Join us in achieving...

Medication Without Harm

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