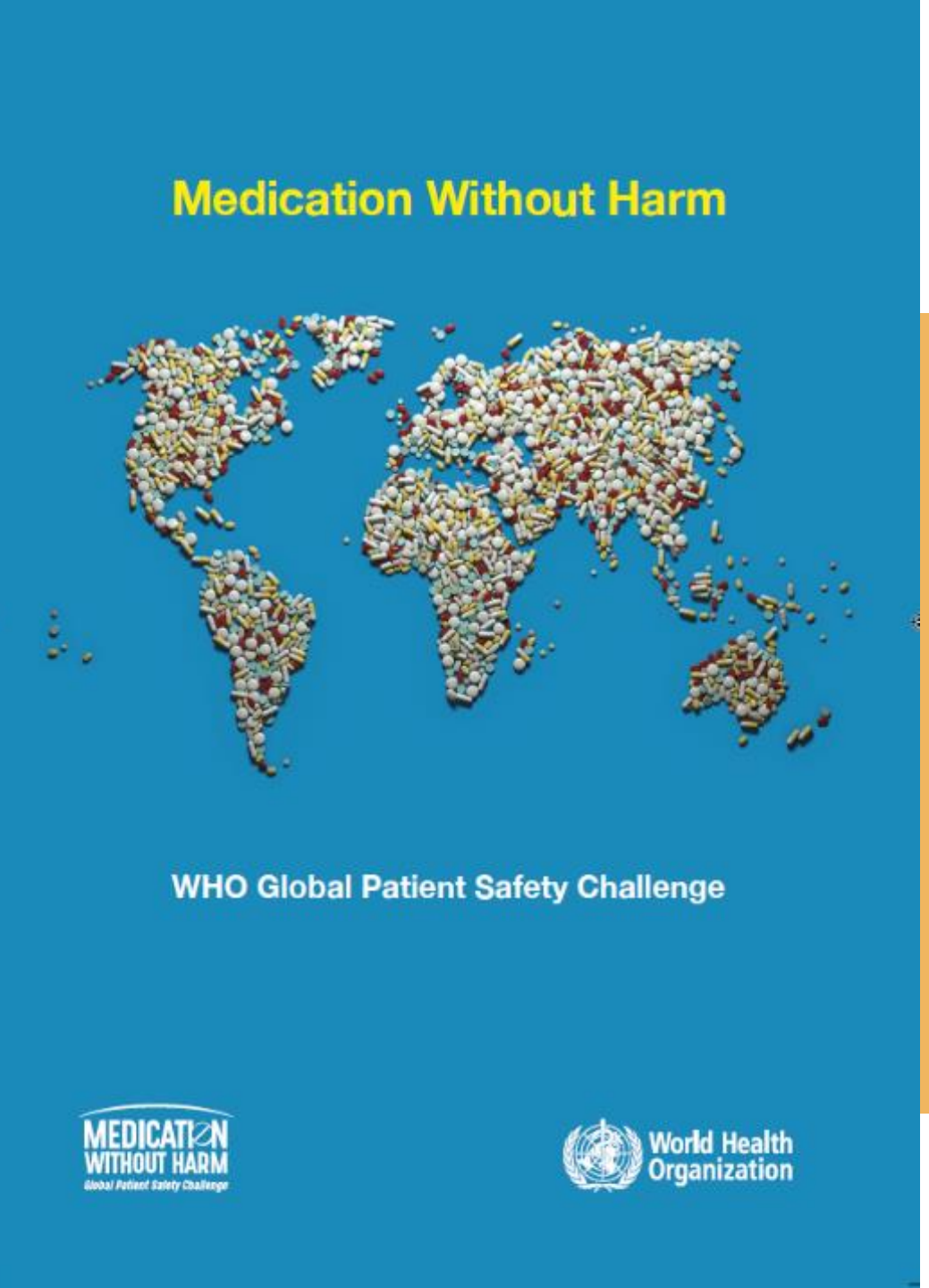


World Patient Safety Day 17 September 2022

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

The role of the health and care workers in reducing medication errors and medication-related harm

Pharmacists

Ms Zuzana KUSYNOVÁ
Lead for Policy, Practice and Compliance
International Pharmaceutical Federation (FIP)

15 September 2022

The role of pharmacists in reducing medication errors and medication-related harm

Zuzana Kusynová
Lead for Policy, Practice and Compliance

FIP's commitment

Long term partnership with WHO

Technical work

Policy work

fip International Pharmaceutical Federation | ADVANCING PHARMACY WORLDWIDE

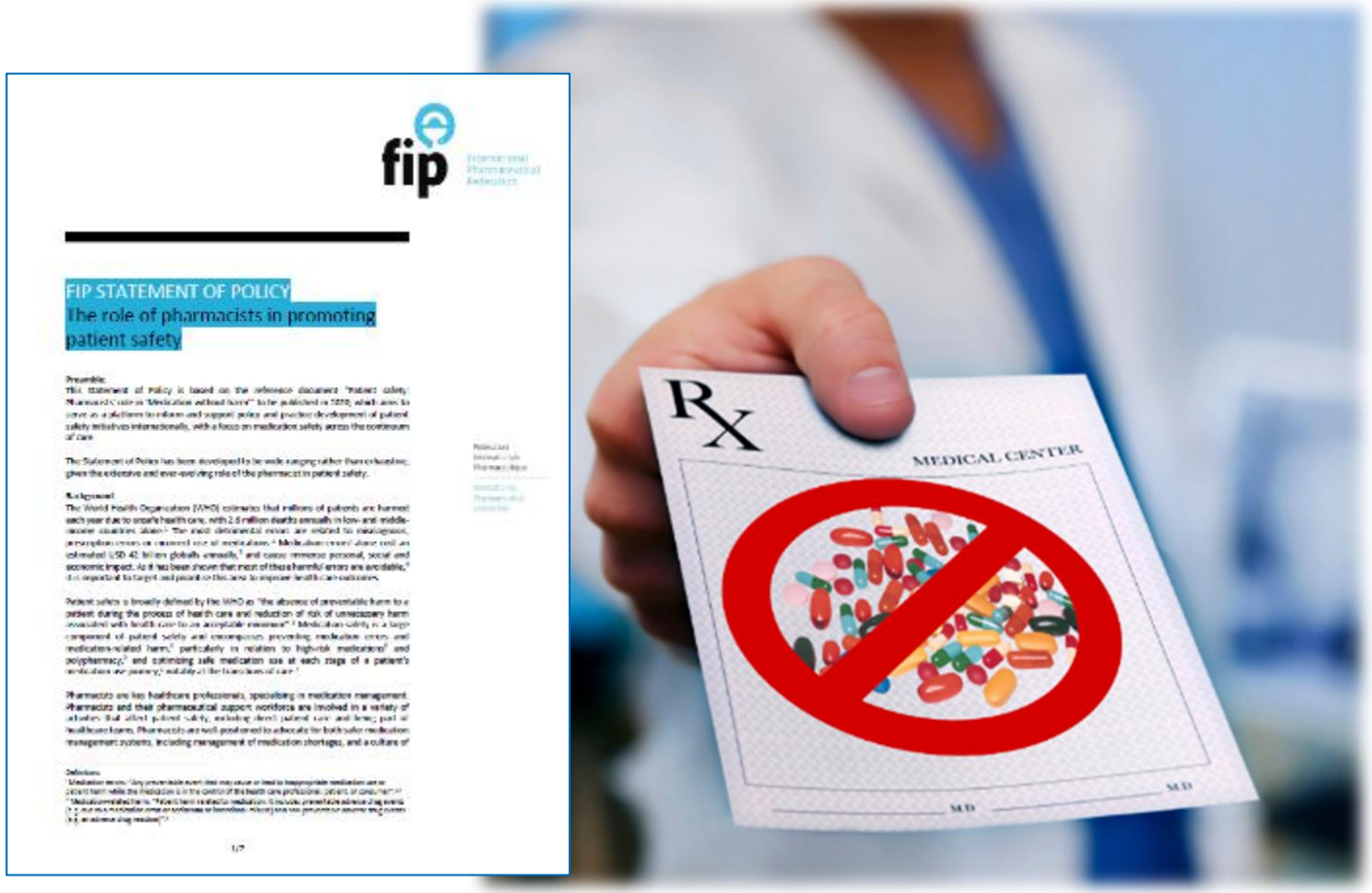
FIP Statement of policy

Patient safety

FIP's commitment to patient safety & recommendations for:

- *Practicing pharmacists*
- *Pharmaceutical scientists*
- *National pharmacy organisations*
- *Industry partners*
- *Academia and educators*

Adopted by 140+ pharmacy organisations around the globe



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Patient and Medication Safety

Recommendations

Minimising avoidable harm:

- ✓ Using the evidence to implement just culture
- ✓ Collaborating with other health professional associations to implement interprofessional strategies to foster close working relationships
- ✓ Developing educational tools to support appropriate pharmacist workforce development and safety culture
- ✓ Developing new services and health programmes while securing appropriate remuneration models
- ✓ Advocating for access to patient medication history
- ✓ Empowering and engaging patients to ‘Know, Check, Ask’ about their medications
- ✓ Advocating locally and globally for the importance of pharmacists in patient safety

Pharmacists can improve patient safety by promoting patient engagement, interprofessional collaboration and a safety culture to reduce avoidable harm caused by medication errors

fip International Pharmaceutical Federation | ADVANCING PHARMACY WORLDWIDE

Patient and Medication Safety

Recommendations

Minimising avoidable har

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Pharmacists can improve patie

and a safety cul

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sed by medication errors

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Minimising preventable harm

Pharmacists' role

Pharmacists are well-positioned to minimise safety risks related to the entire medication use process by:

- Safeguarding accurate supply of medicines
- Validating appropriateness of prescription at initiation of treatment
- Ensuring correct medication use: drug-drug/food interaction and adherence barriers, educating patient
- Assisting interdisciplinary teams during the medication selection, use and follow-up
- Warranting safety in transitions of care between health care units and the community

FIP Reference Document on Patient and Medication Safety. Available from: fip.org/publications

fip International Pharmaceutical Federation | ADVANCING PHARMACY WORLDWIDE

Minimising preventable harm

Pharmacists' role

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- Saf
- Validating appr
- Ensuring cor
- Assisting interdisciplin
- Warranting safety in transitions of care between health care units and the community

- Individual patient level: **medication journey**, role as **patient advocates** and members of health care **teams**;
- **Evidence** of the positive **impact;**
- Parallels with other **"*safe*" industries**;
- Changes needed in the health care systems and practices: **redesigning systems or services collaboratively** between all key stakeholders;
- **Mapping** exercise: Case studies from 8 countries

FIP Reference Document on Patient and Medication Safety. Available from: fip.org/publications

Promoting a Safety Culture

Why is healthcare hesitant to report adverse events?

”Blame Culture”

- *Individuals responsible blamed & suffer consequences → encourages covering up of errors in fear of retribution.*

Healthcare culture needs to shift

FIP digital events on patient safety

”Safety/Just Culture”

- *Focuses on identifying system flaws that can be resolved*
- *The goal is promoting patient safety*
- *An integrated pattern of individual and organizational behavior*

FIP Resources

Toolkits for practitioners

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Conclusions

Commitment of pharmacists

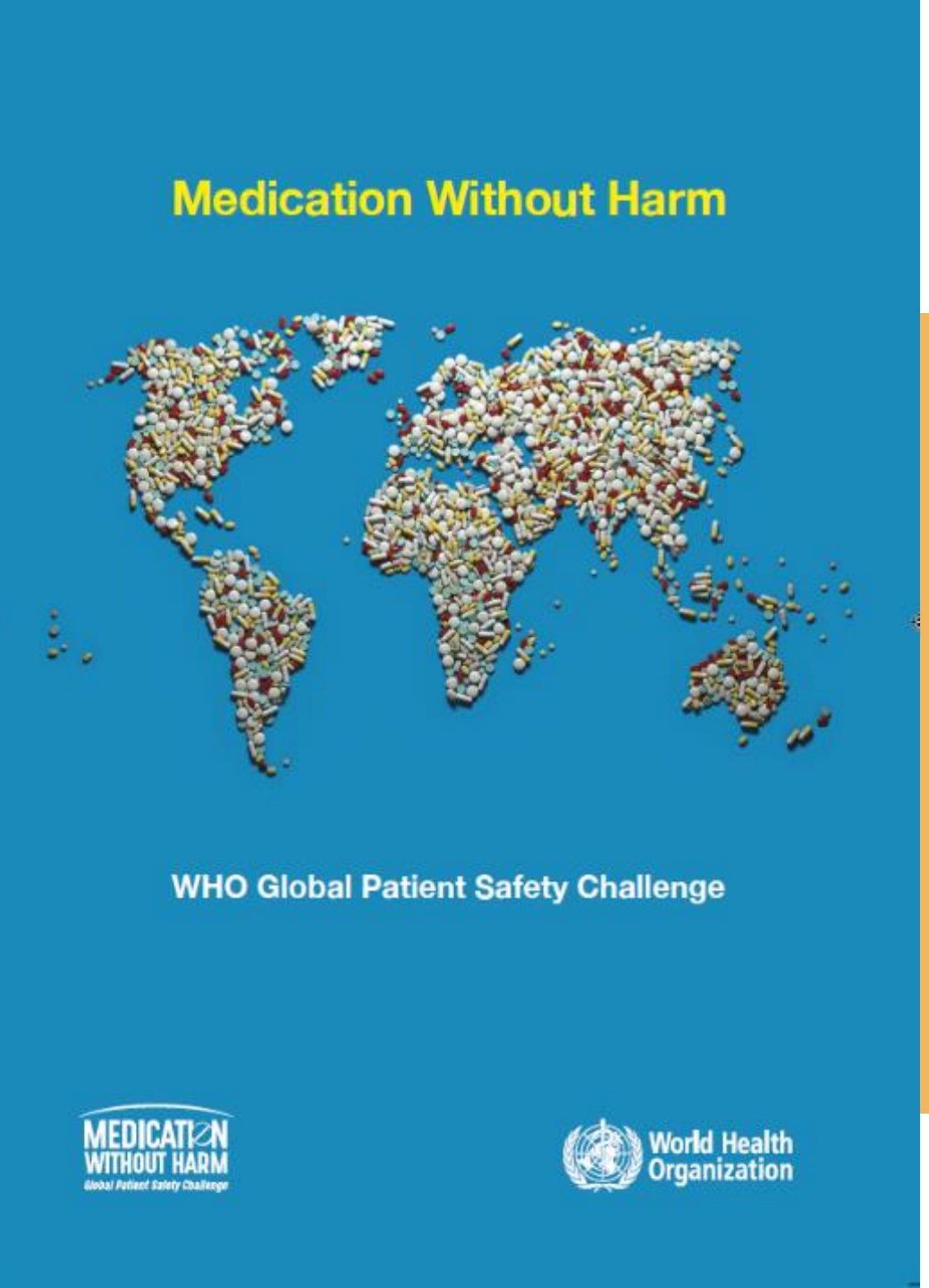
- Pharmacists are in a unique position to address the challenges related to medication use.
- They are well-positioned to minimise safety risks related to the entire medication use process.

- Pharmacists can improve patient safety by promoting patient engagement, interprofessional collaboration and a safety culture to reduce avoidable harm caused by medication errors

- FIP is representing voices of over 4 million pharmacists around the globe – visible commitment through collaboration with partners, and at supporting pharmacists both at individual and systems/policy level

#WPSD2022


Questions?



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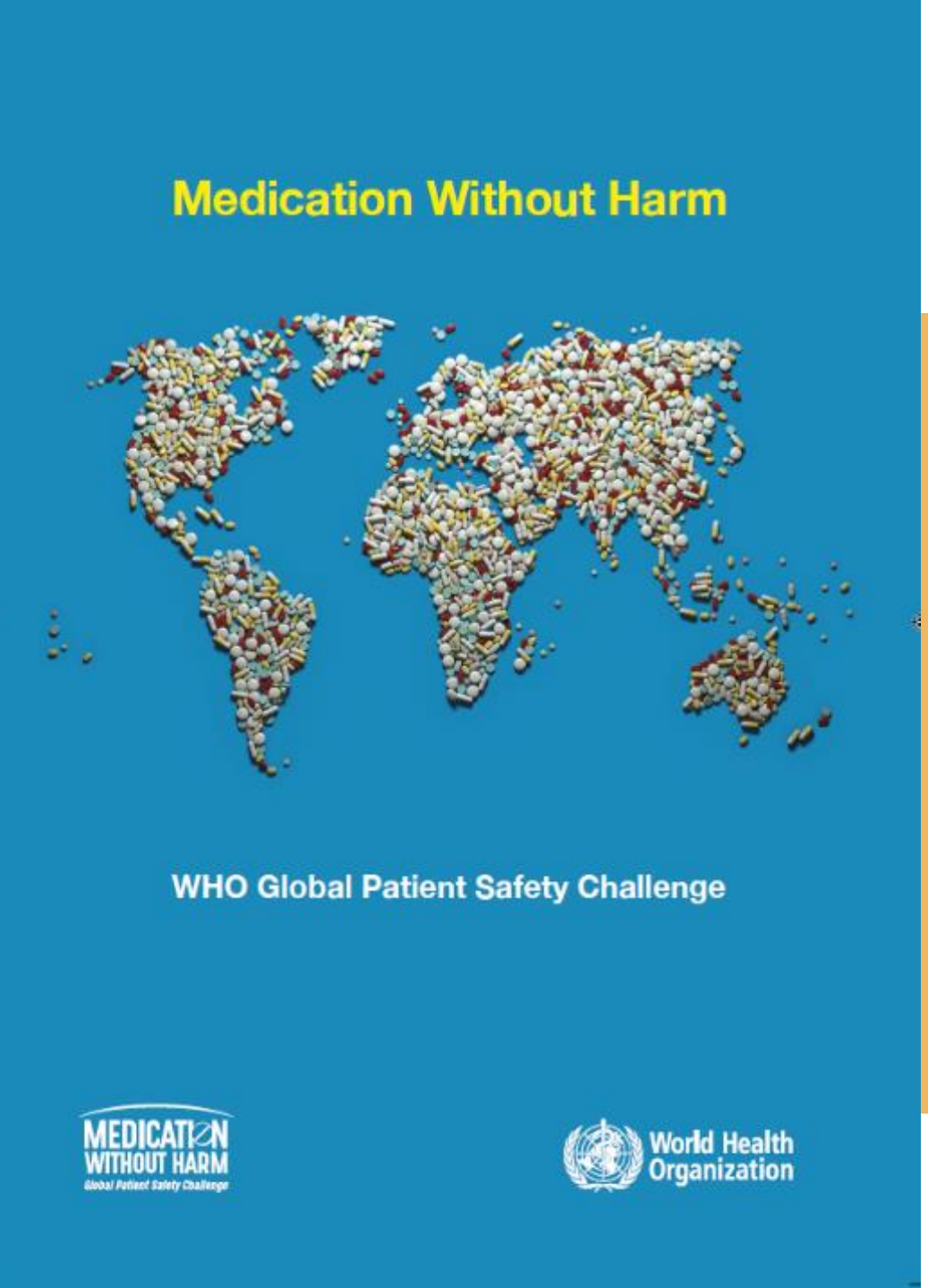
Message on World Patient Safety Day 2022 from the WHO Regional Office for the Eastern Mediterranean

Dr Ahmed AL-MANDHARI
WHO Regional Director for
Eastern Mediterranean

15 September 2022



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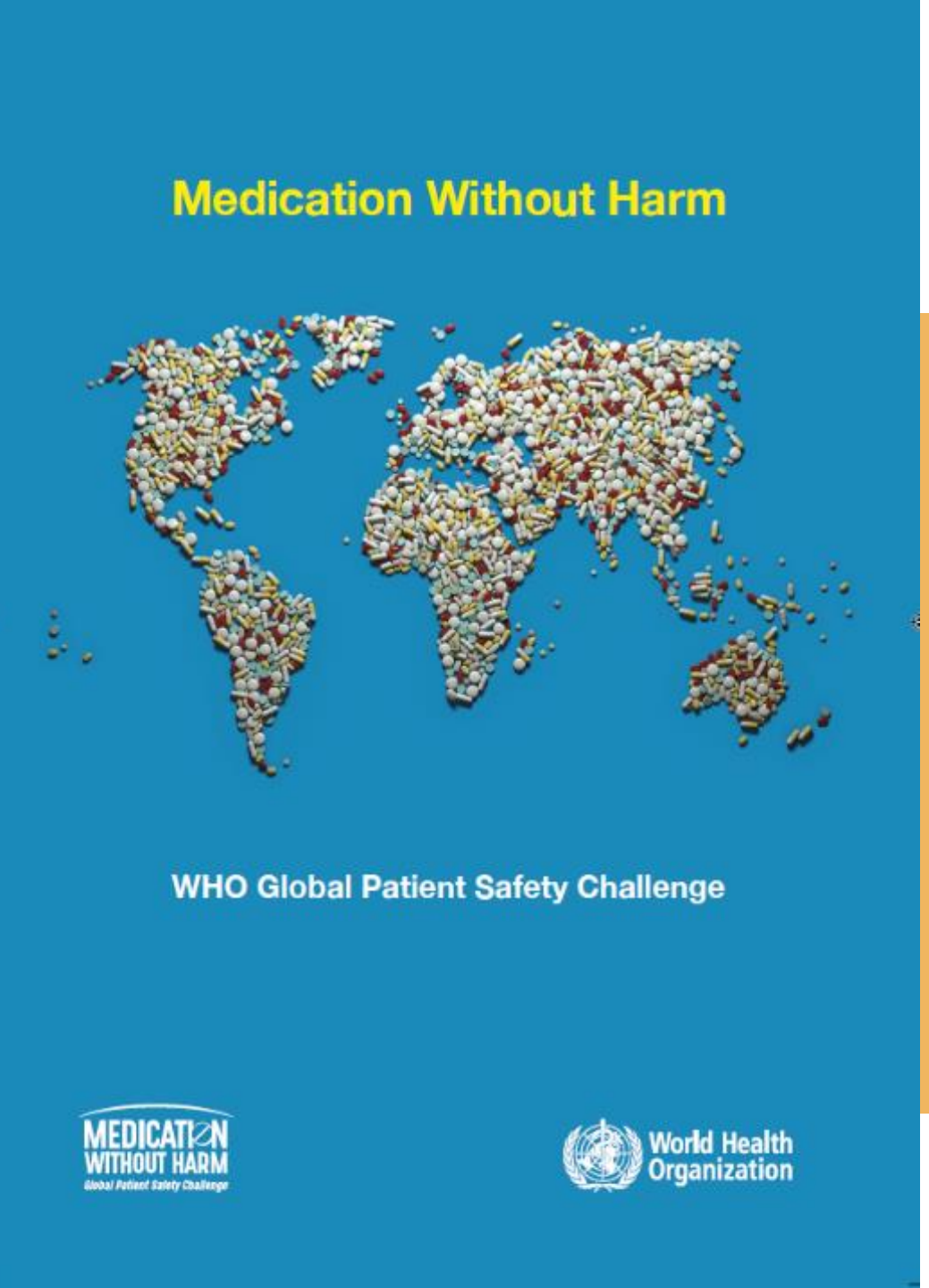
World Health Organization

Session 3

Medication safety: medicines as products

Chair: Dr Shanthi PAL
Team Lead
Pharmacovigilance, Regulation and Prequalification department
WHO headquarters, Geneva

15 September 2022



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Global Patient Safety Challenge

World Health Organization

Naming, labelling and packaging solutions to avoid LASA errors

Prof Hisham S. AL JADHEY
Executive President
Saudi Food & Drug Authority
Saudi Arabia

15 September 2022

Kingdom of Saudi Arabia
Saudi Food & Drug Authority

SFDA Naming, Labelling and Packaging Solutions to Avoid Medication Errors

Prof. Hisham Aljadhey
Executive President of Saudi Food & Drug Authority (SFDA) Saudi Food and Drug Authority

Outline

- **Medication Error Definition**
- **Medication Errors Department Activities in Medication Naming, Labelling and Packaging to Avoid Medication Errors**
- **Pre-Registration**
- **Post-Registration**

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)

Medication Error
Definition

"A medication error 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."

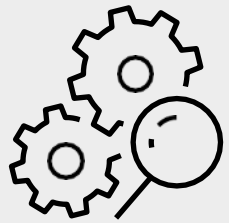
Product-related Evaluation

Invented Names Evaluation

Product labels/ labeling

Product packaging

Postmarket Pharmacovigilance



Medication Error Department Scope of Services

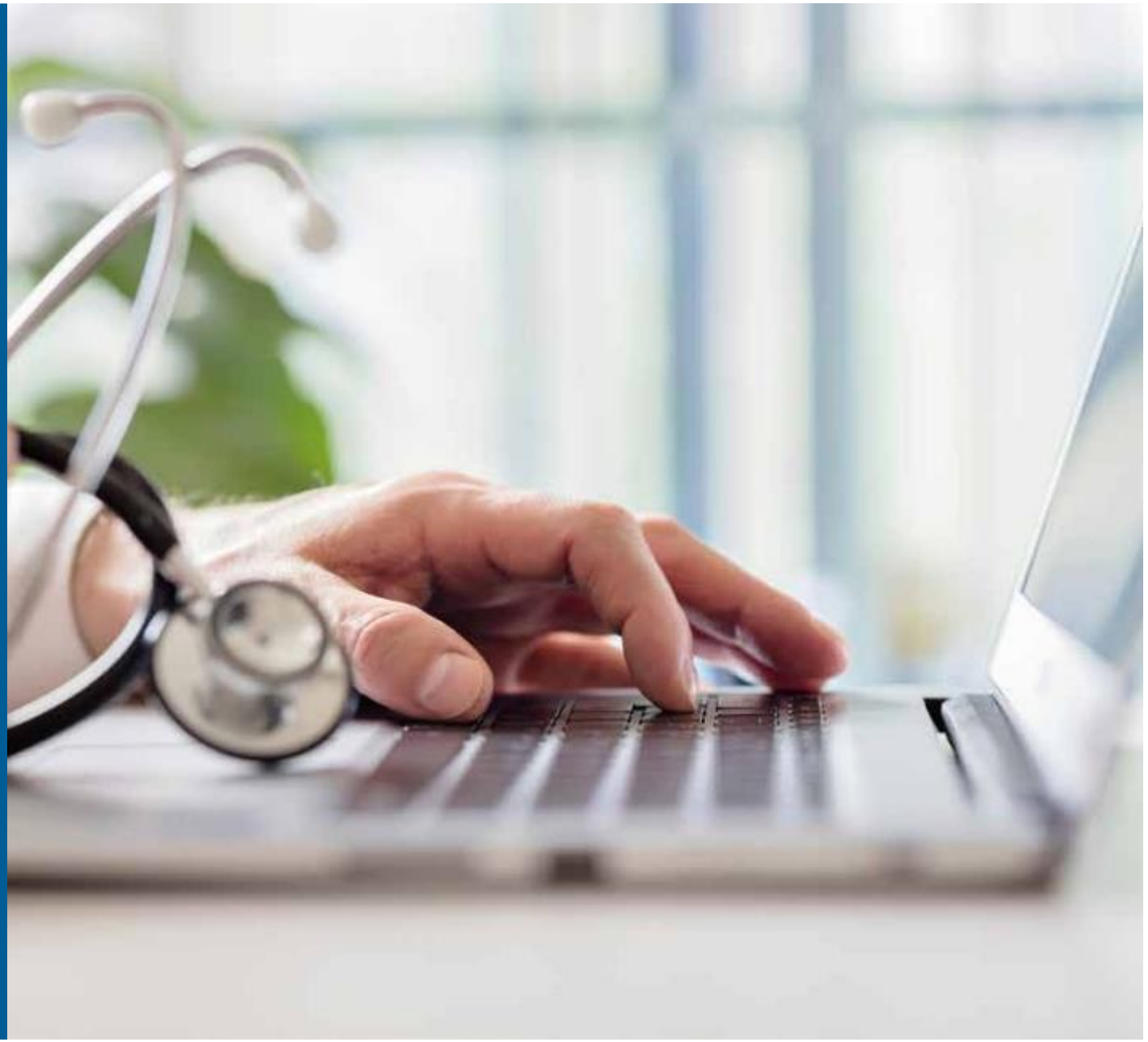
WHO Global

Patient Safety Challenge

Role of SFDA
in preventing Medication Errors

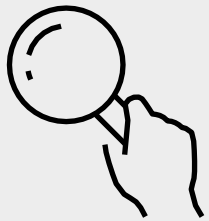
- **Pre-Registration**
  - Naming Evaluation
  - Packaging Evaluation
- **Post-Registration**
  - Variation Requests
  - Reporting
  - Published Reports

Pre-Registration Activities



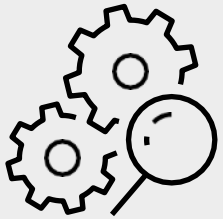
Naming Evaluation

- **SFDA Guidance for Naming of Medicinal Products**
  - Assessment for any error-prone attributes
  - Best practices for invented names design
  - Misleading/promotional concerns
  - Medicinal characteristics-related attributes
  - Name similarity evaluation including generic names
- **International Nonproprietary Names (INN) Stem Book 2018 (WHO)/United States Adopted Names (USAN) approved stems**



Naming Evaluation Name Similarity

- Saudi Naming Registration (SNR)/SFDA Drugs List
- Phonetic and Orthographic Computer Analysis (POCA)
- WHODrug Insight
- Martindale: The Complete Drug Reference
- Micromedex
- Lexicomp



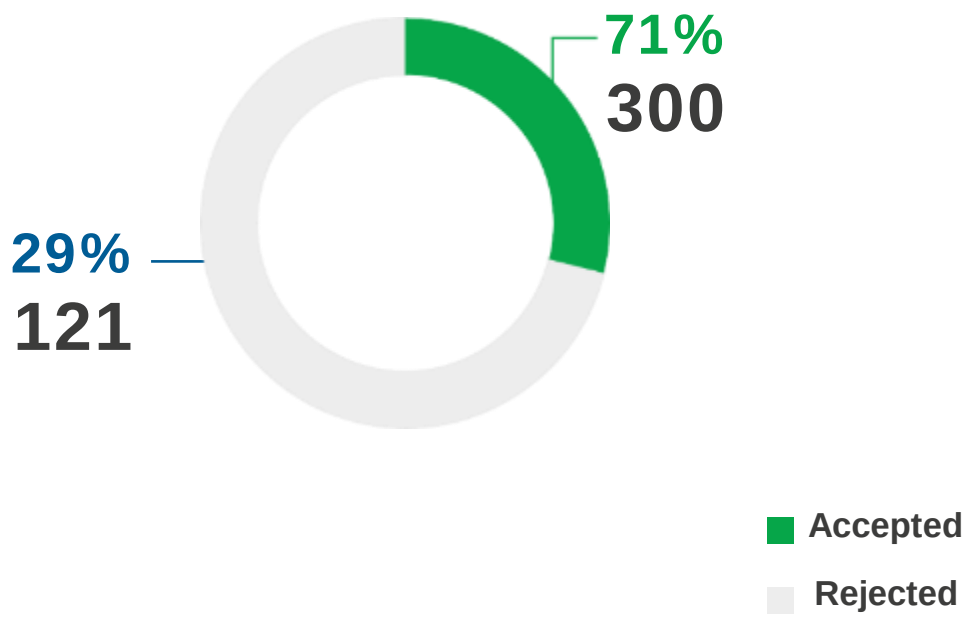
Name Similarity Evaluation:

A Look at Product Characteristics

- **Active ingredient**
- **Strength**
- **Dosage form**
- **Route(s) of administration**
- **Indication**
- **Frequency**

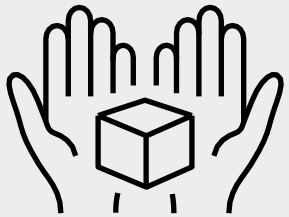
Acceptance vs. Rejection Rate

of Proposed Invented Names (Calendar Year 2021)



Safety Concerns Associated with Rejected Proposed Invented Names

Name Similarity	73 (47.7%)
Incorporation of International Nonproprietary Names Stem	24 (15.7%)
Promotional/Misleading Names	15 (9.8%)
Inappropriate Use of Qualifiers	13 (8.5%)
Inappropriate Use of Company Name	8 (5.2%)
Inclusion of Dosage form/Frequency/Strength	6 (3.9%)
Use of Abbreviations	5 (3.3%)
Name Discrepancies in Submitted Files	4 (2.6%)
Indication Derived Names	3 (2.0%)
Use of Ambiguous Numbers	2 (1.3%)



Packaging Evaluation

- **SFDA Guidance for Graphic Design of Medication Packaging**
- **Artwork Catalogue**
- **Country of origin packaging**

Naming Evaluation Look-Alike Names

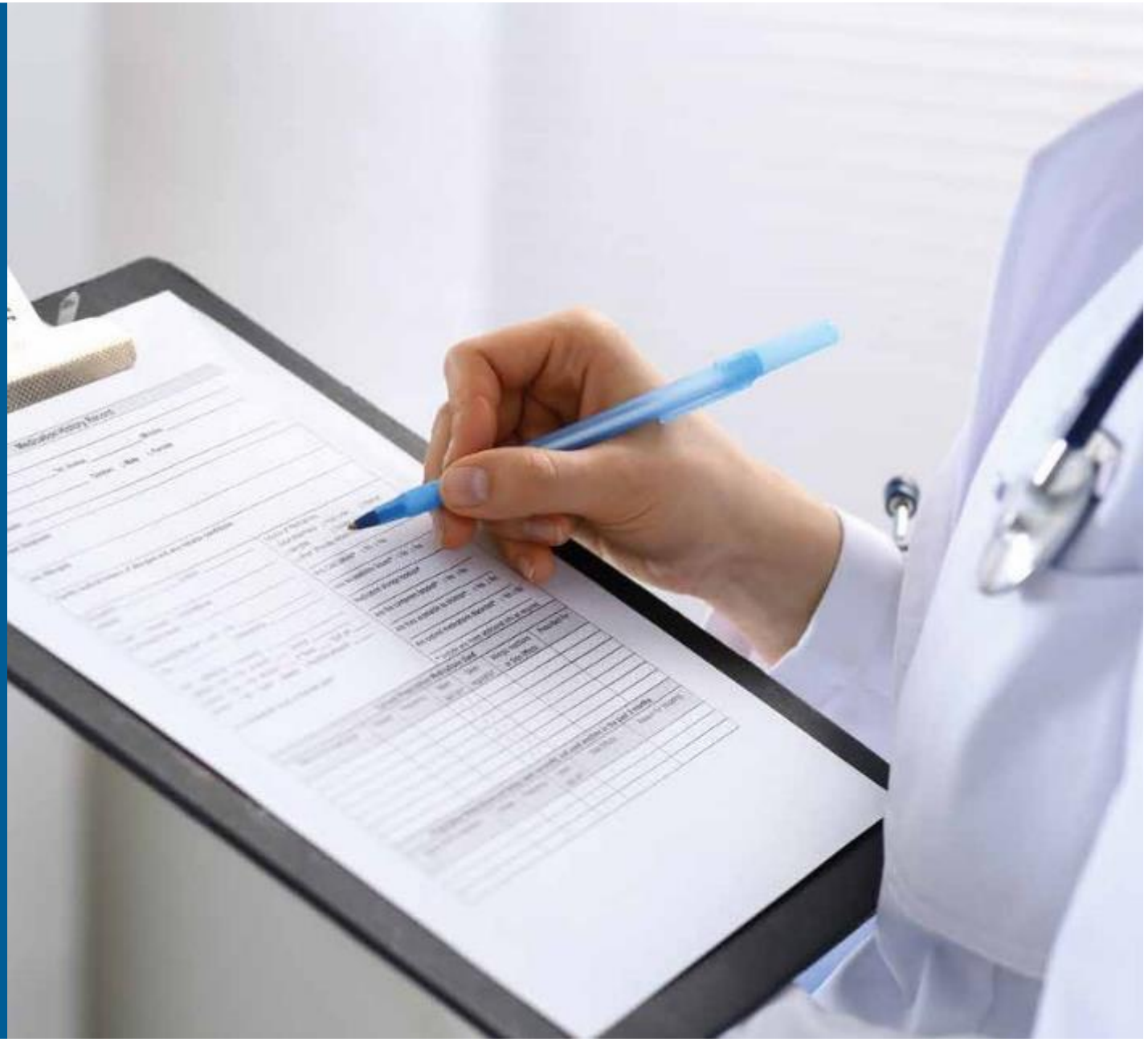
and Tall Man Lettering

Prescribed	Given	Adverse Drug Event (ADE)
Morphine	HYDROmorphone	Respiratory Arrest, Death
ChlorproMAZINE	ChlorproPAMIDE	Anoxic Brain damage from sustained hypoglycemia

Packaging Evaluation Cont.’

Color Differentiation among different strengths

Post-Registration Activities Reporting



Importance of Med

Error Reporting

Providing knowledge & updates of medication errors to boost activities in both pre & post marketing

How to Report

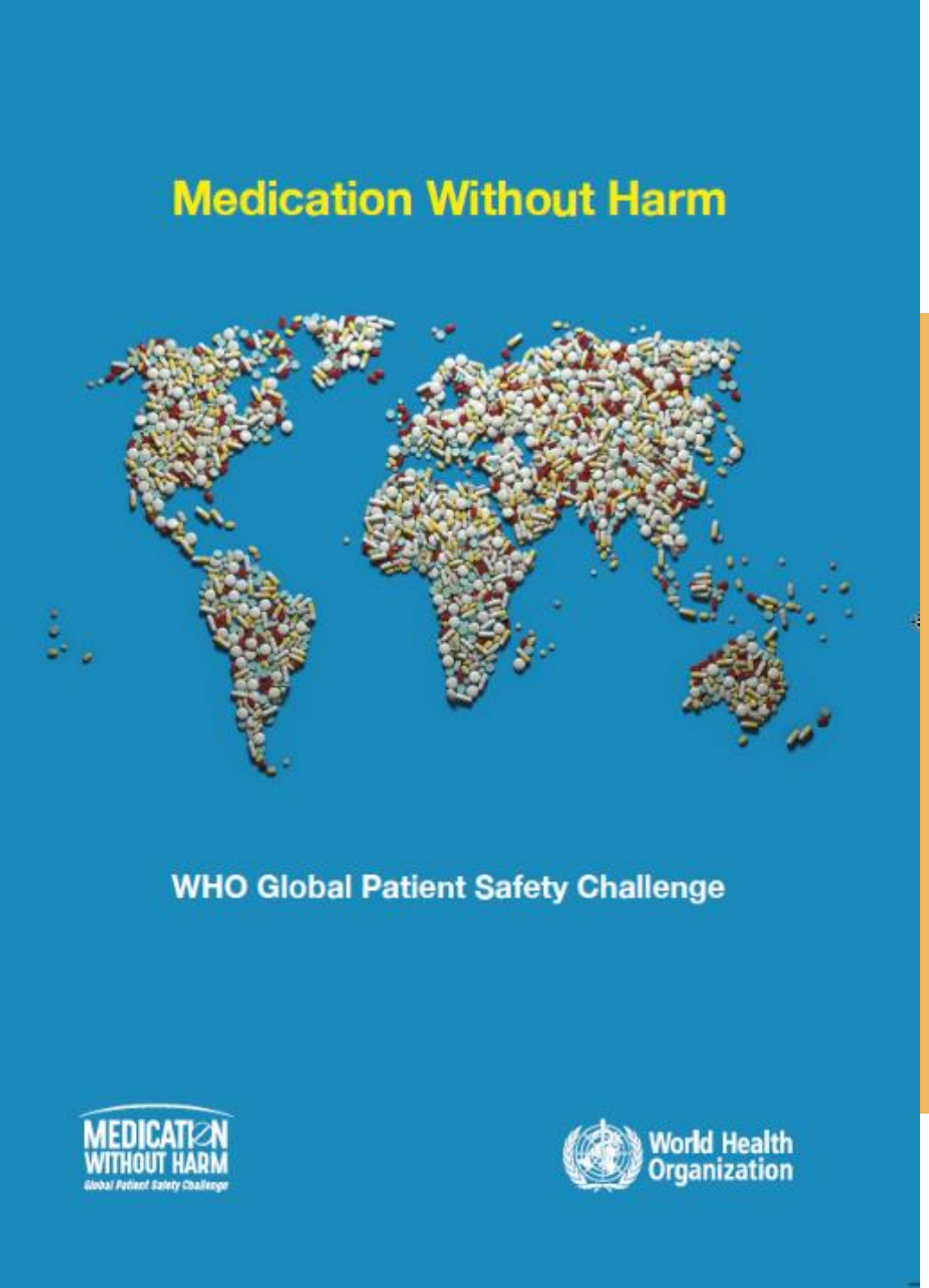
SFDA Call center

19999

Saudi Vigilance

بالأهـــم نهتـــم

Saudi_FDA | www.sfda.gov.sa



World Patient Safety Day 17 September 2022

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

The safety of opioid medications: practical action at a system level

Mr Ewan MAULE
Director of Medicines and Pharmacy
North-East and North Cumbria
Integrated Care Board
UK

15 September 2022

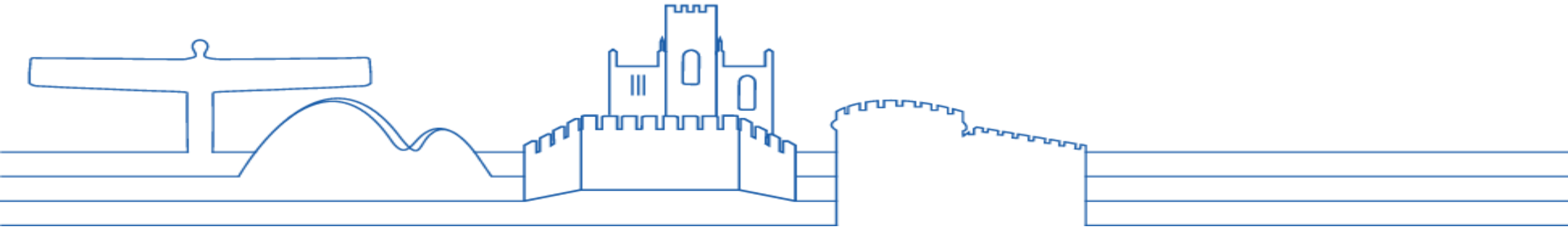
NHS
North East & North Cumbria

Tackling the opioid crisis: one region's experience

Ewan Maule

Director of Medicines and Pharmacy

WHO World Patient Safety Day Sept 2022



Global scale of the opioid crisis

Worldwide, about 0.5 million deaths are attributable to drug use, both prescribed and illicit

More than 70% of these deaths are related to opioids

*'The epidemic of **opioid addiction** and its consequences touch every community, every demographic and every single one of us in some way.'*

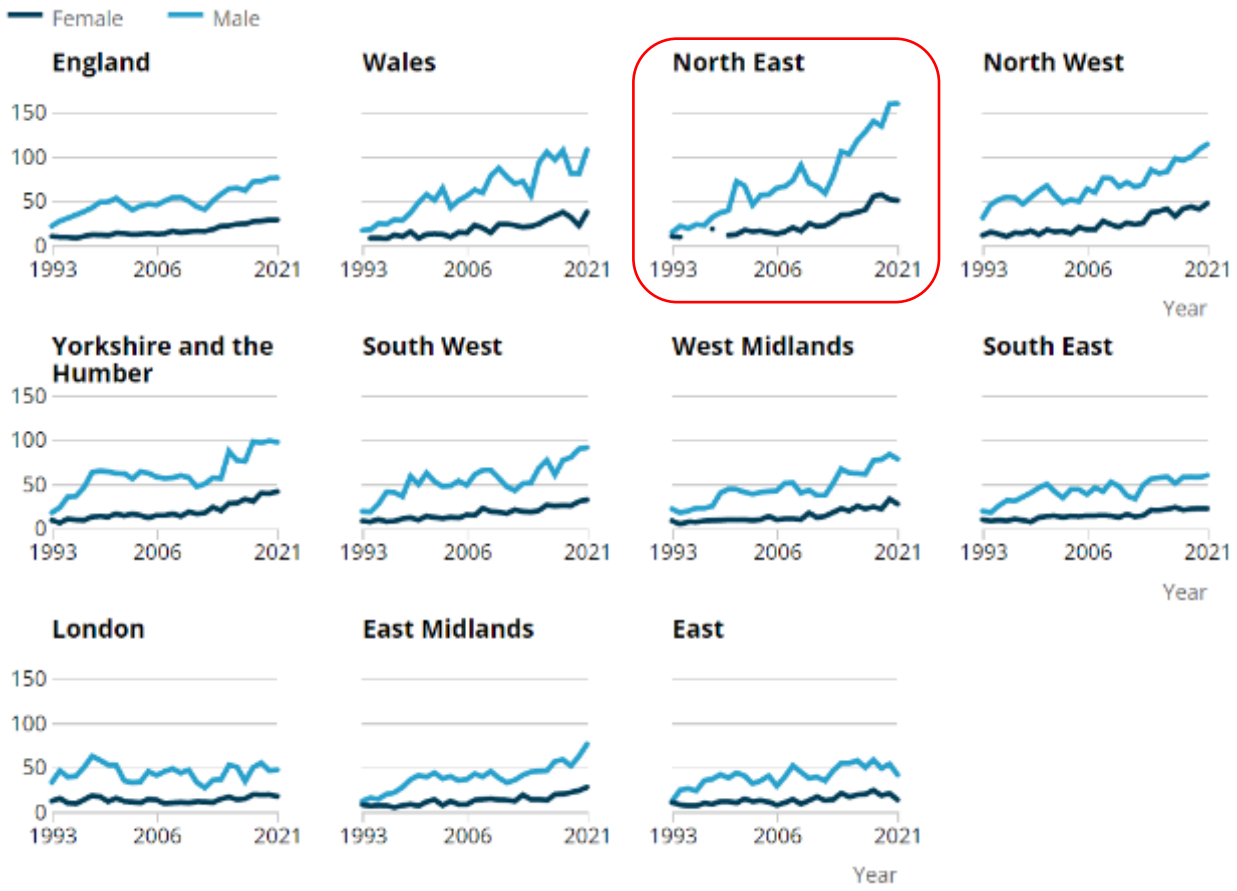
- John Suthers – Colorado Attorney General

How a patient can suffer avoidable harm from opioids

- Faye, a 28 year old woman, sustained a back injury lifting a heavy object at home
- Two years later she had surgery to try to resolve the problem
- Oxycodone was given post operatively as 80mg a day (morphine equivalent 160mg)
- Faye's continuing chronic pain was treated with higher and higher doses of oxycodone
- Four years on from the original injury Faye was taking a cocktail of drugs including
  - oxycodone, gabapentin, amitriptyline, sertraline, diclofenac and paracetamol
- She developed a range of symptoms including huge weight gain, sleep apnoea and depression
- A late stage introduction of cognitive behavioural therapy brought some improvement, but she tragically died with a respiratory arrest at the age of 32 years

Source: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2020/10/C-CDLIN-LE-Sep-20-opioids-CNCP-East-Sussex-slides-for-sharing.pdf

Opioid deaths in the North East of England are higher and rising faster than the rest of the country



1. https://www.who.int/initiatives/medication-without-harm
2. https://jamanetwork.com/journals/jama/fullarticle/2757570

A single agency approach to opioid harm will not work

A public facing campaign to tackle opioid harm

Progress with the opioid harm reduction programme over five years

30% reduction in overall opioid use

50% reduction in high dose opioid use

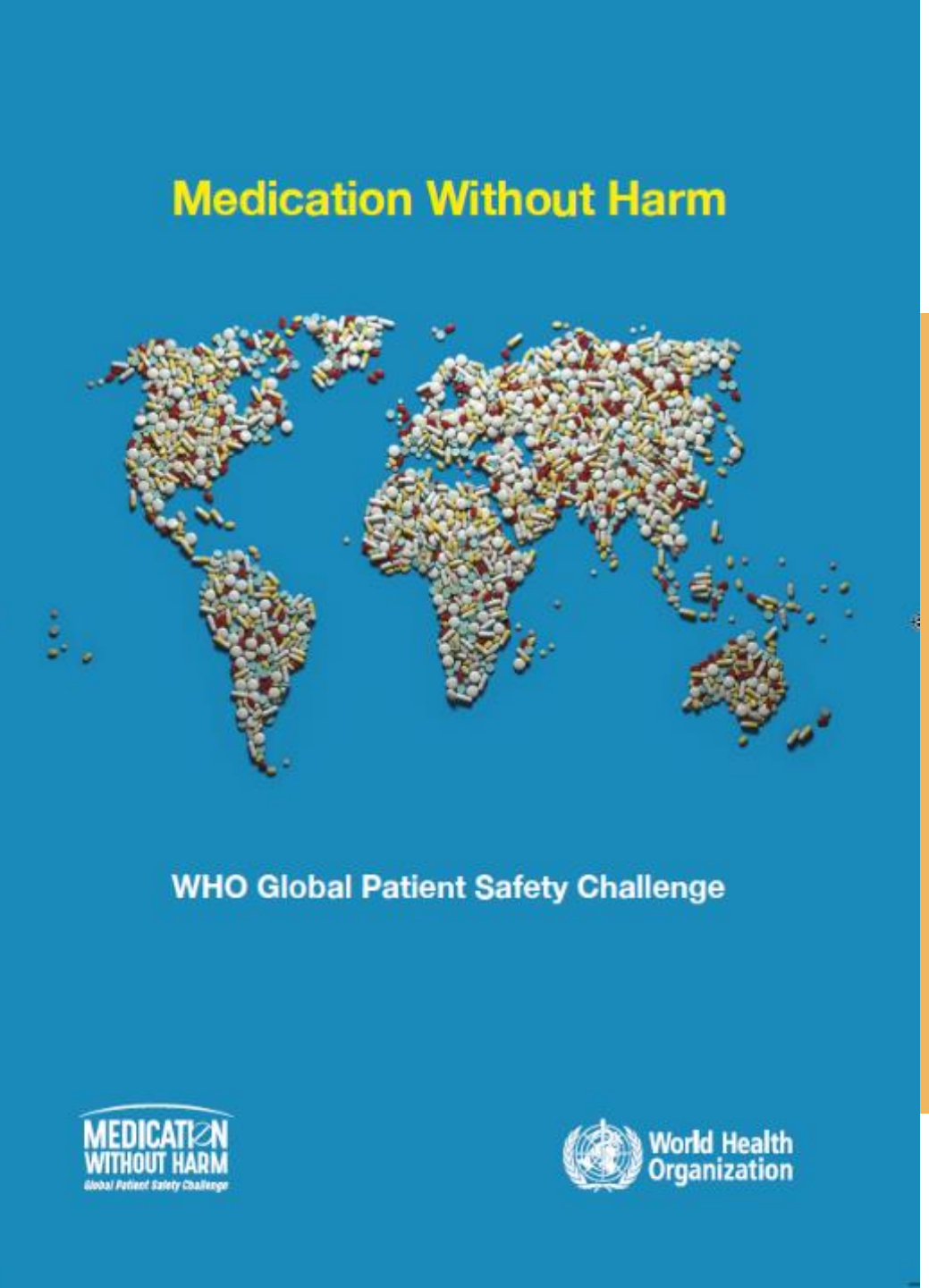
It may be a crisis, but lives can be and are being saved

- *It's taken me five years to get to where I am now. I understand I can live with some pain in my life.* ***I was looking for the magic pill that does not exist.*** *By accepting that the painkillers were doing more harm than good, that they were actually at the root of many of my problems, I am now in a much better place.*

- *I've lost 8 ½ stone. I walk most days. Everything starts to hurt more when I stay still, so the solution is to be more active. I'm a better mum because I'm present. I'm much more social, I love listening to music and when my restless legs kick in, well,* ***I turn up the music and have a dance instead of turning to pills that stopped working a long time ago.***

Louise Trewern

@Loulouscorpio



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MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

Product quality and Safety: scale of the problem and solutions – substandard and falsified medical products

Mr Rutendo KUWANA
Team Lead
Regulation and Safety
WHO headquarters
Geneva

15 September 2022

World Patient Safety Day 2022 Global Virtual Event

"Medication Without Harm"

World Health Organization

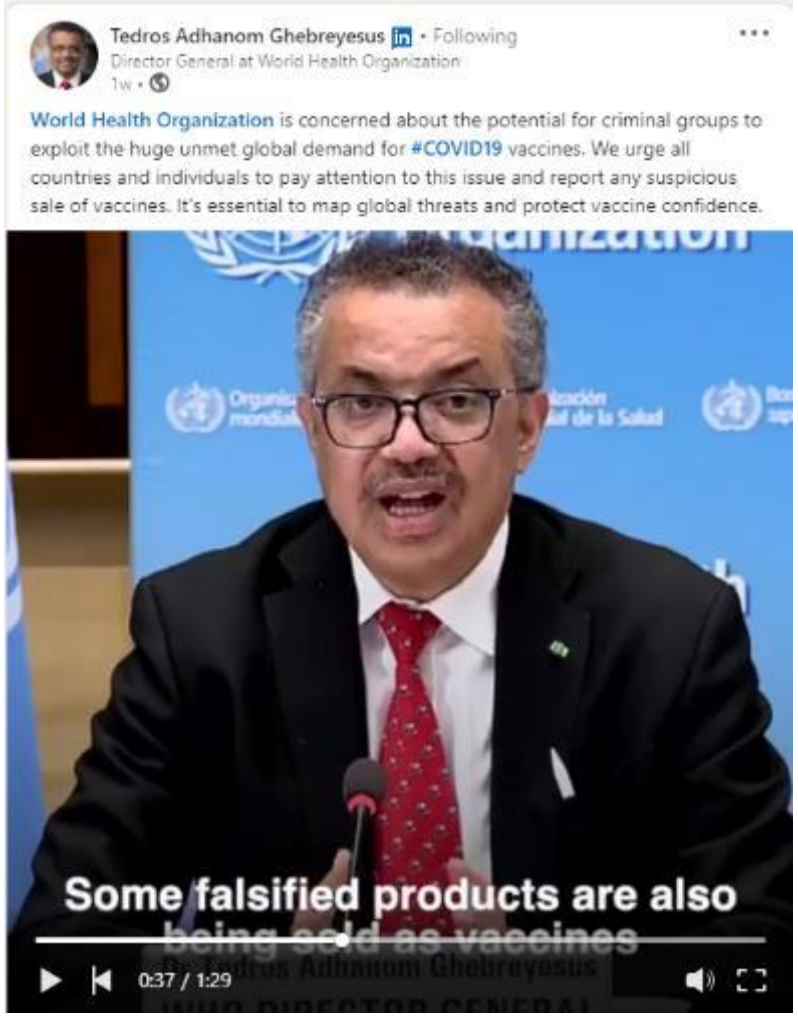
Product quality and safety: scale of the problem and solutions for substandard and falsified medical products

15 September 2022

Rutendo KUWANA

Tedros Adhanom Ghebreyesus -

Director General, WHO
26 March 2021



*"Some falsified products are also being sold as vaccines on the **internet**, especially on the **dark web**…..we are aware of other reports of corruption and re-use of **empty vaccine vials**. We urge the secure disposal or destruction of used and empty vaccine vials to prevent them from being reused by criminal groups.*

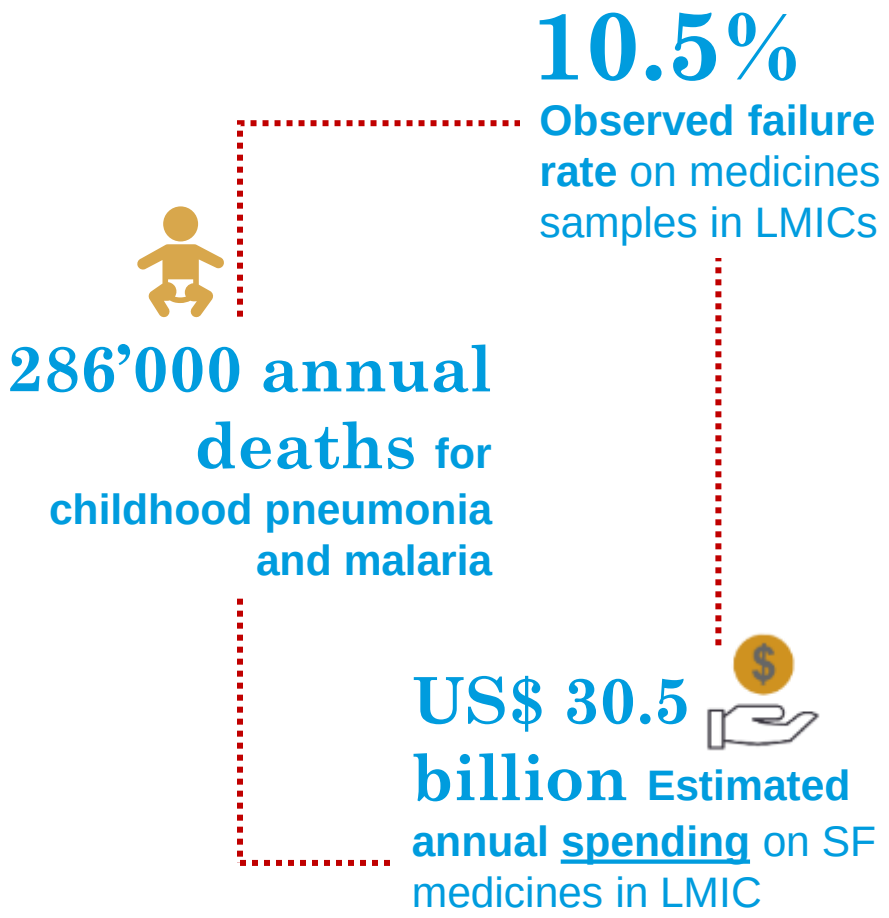
And we urge all people not to buy vaccines outside government-run vaccination programmes. Any vaccine bought outside these programmes may be substandard or falsified, with the potential to cause serious harm.

*WHO regularly issues **global medical product alerts on substandard and falsified products**, and we will do so when and if necessary for COVID-19 vaccines and therapeutics.*

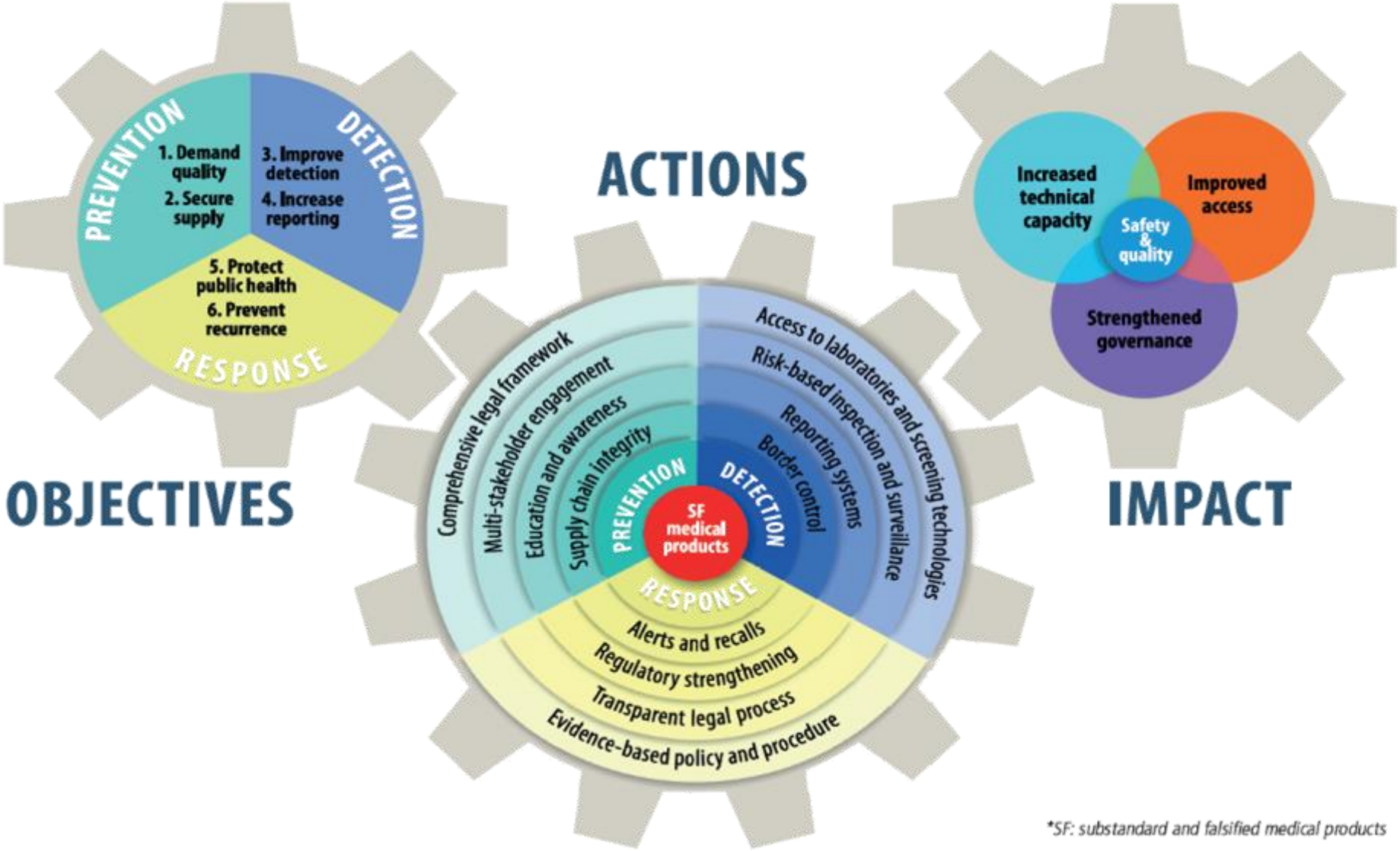
*We urge all countries and individuals to pay careful attention to this issue. Any suspicious sale of vaccines should be reported to national authorities, who will report it to WHO. **Information flow is essential to map global threats and protect confidence in vaccines**"*

SF medical products – scale of the problem

- Undermine all global public health investments through treatment failure or harm to patients
- Antimicrobial resistance
- Damage trust in public systems
- Increase out-of-pocket spending
- Increase morbidity and mortality
- lost income and increased poverty, etc.



A holistic strategy to address a cross cutting issue



*SF: substandard and falsified medical products

WHO's dual approach

Political, operational and technical response

- Influence change in health and governance systems
- Technical and operational support to countries to prevent-detect-respond to SF medical products
- Various services e.g. global medical product alerts based on reports and analysis of the global surveillance & monitoring system
- Facilitate effective collaboration through the Member State mechanism
- Provide validated evidence base to guide policy and regulatory capacity building

World Health Organization

The Global Surveillance and Monitoring System for substandard / falsified (SF) medical products

What is in it?

- Confirmed or suspected Falsified medical products
- Unexpected Adverse Reactions caused by medical products – including lack of efficacy
- Stolen medical products or products removed from the regulated supply chain

World Health Organization

Why report?

- Product and batch may have already been reported by another Country
- The product may pose a risk to public health, perhaps in another country or region
- The product may have already undergone laboratory analysis - which can be shared
- Another country may be investigating the origin of the product and have helpful information

WHO Member State Mechanism

Established by World Health Assembly Resolution 65.19 to address SF medical products

Led by a Steering Committee chaired by Australia and supported by 11 Vice Chairs from all WHO Regions

WHO Member States agree on a 2-year workplan; current prioritized activities are for 2022-2023 and include work on:

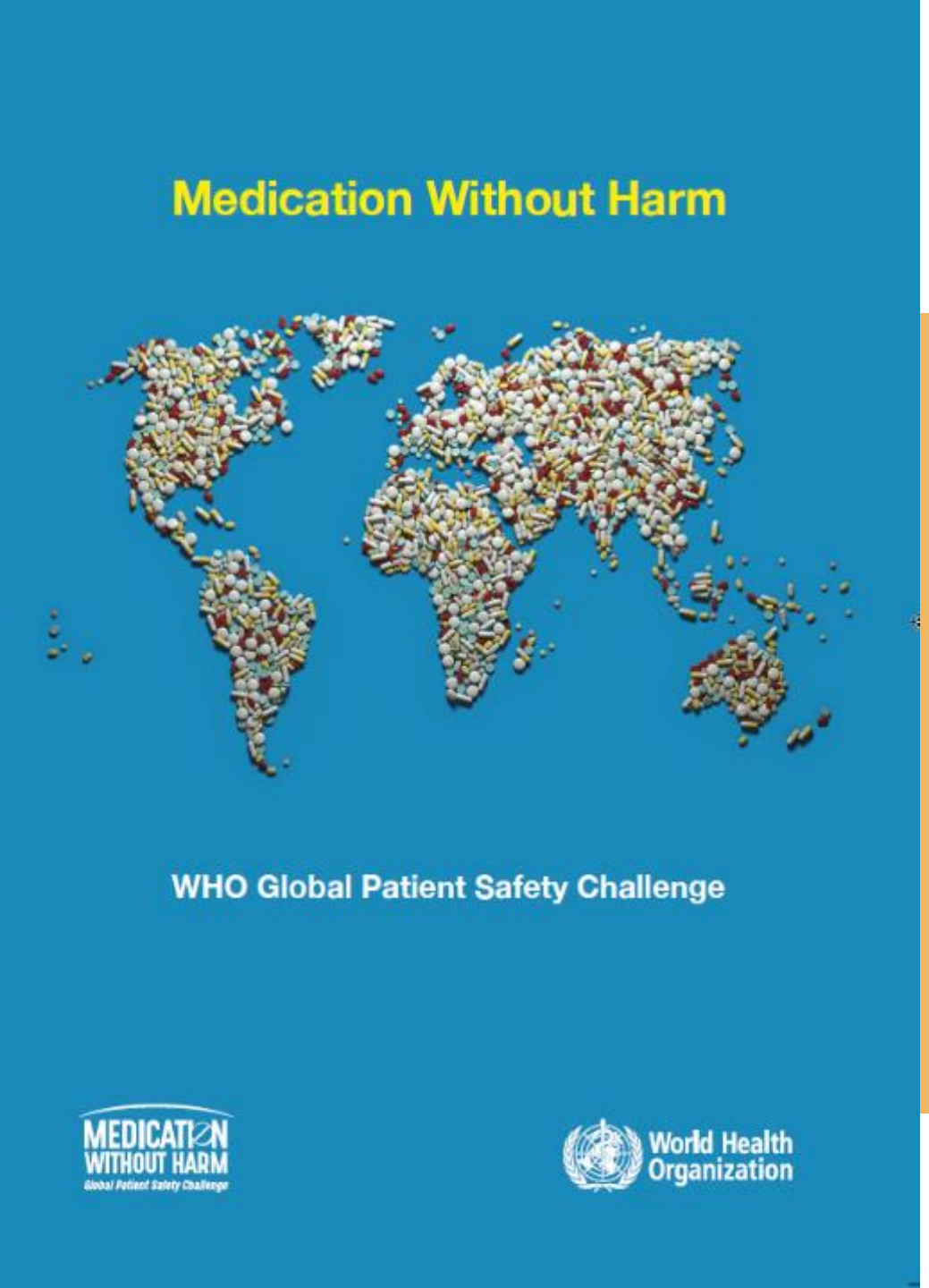
- Regulatory capacity-building for prevention, detection and response
- Global networks
- Detection technologies and traceability
- Competencies and good governance
- Risk communication
- Impact and awareness
- Internet distribution and sale
- Informal markets

"The goal of the Member State Mechanism is to protect public health and promote access to affordable, safe, efficacious, and quality medical products, and to promote through effective collaboration among Member States and the Secretariat, the prevention and control of substandard and falsified medical products and associated activities."

World Health Organization

Rutendo KUWANA
Team Lead
WHO ISF Medical Products Team

rapidalert@who.int



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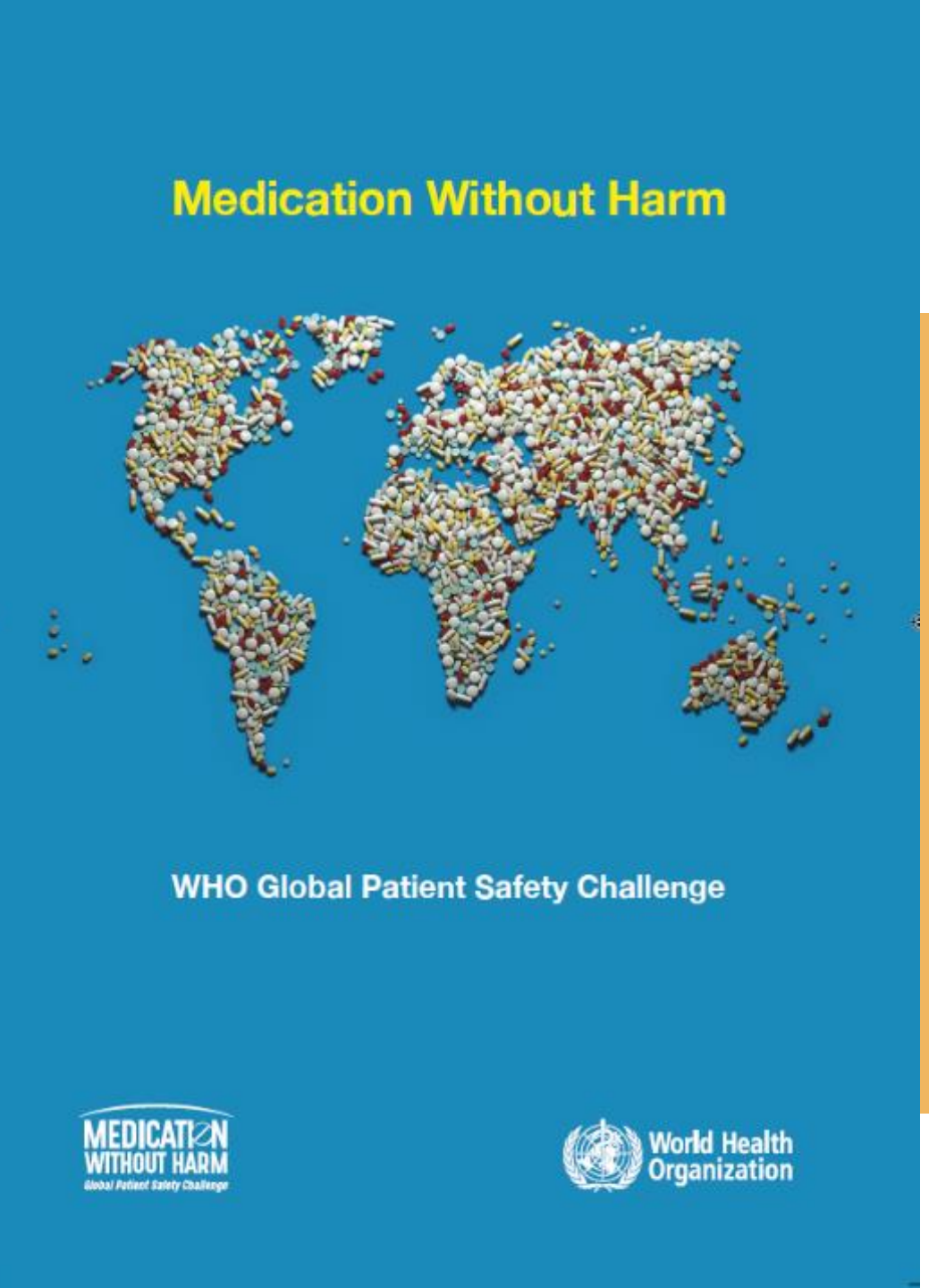
Global Patient Safety Challenge

World Health Organization

Message on World Patient Safety Day 2022 from the WHO Regional Office for Africa

Dr Matshidiso MOETI
WHO Regional Director for Africa

15 September 2022



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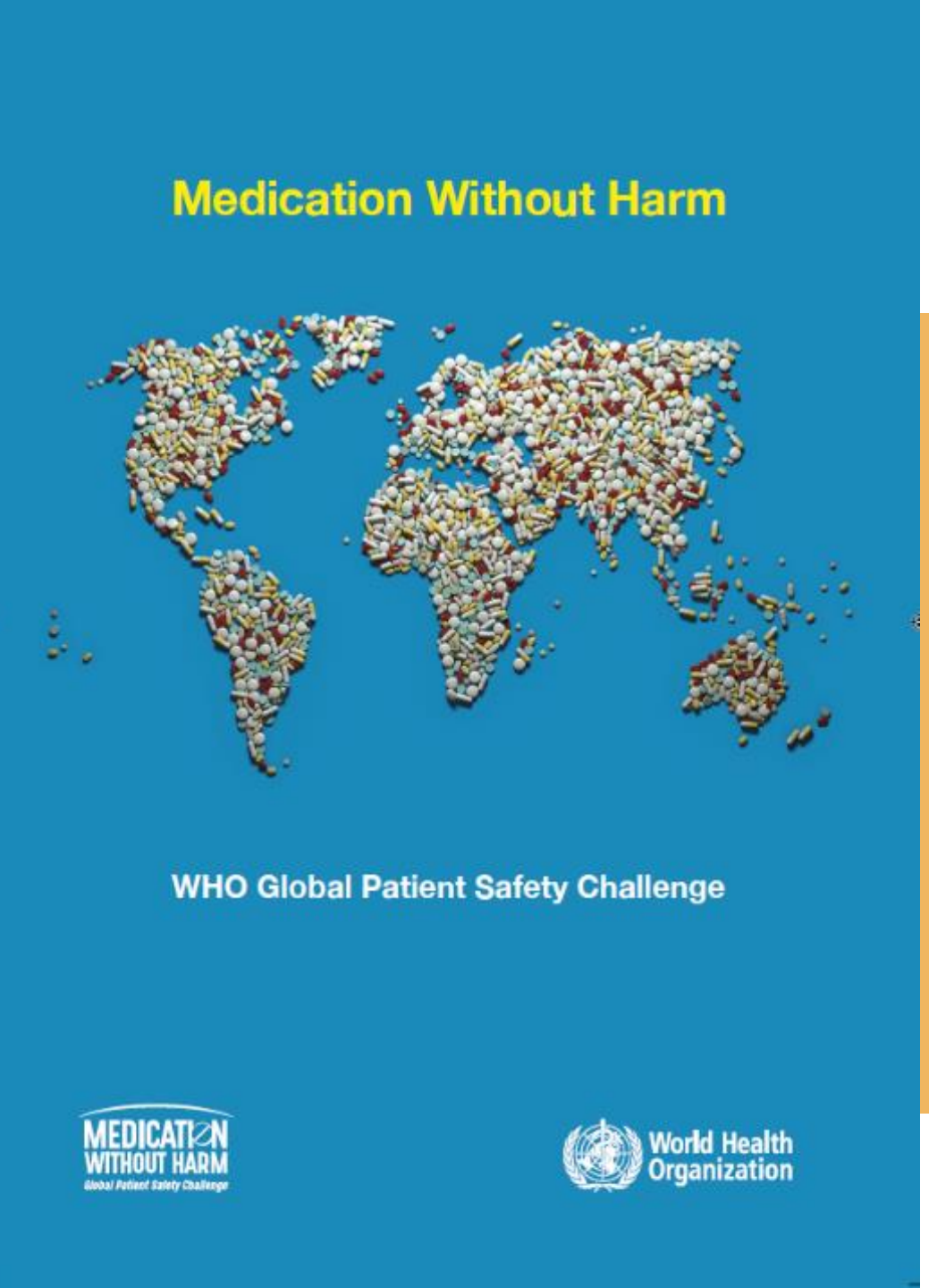
World Health Organization

BREAK



World Patient Safety Day 17 September 2022

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

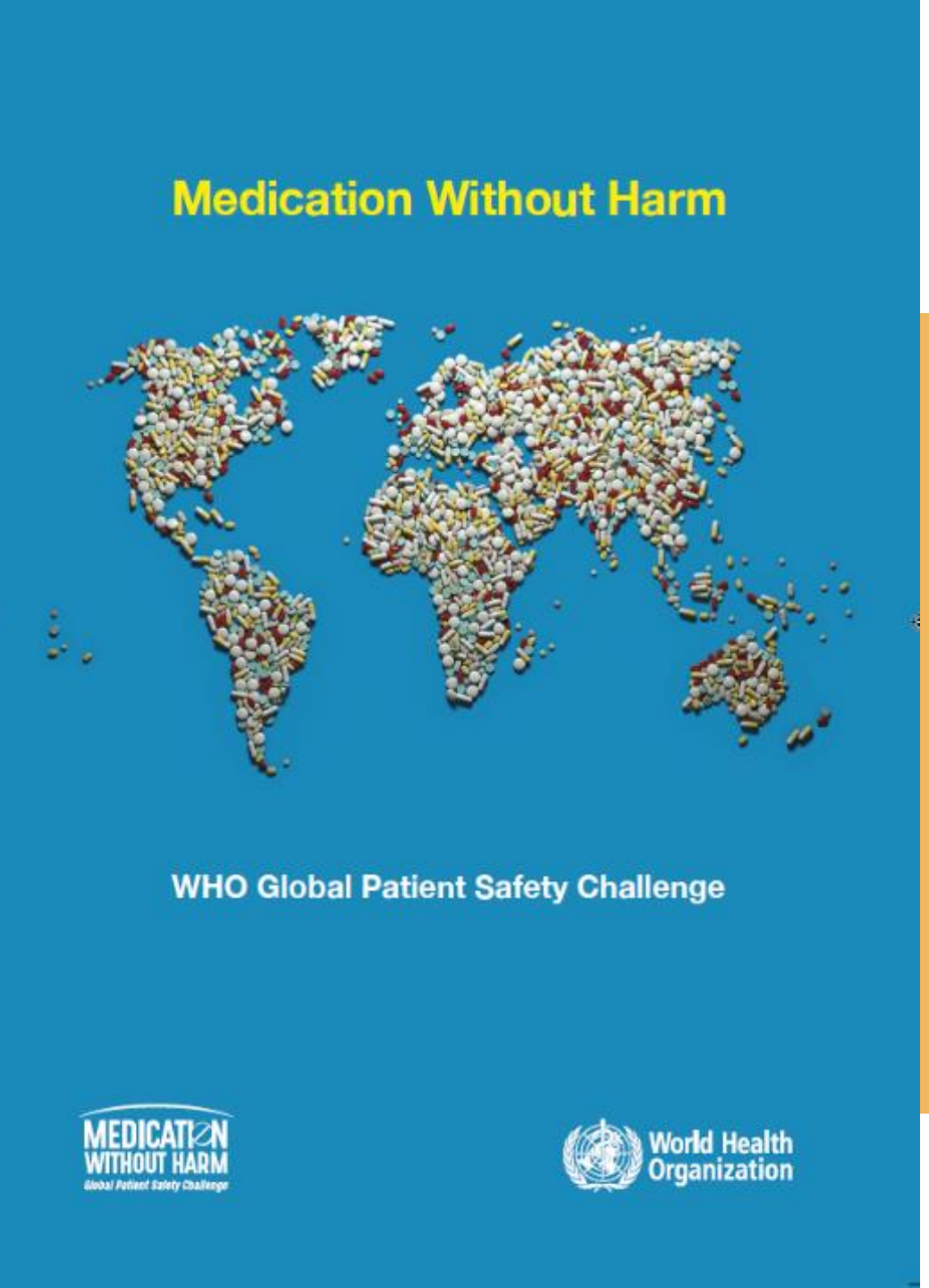
World Health Organization

Session 4

Medication safety: systems and practices

Chair: Mr Frank FEDERICO
Faculty for Institute for Healthcare Improvement (IHI)
Senior Safety Expert

15 September 2022



World Patient Safety Day 17 September 2022

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

Reducing patient harm through safe medication use process – focusing on prescribing, administration and monitoring

Ms Carolyn HOFFMAN
Chief Executive Officer
Institute for Safe Medication Practices Canada (ISMP-Canada)

15 September 2022

Preventable Harm from Medications

"Medications are the most widely utilized interventions in health care, and medication-related harm constitutes the greatest proportion of the total preventable harm due to unsafe care, let alone the economic and psychological burden imposed by such harm."

World Health Organization, 2022

April 2012 feature article:
https://thewalrus.ca/the-errors-of-their-ways/

A complex system…

"Just telling doctors and nurses to be more careful won't do much. We need to change the systems that allow errors to happen."

Dr. James Bagian
Anesthesiologist and Astronaut

5 Stages of Medication Use

Prescribing

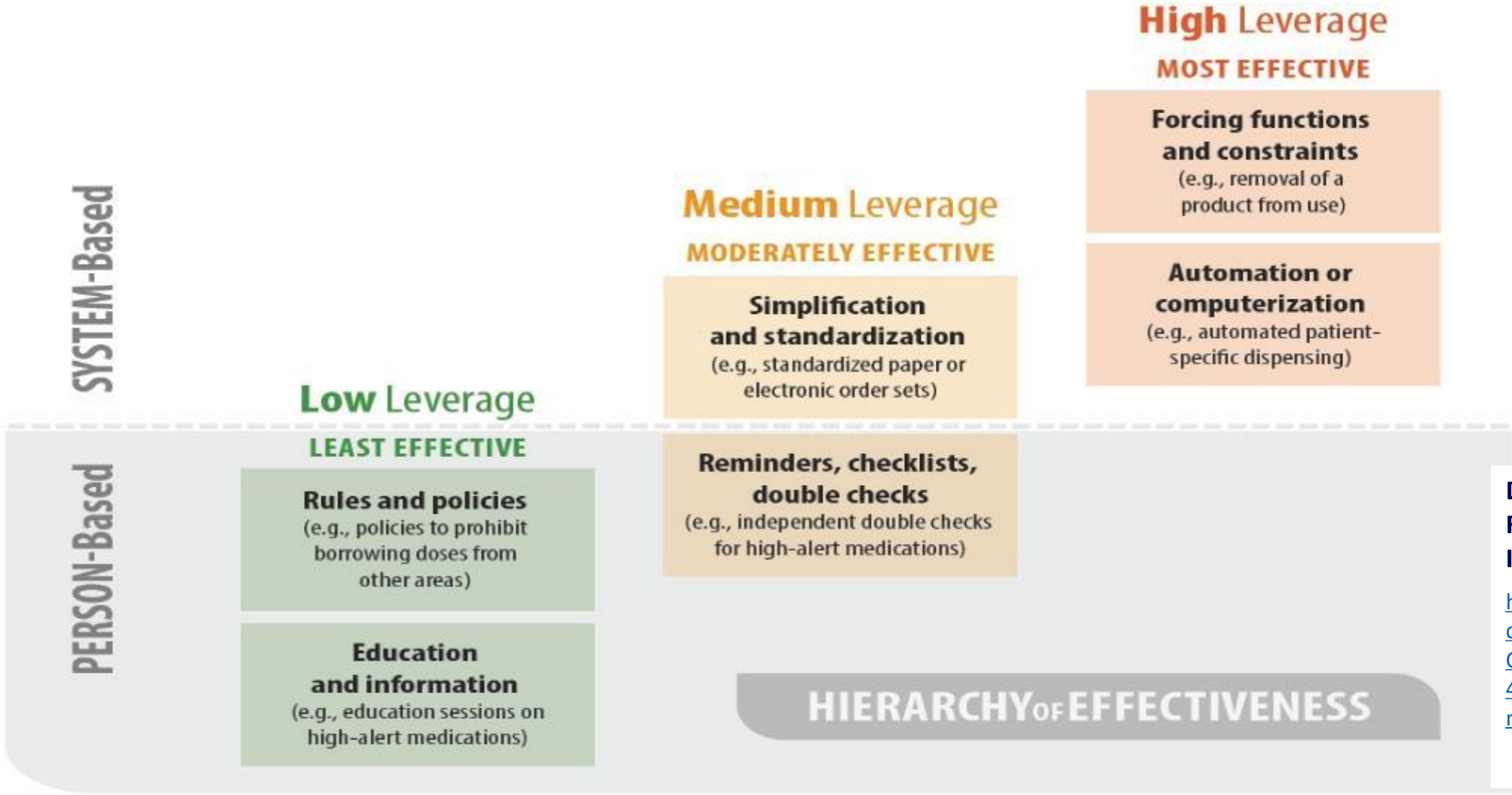
Order Entry or Transcribing

Dispensing

Administration

Monitoring

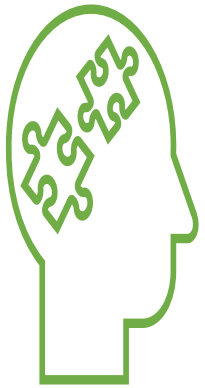
The Hierarchy of Intervention Effectiveness



Designing Effective Recommendations, ISMP Canada (2013)

https://ismpcanada.ca/wp-content/uploads/ISMPCONCIL2013-4_EffectiveRecommendations.pdf

Reduce the risk of prescribing errors



Prescribing

- Have essential patient information (e.g. age, weight, allergies, lab results)
- Use clinical decision support resources to inform evidence-based decisions
- Use computerized prescriber order entry
- Engage the patient/family so they can KNOW about their medications, CHECK for accurate dispensing / administration, monitor for ongoing safety, and ASK questions

Remember that abbreviations, symbols and dose designations can be error prone – comply with 'Do Not Use' lists

ISMP Canada - https://ismpcanada.ca/resource/do-not-use-list/
ISMP - https://www.ismp.org/recommendations/error-prone-abbreviations-list

Reduce the risk of administration errors

Administration

- Practitioners at the bedside play a key role in preventing errors
- Implement TALLman lettering for medications that may be confused, particularly look-alike/sound-alike (LASA) meds
- Implement independent double-checks for high-alert medications
- Verify the correct patient with 2 patient identifiers
- Use barcode-assisted medication administration technology
- Engage the patient/family in verifying medications so they can be a partner in their safety

Reduce the risk of monitoring errors

Monitoring

- Ensure all healthcare providers on the team know:
  - what measures will be taken to monitor the patient following administration of high-risk medications, and
  - what assessment results will trigger required action (e.g. blood glucose testing, sedation monitoring, INR monitoring)
- Integrate monitoring protocols into workflow design and health record documentation
- Engage the patient and family in the monitoring plan and results so they can be a partner in their safety

Reduce errors across all stages of medication use

- ✓Use standardized order sets and standardized concentrations of medications wherever possible and integrate across prescriber and pharmacy systems, IV pump libraries, and monitoring records

- ✓Make errors visible, use a systems approach to analyzing errors locally, integrate learning from others, and take action

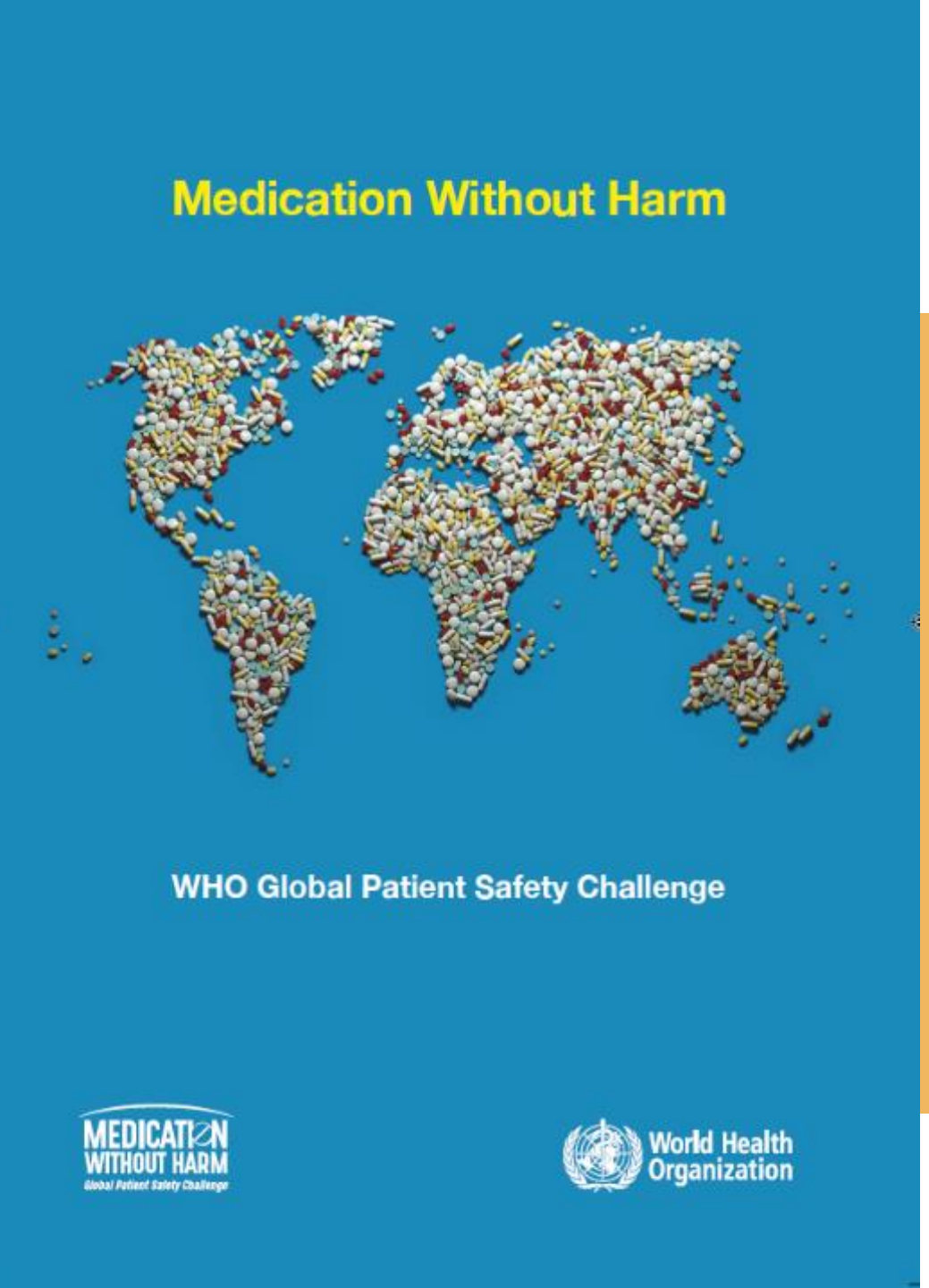
Thank you!

Carolyn Hoffman, CEO

Carolyn.hoffman@ismpcanada.ca

ZERO Preventable Harm From Medications

Institute for Safe Medication Practices Canada



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Challenges of reducing medication errors in primary, ambulatory, residential and home care

Prof Jose M VALDERAS
Chairman, WONCA Working Party
In Quality & Safety

15 September 2022


Patients and the public
Public awareness & medication literacy
Patient engagement
Reporting by patients
Involvement of patient organizations
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
KEY ACTION AREAS
Polypharmacy
Transitions of care
High-risk situations
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Critically different, increased challenges, opportunities

- Professional roles and scope of practice:
  - continuous (rather than episodic)
  - whole person oriented (rather than disease/problem oriented)
  - comprehensiveness
  - critical role in care coordination
    - high risk situations
    - polypharmacy
    - transitions
- Setting
  - less technology intensive
  - interface with multiple different settings
  - range of arrangements:
    - less hierarchized
    - less standardised (across settings)

Critically different, increased challenges, opportunities

- Patient and family
  - knowledge of patients
  - ongoing personal relationships
  - case-mix range: signal to noise ratio
- Medications
  - range of medications:
    - medication specific
    - interactions

High risk situations

Specific groups

- young children
- frail patients and those with cognitive impairment
- those living alone

Specific medications

- Antibiotics
- Insulin
- Narcotics
- Heparin and anticoagulants

Tools and technologies

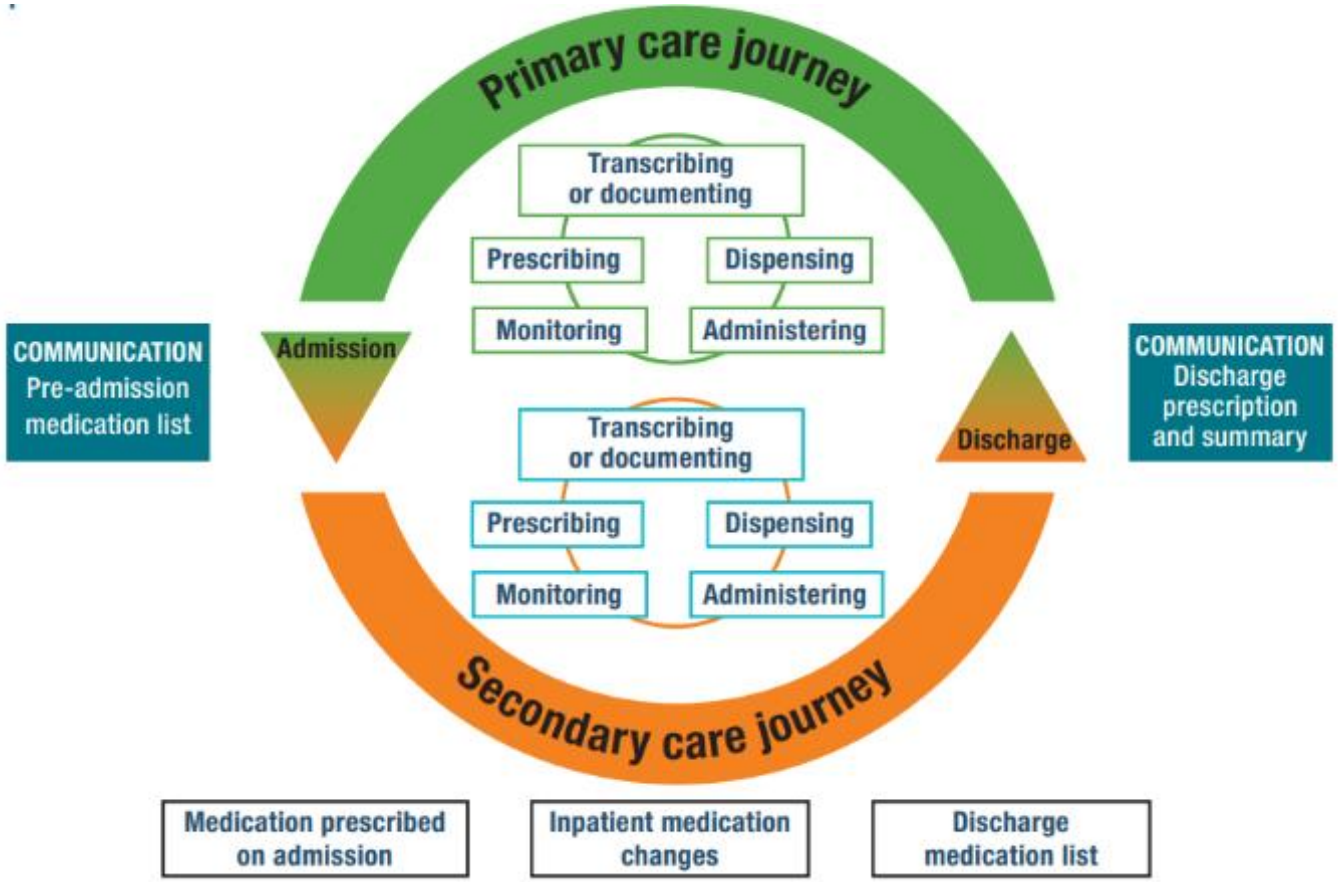
- high-alert medications

Patient and family empowerment

Polypharmacy

- Integrating care as provided by multiple specialists and settings
- Increased uncertainty about risks and benefits
- Medication history
- Medication reviews
- Tools and technologies
- Patient and family empowerment

Transitions of care



Transitions of care

- Multiple interfaces
- Multiple multidisciplinary teams
- Medication reconciliation
- Tools and technologies
- Patient and family empowerment

Key role of Family Medicine

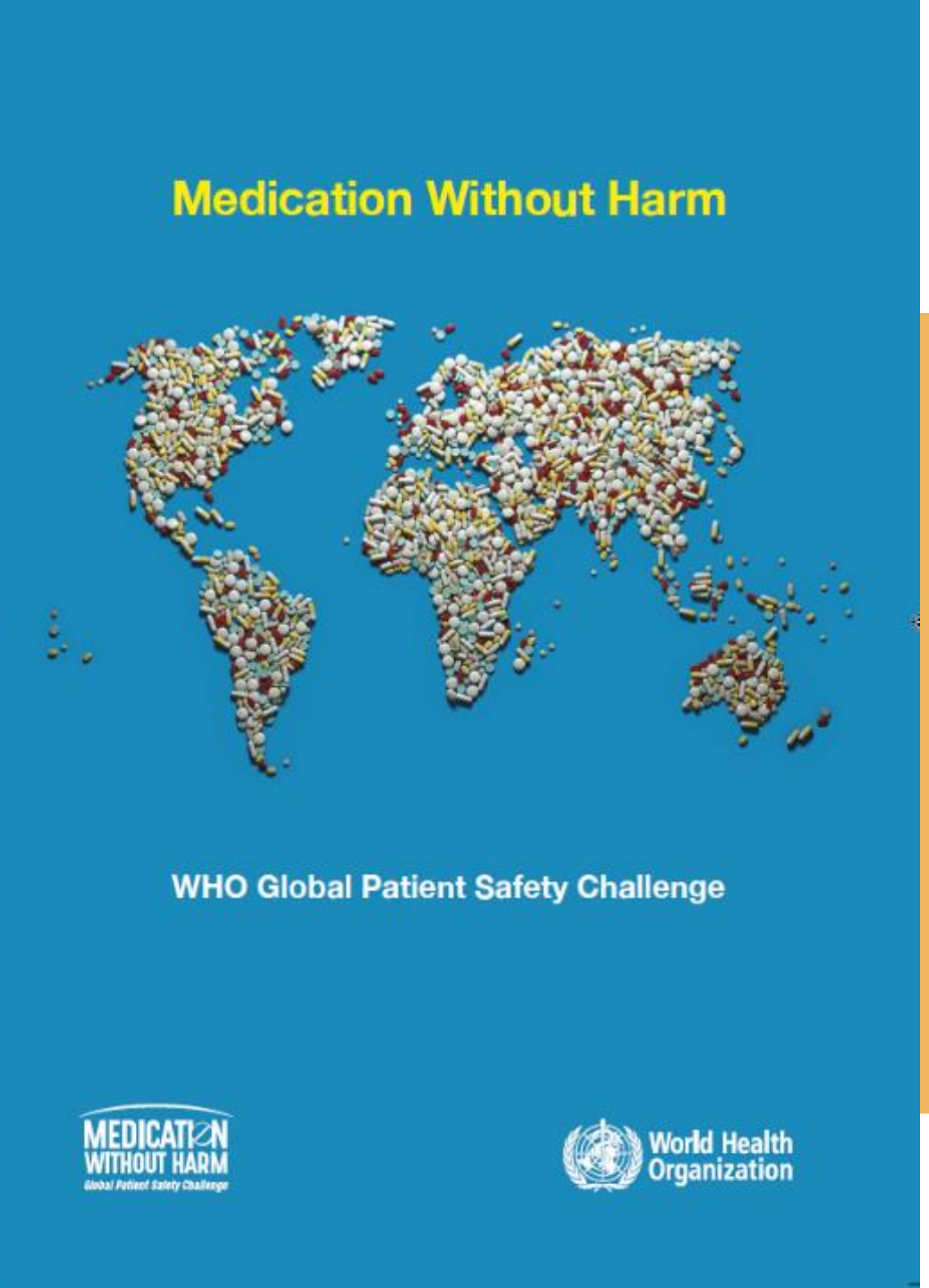
- At the intersection of high risk, polypharmacy and transitions
- Whole patient orientation and life course approach
  - Not just about the condition or the indication or the strength of evidence for a given pharmacological treatment
  - “Will THESE medications help THIS patient?”
- Partner with patients and families

Key role for Primary Care

- Need for settings and level specific evidence
- High quality primary care as a pre-requisite
- Monitoring of medication safety in primary care
  - OECD PaRIS Project

Thank you

All images from WHO documents of the Medication Without Harm series



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The Economics of Medication Safety: Improving medication safety through collective, real-time learning

Ms Katherine DE BIENASSIS
Health Policy Analyst, Health Division
The Organisation for Economic Cooperation and Development (OECD)

15 September 2022

THE ECONOMICS OF MEDICATION SAFETY

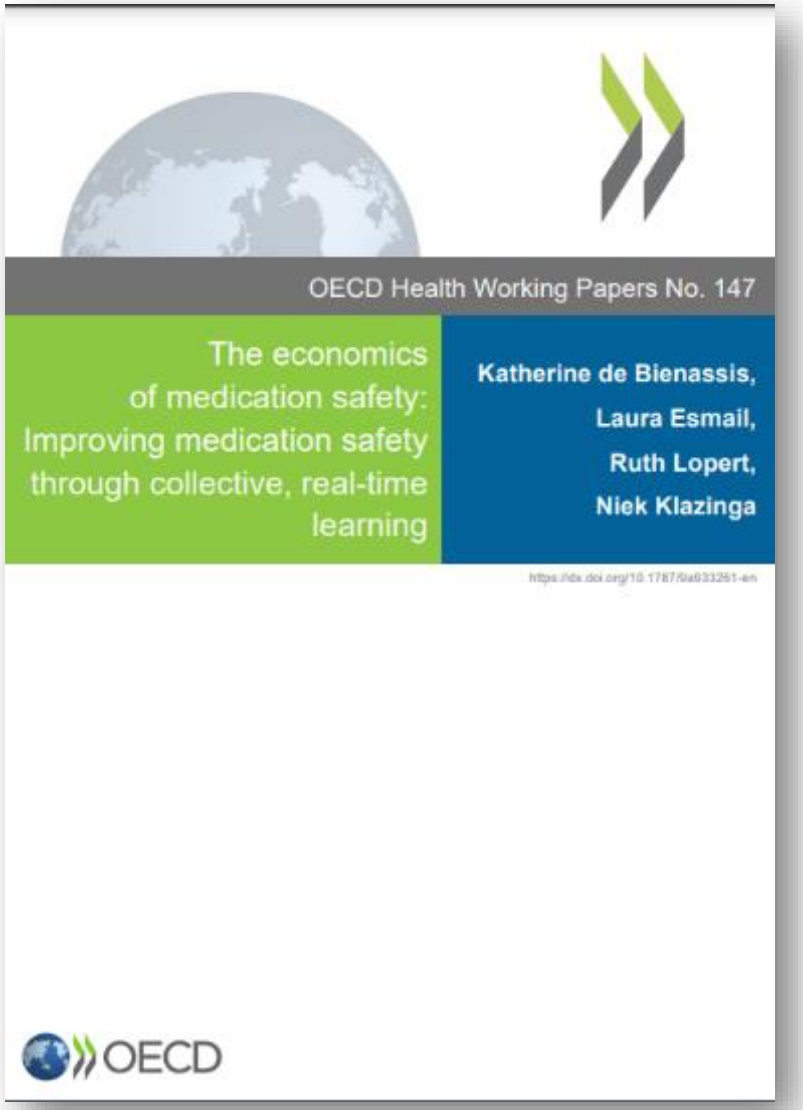
Katherine de Bienassis, Health Policy Analyst
15 September 2022

OECD
BETTER POLICIES FOR BETTER LIVES

The Economics of Medication Safety

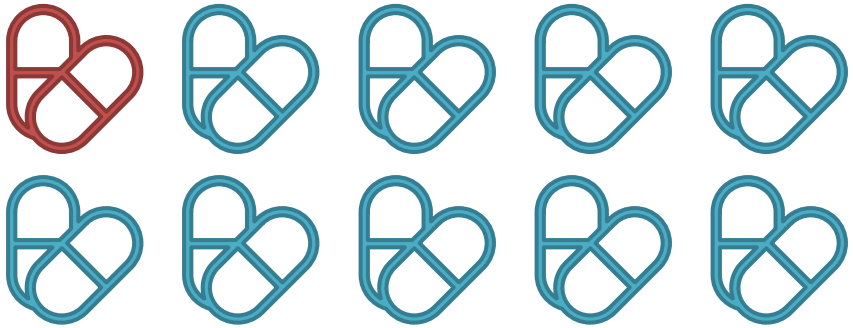
https://doi.org/10.1787/9a933261-en

https://www.oecd-ilibrary.org/social-issues-migration-health/the-economics-of-medication-safety_9a933261-en

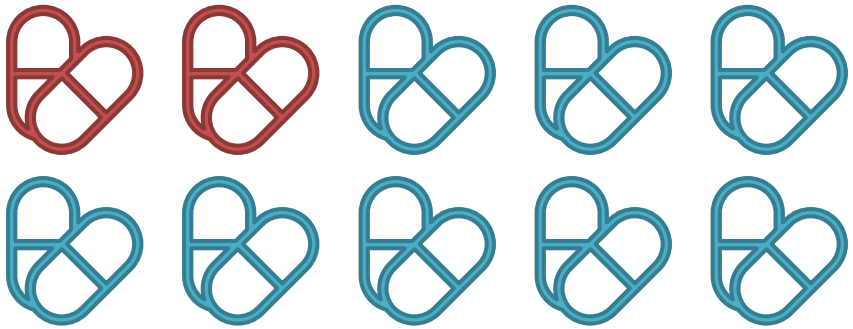


There has been **limited progress** in improving medication safety due to a number of converging factors

The scope of medication related harms

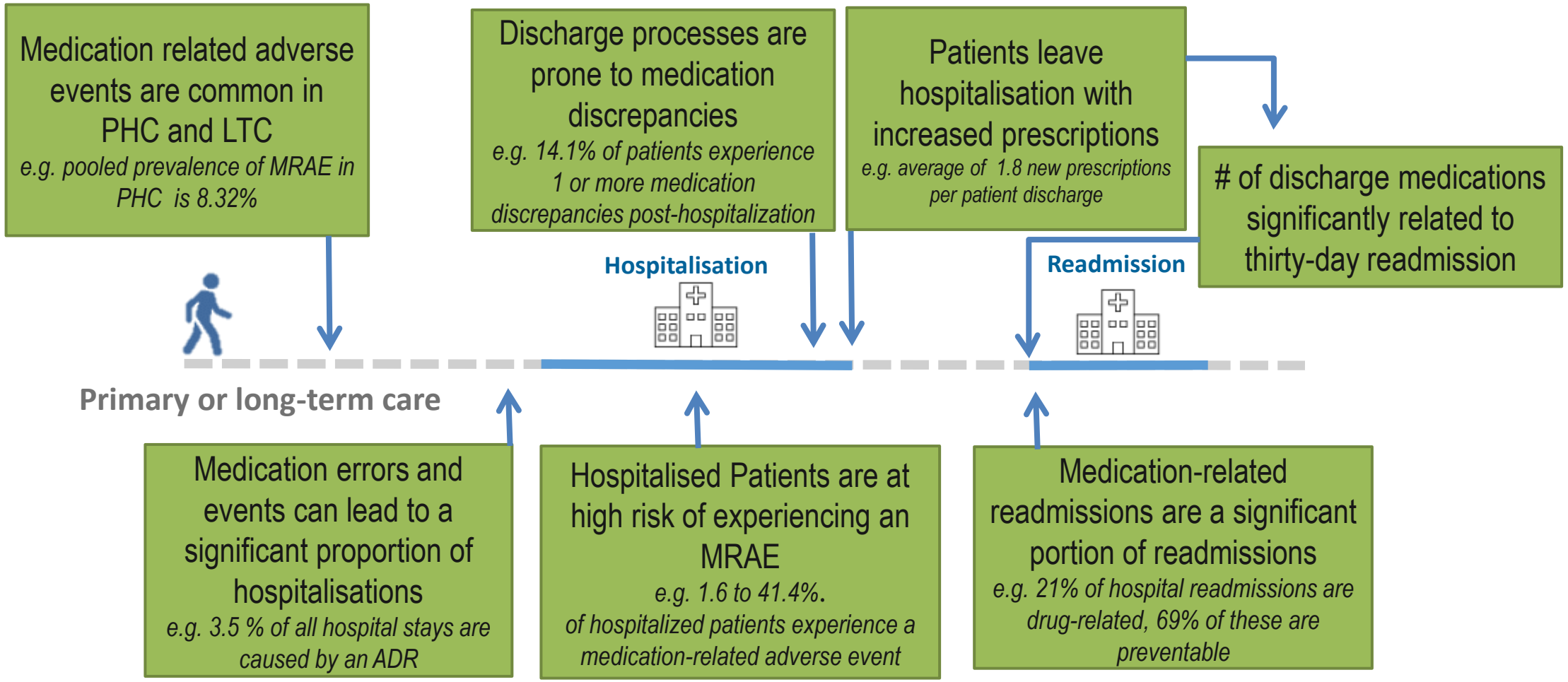


As many as **one-in-10 hospitalizations** in OECD countries may be caused by a medication-related harm and…



One-in-five inpatients experience medication-related harms during hospitalization

Medication safety is a **compounding problem**



Source: Authors using data from (Cano and Rozenfeld, 2009[21]; Bouvy, De Bruin and Koopmanschap, 2015[22]; Wolfe et al., 2018[23]; El Morabet et al., 2018[24]; Coleman et al., 2005[25]; Picker et al., 2015[26]; Elson, Cook and Blenkinsopp, 2017[27]; Gurwitz et al., 2005[14]). Inspired by similar figure in (Roughead, Semple and Rosenfeld, 2016[18]) and based on a template developed by Eliana Barrenho.

Total cost to OECD countries > **USD 54 billion** annually; ≈ **11% of total pharmaceutical spending**

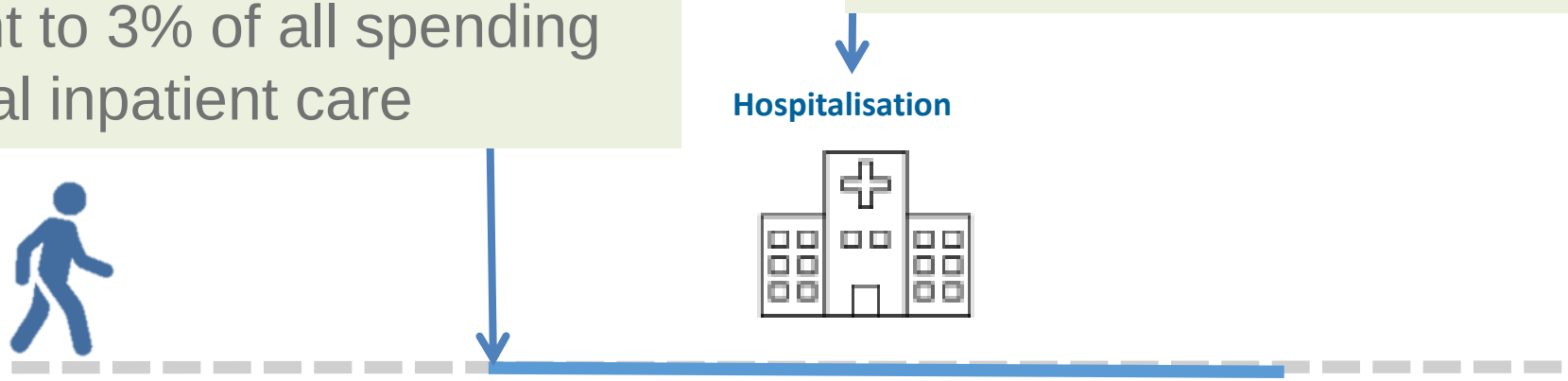
Six million hospital admissions annually are the result of adverse medication reactions

Costing OECD health systems over **USD 50 billion**

Equivalent to 3% of all spending on hospital inpatient care

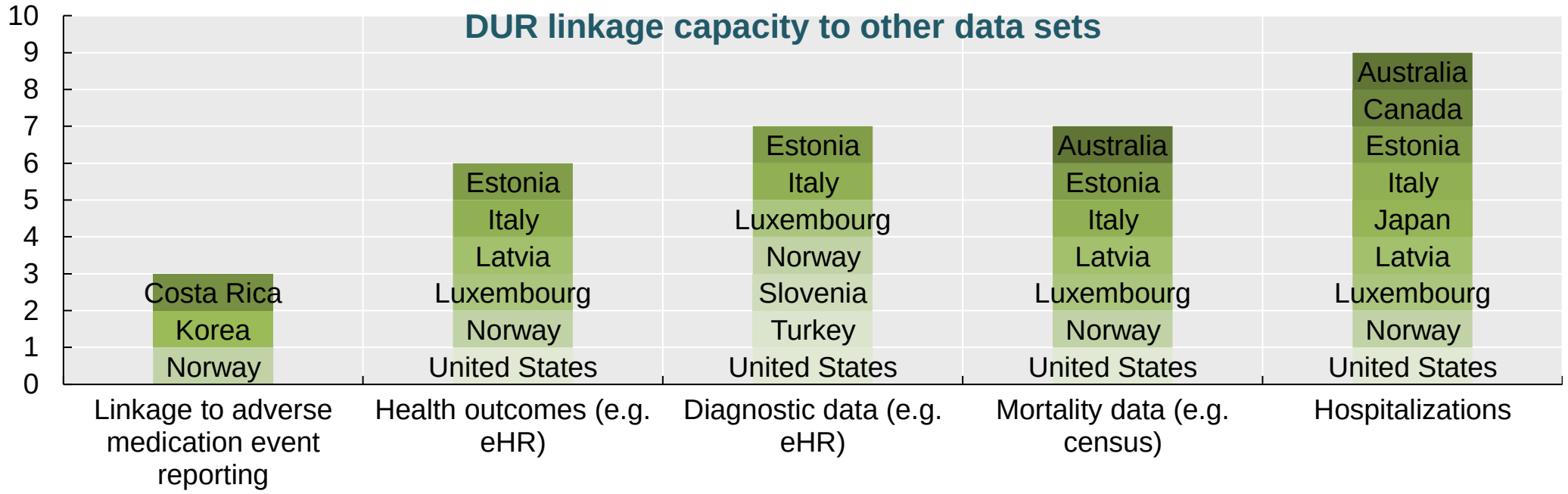
Medication related harms are experienced by an additional **one million hospitalised patients**, causing 3 million avoidable hospital days

Costing an additional USD **3.4 billion**.



Scope of **Drug Utilisation Review Systems** in OECD Countries

70% of survived countries have systems in place to conduct **drug utilisation review on a national level**



Note: N=20 responding countries, Countries may be counted in multiple categories. In Italy data are linkable at the regional level only.
Source: OECD survey on the assessment of the adoption of systems and interventions to improve medication safety, 2022

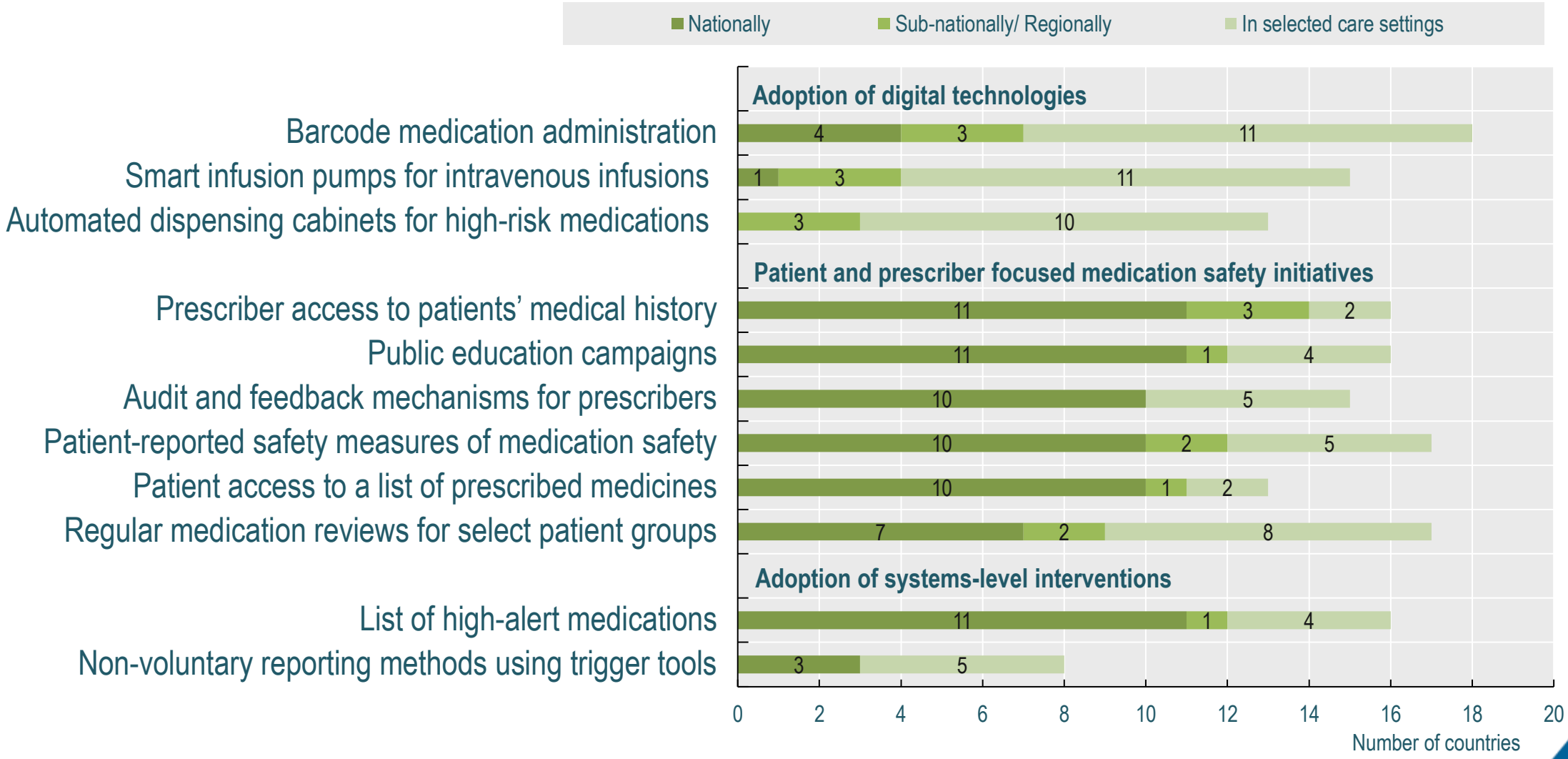
Use of DUR data for **provider feedback, quality improvement, and policy purposes**

Domain	Use of DUR data	Implementing Countries
Clinician/ prescriber feedback	**Clinician-level alert system**	Estonia, Republic of Korea, Netherlands, United States
	Practice-level prescribing	Costa Rica, Netherlands, Portugal, United States, Turkey, Luxembourg
	Individual clinician prescribing	Estonia, Japan, Republic of Korea, Netherlands, United States, Turkey,
	Real time dispensing decision support for pharmacists	Estonia, Netherlands, Republic of Korea, United States
	Facilitates interactions between clinicians and pharmacists/others	Estonia, Netherlands, Portugal, United States
Quality improvement	**Local practice guidelines for prescribing**	Costa Rica, Estonia, Netherlands, Portugal
	Professional standards	Netherlands, Portugal, Luxembourg
	Practice performance indicators	Estonia, Norway, Italy, Republic of Korea, Netherlands, Portugal, United States, Turkey
	Audit studies	Estonia, Netherlands, Portugal
	Structured dialogue between clinicians and pharmacists	Netherlands, Portugal, United States
	Linked to clinical care guideline development and evaluation	Estonia, Norway, Netherlands, Portugal, United States
Policy Purposes	**Reimbursement coverage decisions**	Estonia, Germany, Norway, Italy, Portugal, Australia, Republic of Korea, Luxembourg, Switzerland
	Formulary inclusion	Costa Rica, Italy, Japan, Portugal, Luxembourg

[1] The "rate of prevention of overlapping prescription" was implemented in 2020 as a patient safety indicator from Indicators for the Healthcare Quality Evaluation Grant initiative of Korea National Health Insurance Program. This indicator is calculated based on DUR data.

[2] In principle, prescription of drugs with drug-drug interactions and age and pregnancy contraindications are not reimbursed (under the NHI). If these drugs were medically necessary, the reasons for prescription and dispensing must be specified on the claim, and the appropriateness of the c

Digitization and medication safety initiatives by level of adoption by country



To improve medication safety, countries can:

Enhance real-time information sharing and patient access to data

Build on the expanded roles of pharmacies and pharmacists

Strengthen pharmacovigilance and drug utilization review systems

Promote good prescribing practices and invest in ePrescribing systems

Capture patient experience of medication-related harms and medication side-effects

Evaluate and calibrate the implementation of new medication safety strategies

THANK YOU AND STAY SAFE

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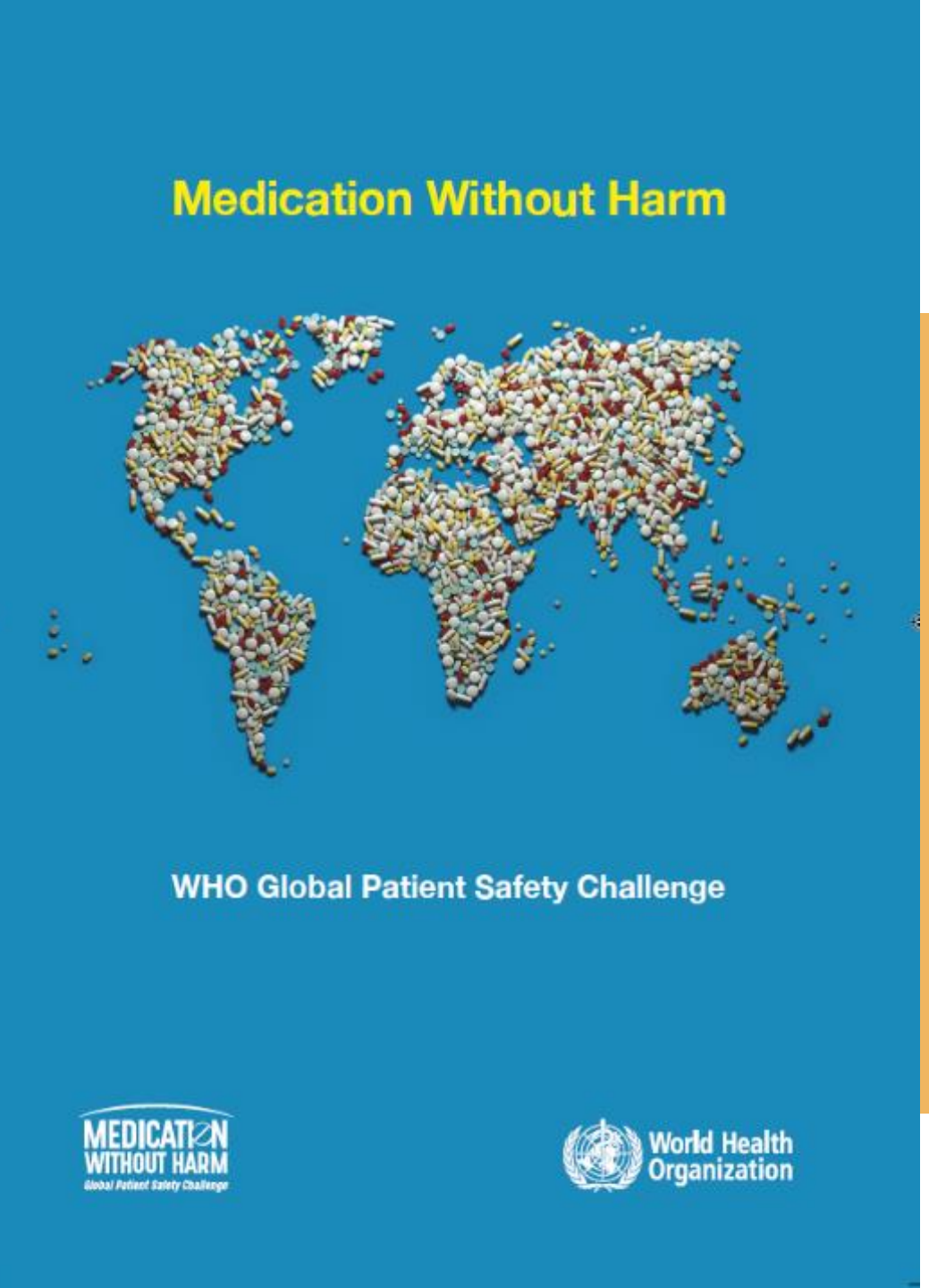

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Message on World Patient Safety Day 2022 from the WHO Regional Office for the Americas

Dr Carissa F. ETIENNE
WHO Regional Director for Americas

15 September 2022

PANEL discussion: "Medication safety: how to get better faster"

MODERATOR

Sir Liam DONALDSON
WHO Envoy for Patient Safety

PANELISTS

Dr Gitanjali BATMANABANE
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Patient Safety Champion
Mothers Against Medical Error

Mr Joe KIANI
Founder and Immediate Past Chairman
Patient Safety Movement Foundation
Co-Chair, Patient Safety Working Group US President's Council of Advisors on Science and Technology (PCAST)

Dr Aquiles Rodrigo HENRIQUEZ
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Ecuador

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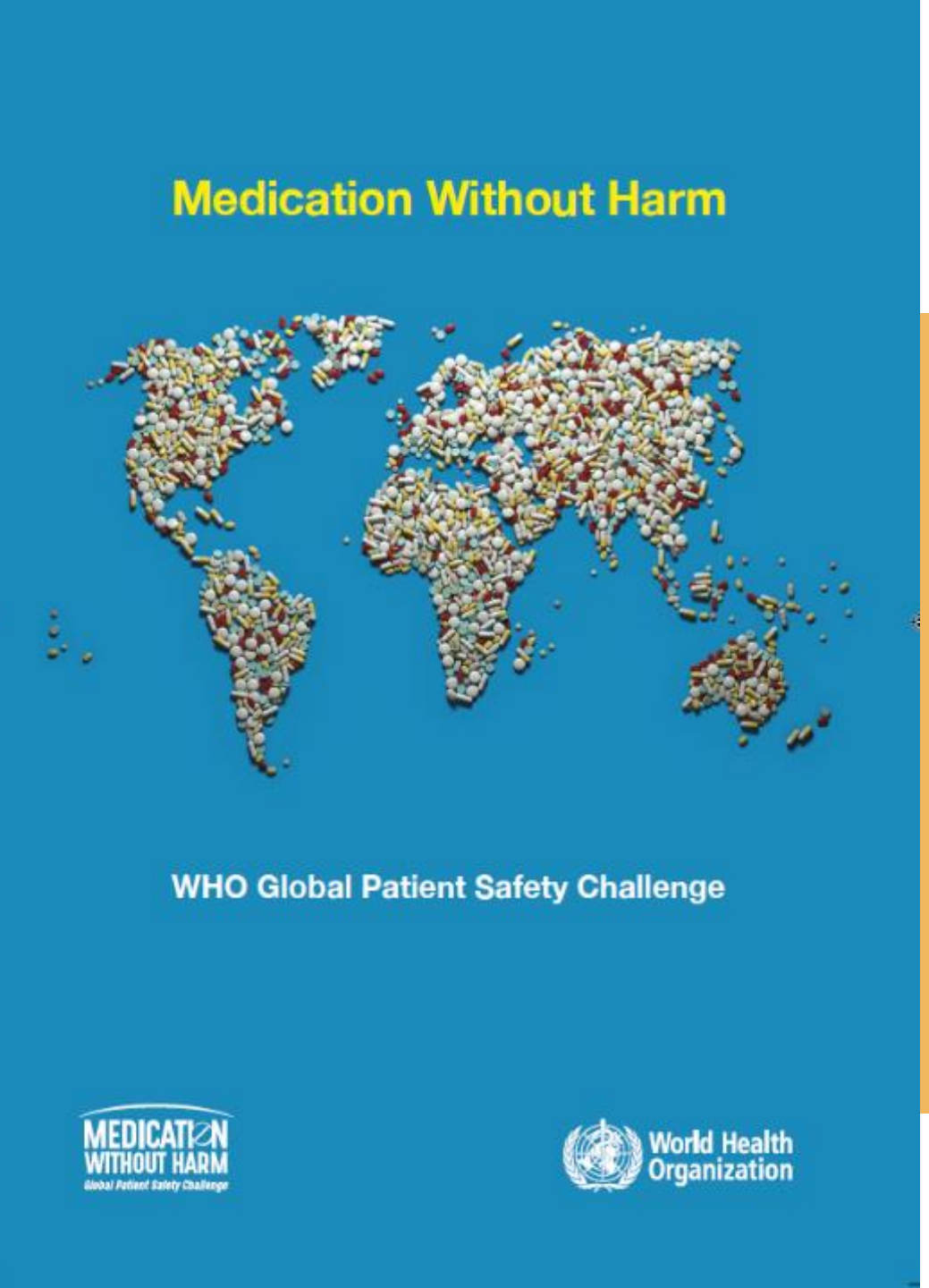
President Emeritus
Institute for Safe Medication Practices (ISMP) USA and Chairperson, International Medication Safety Network (IMSN)



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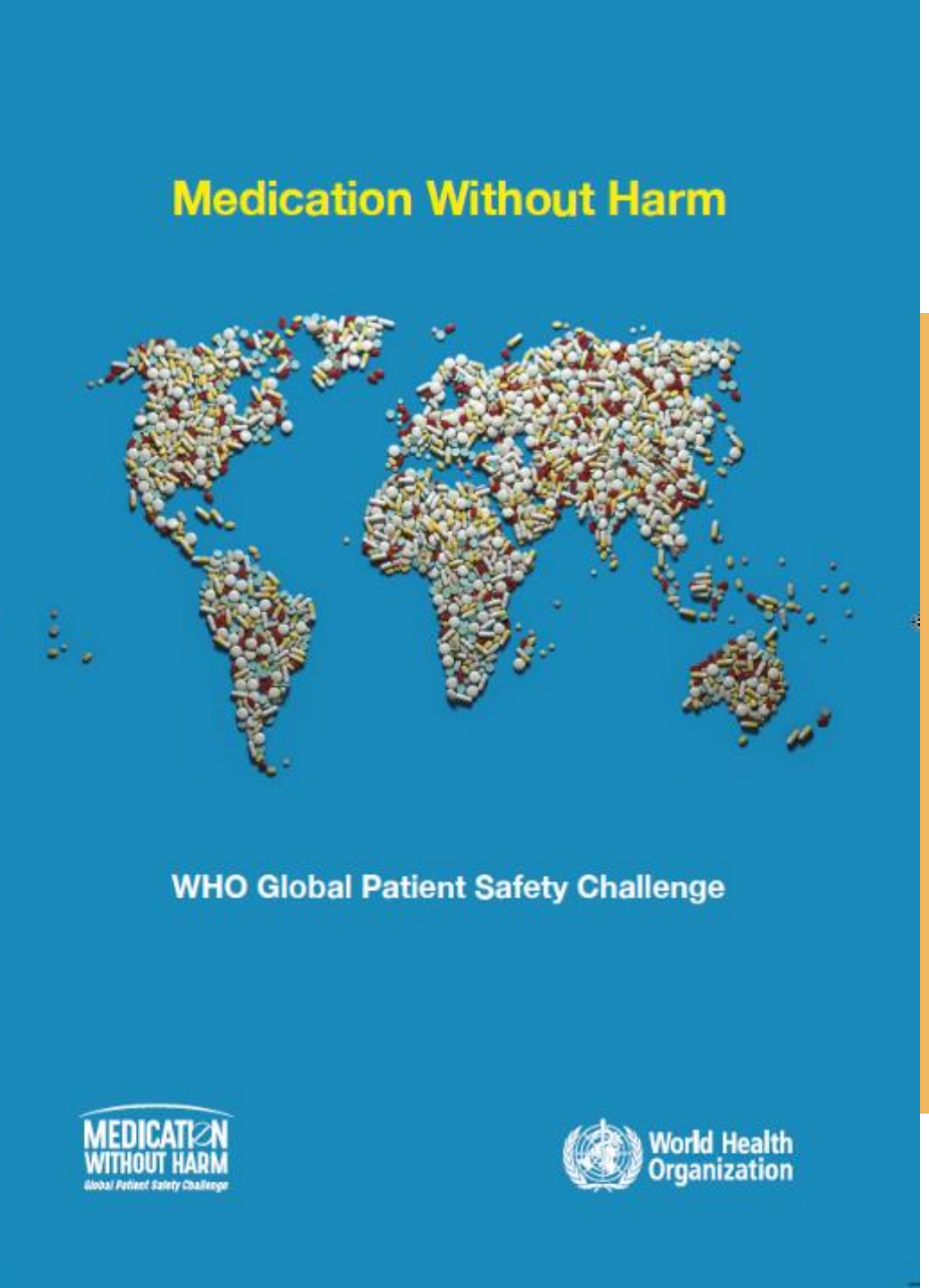
Message on World Patient Safety Day 2022 from the WHO Regional Office for the South-East Asia

Dr Poonam Khetrapal SINGH
WHO Regional Director for
South-East Asia

15 September 2022



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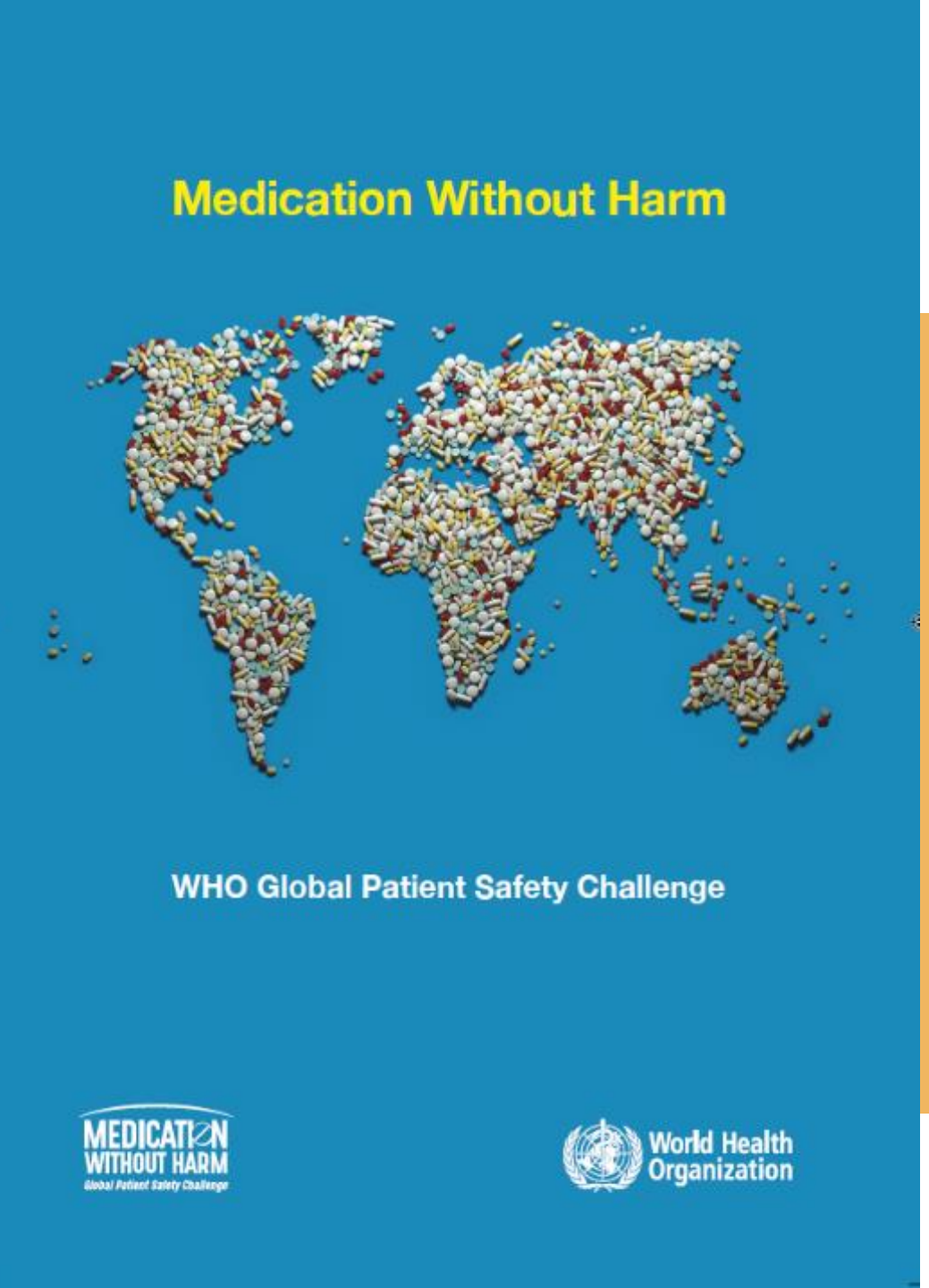
Closing session



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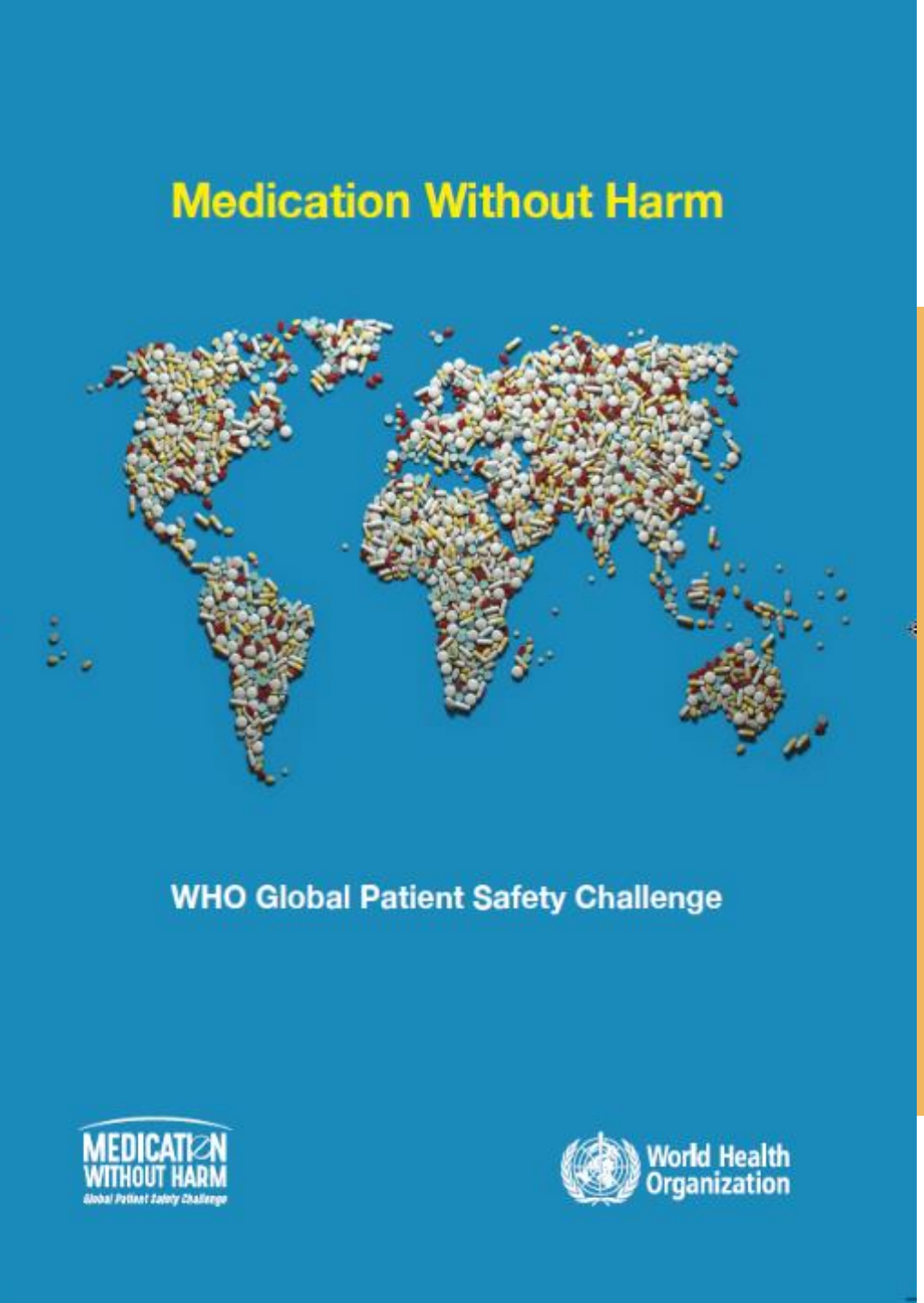
Message on World Patient Safety Day 2022 from WHO Director-General

Dr Tedros Adhanom GHEBREYESUS
WHO Director-General

15 September 2022



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Key messages and conclusion

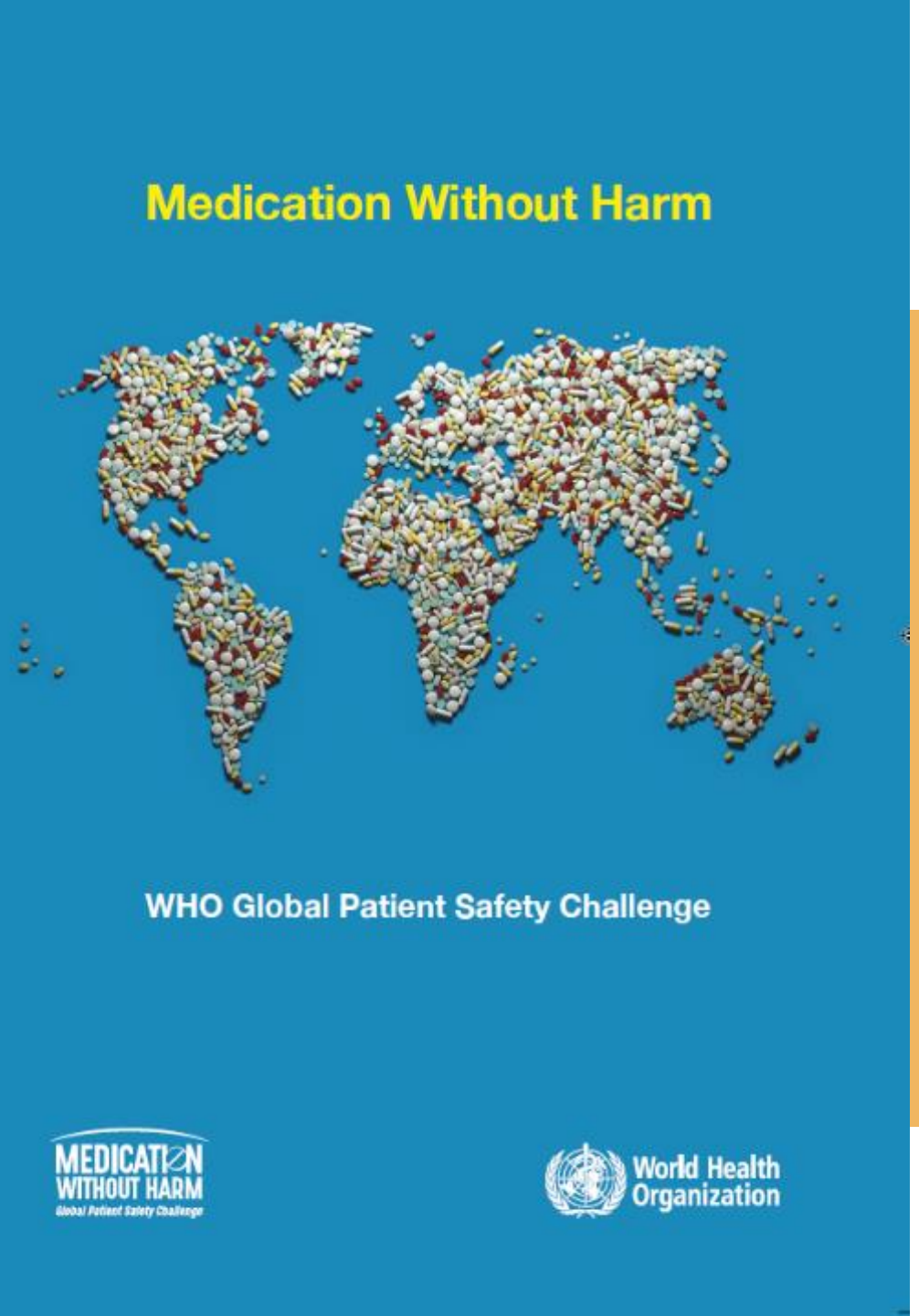
Sir Liam DONALDSON

WHO Envoy for Patient Safety

Dr Neelam DHINGRA

Unit Head
Patient Safety Flagship
WHO headquarters

15 September 2022



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Closing remarks

Dr Rudi Eggers

Director
Integrated Health Services (IHS)
WHO headquarters

15 September 2022