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مؤسسة حمد الطبية
Hamad Medical Corporation

Presentation:
Medication Safety from Pharmaceutical Policy Perspective

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Disclaimer:

PRESENTING AUTHORS HAVE NO RELATIONSHIPS TO DISCLOSE

Learning objectives

At the end of the symposium, participants are able to:

1. Outline the medication safety management strategies applicable to their institutions
2. Outline the institutional medicines policy components to ensure rational use of medicines

Presentation Outline

- ❑ Background
- ❑ Cases
- ❑ Plan of Actions
- ❑ Recommendations

Background

❑ Medicines help million of people around the world. However, they are not without risk.

❑ A deep understanding of legal, ethical and policy context is required to effectively navigate through today's regulatory environment.

❑ Errors involving medications have been identified as the major source of preventable error in healthcare.

❑ The World Health Organization describes the new discipline of patient safety as involving “the coordinated efforts to prevent harm, caused by the process of health care itself, from occurring to patients.”

Wrong vaccines send schoolgirl into coma

Saudi Gazette Saudi Gazette – Wed, Nov 19, 2014

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A female student has been admitted to Al-Hada Armed Forces Hospital in a coma and put into isolation after being administered three vaccines that were given to her by a medical team at a hospital earlier this week.

While the family demanded that the people accountable for their daughter's deteriorating health be brought to justice, Taif Health Affairs absolved itself of any responsibility.

Siraj Al-Hemaidan, director of Taif Health Affairs, said in a statement that the medical team does not belong to the directorate.

The girl's family was shocked when they saw her taken to an isolation room where no visits were allowed. They could only see her through the glass outside the room.

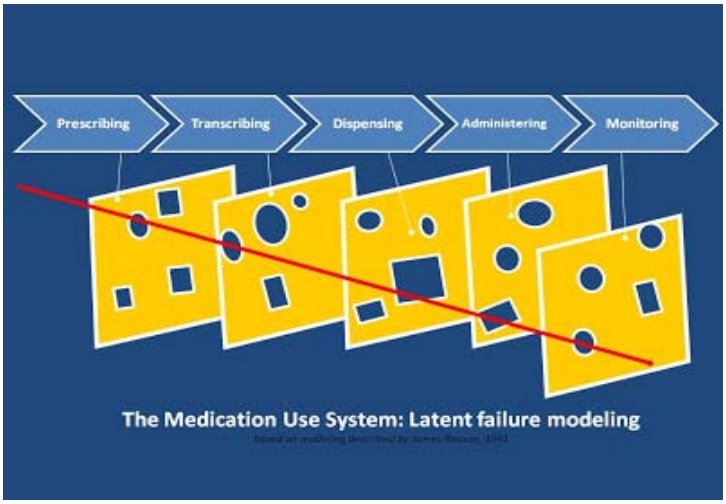
The family is still waiting for the medical report to be issued that would explain the medical condition of the student.

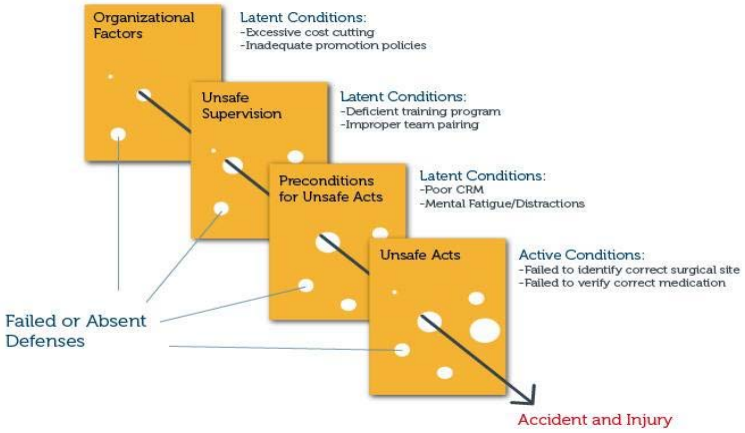
A preliminary diagnosis revealed that the girl suffered a severe breakdown in blood circulation and shortness of breath. She has been in a coma for six days.

Video

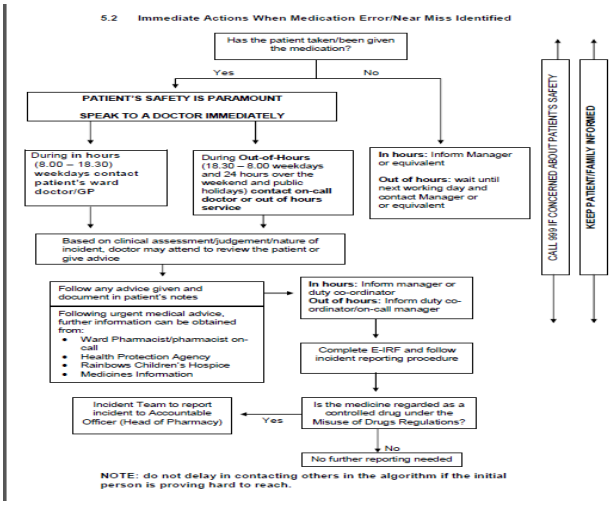
http://www.independent.co.uk/life-style/health-and-families/health-news/40-of-hospital-drugs-administered-incorrectly-6276354.html?origin=internalSearch

Swiss cheese model





Fast Actions Needed !!



Risk Management: Stakeholders Engagement Model

Evidence of Unsafe Medicines

Alarm over hospital medication errors

Share: Save: Subscribe: Print:

Wednesday December 14 2011

The headline "Four in 10 drugs wrongly administered in hospitals" may have caused undue concern to readers of *The Daily Telegraph* today. Similar claims in *The Independent* gave a misleading impression of some valuable new research into the way medicines are given in hospital.

Patients with swallowing problems were more prone to medication errors

The stories are based on a UK study looking at how nurses administered oral medicines to 679 patients with and without dysphagia (difficulty swallowing) on four stroke and care-of-elderly wards in the east of England. They found that of the 2,129 medicine doses administered, 817 doses (38%) contained some type of error. However, about three out of every four of these errors were "time errors" (the drug was given more than one hour earlier or later than planned) and it is not clear what, if any, adverse effects these might have had on patients. The percentage of other errors was closer to 10%. Once time errors were excluded from the analysis, researchers found that drug errors were more likely to affect those who had ongoing swallowing problems.

This finding may be useful in highlighting the need for healthcare

http://www.nhs.uk/news/2011/12December/Pages/hospital-drug-administration-errors-analysed.aspx

Error management

EDITOR'S CHOICE

Patient safety research: an overview of the global evidence

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Accepted 26 November 2008

ABSTRACT

Background Unsafe medical care may cause substantial morbidity and mortality globally, despite imprecise estimates of the magnitude of the problem. To better understand the extent and nature of the problem of unsafe care, the WHO World Alliance for Patient Safety commissioned an overview of the world's literature on patient safety research.

Methods Major patient safety topics were identified through a consultative and investigative process and were categorised into the framework of structure, process and outcomes of unsafe care. Lead experts examined current evidence and identified major knowledge gaps relating to topics in developing, transitional and developed nations. The report was reviewed by internal and external experts and underwent improvements based on the feedback.

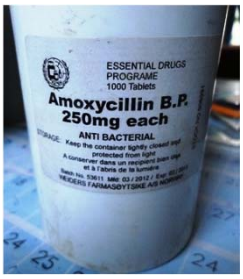
Findings Twenty-three major patient safety topics were examined. Much of the evidence of the outcomes of unsafe care is from developed nations, where prevalence studies demonstrate that between 3% and 16% of hospitalised patients suffer harm from medical care. Data

To better understand the causes and impact of the delivery of unsafe medical care from a global perspective, the World Health Organisation (WHO) Patient Safety team convened an ad hoc expert working group to establish priorities for research on patient safety. To help set priorities, the group commissioned a report on the current evidence available. This assessment was done by identifying topics in patient safety, examining related clinical and organisational issues and distinguishing gaps in current knowledge and directions for future research. This paper highlights the key points of the report. The full report, produced by the working group with the support of leading experts, is far more comprehensive and available on the WHO World Alliance for Patient Safety website (http://www.who.int/patientsafety/research/en/).

METHODS

The group began by identifying the types and causes of adverse events that are particularly harmful to patients. Major patient safety issues

Eg.: FALSIFIED MEDICAL PRODUCTS



Amoxycillin B.P 250 mg (Weiders ; BN 53611)

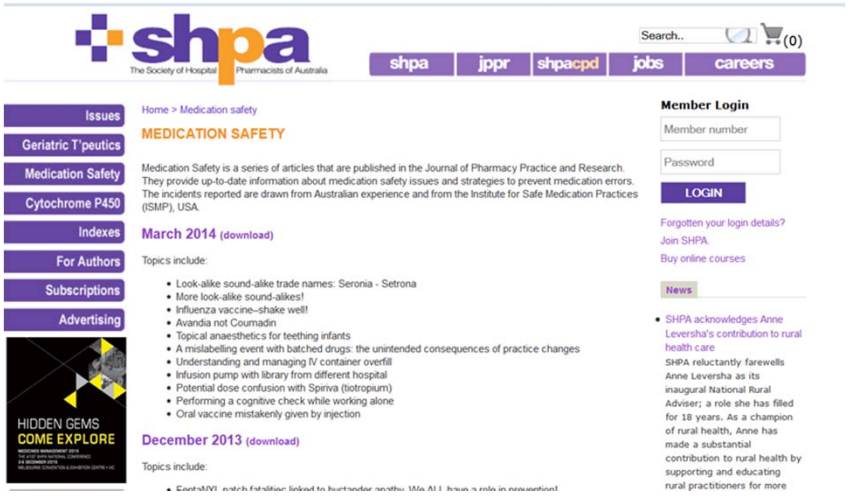
Quinine sulphate 300 mg B.P (Remedica ; BN 44675)

Quinine sulphate 300 mg B.P (Weiders ; BN 9765)

Sulfadoxine + pyrimethamine (Rivopharm ; BN 2869 SP)

Important and Useful Websites


عربي
中文
English
Français
Русский
Español
World Health Organization
Health topics
Data
Media centre
Publications
Countries
Programmes
About WHO
Search
Essential medicines and health products
Medicines
About us
News and events
Areas of work
Medicines publications
Medicines topics
Training resources
Drug Alerts
Drug Alerts
WHO issues a rapid Drug alert whenever a serious problem in the safety of any medicinal product arises. Focal points from different departments within WHO constitute the Alert Committee.
To report a Substandard/Spurious/Falsely labelled/Falsified /Counterfeit Medical product


shpa
The Society of Hospital Pharmacists of Australia
Search..
(0)
shpa
jppr
shpacpd
jobs
careers
Issues
Geriatric T'peutics
Medication Safety
Cytochrome P450
Indexes
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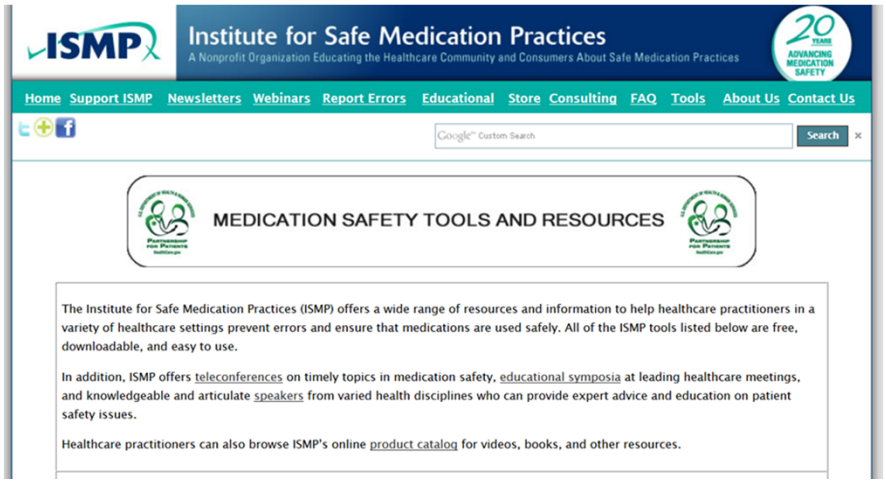
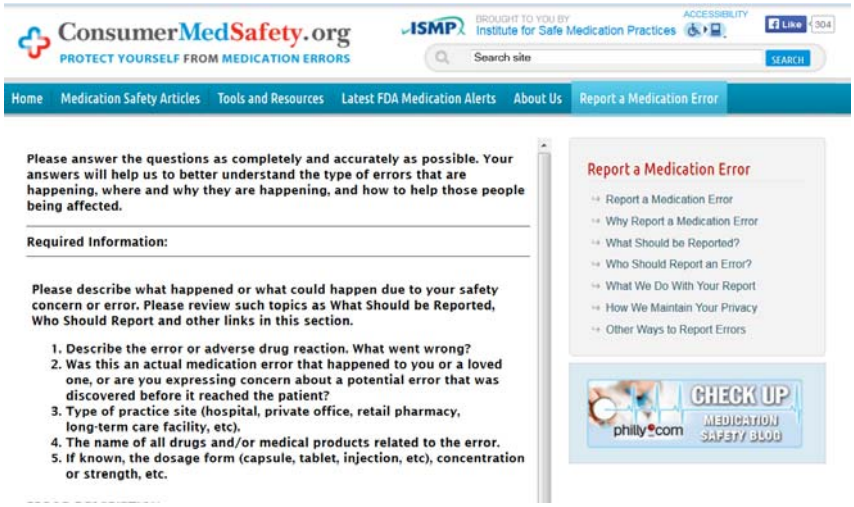
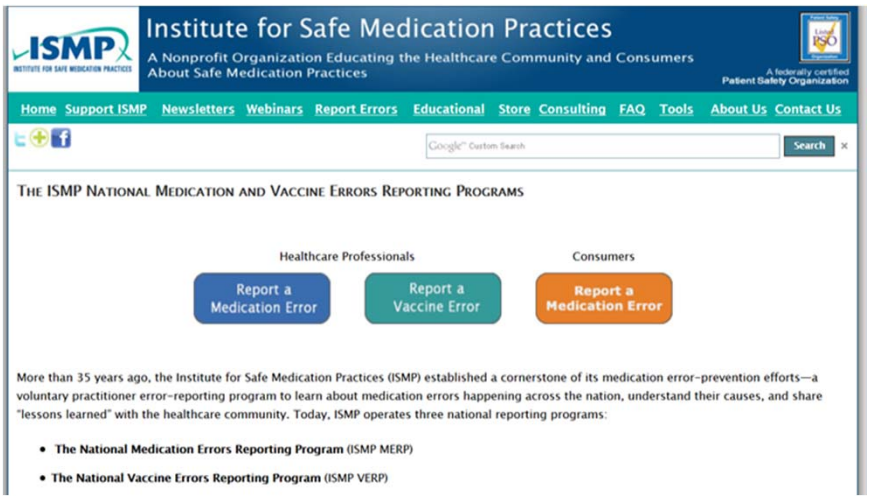
Advertising
HIDDEN GEMS
COME EXPLORE
Home > Medication safety
MEDICATION SAFETY
Medication Safety is a series of articles that are published in the Journal of Pharmacy Practice and Research. They provide up-to-date information about medication safety issues and strategies to prevent medication errors. The incidents reported are drawn from Australian experience and from the Institute for Safe Medication Practices (ISMP), USA.
March 2014 (download)
Topics include:
Look-alike sound-alike trade names: Seronia - Setrona
More look-alike sound-alikes!
Influenza vaccine–shake well!
Avandia not Coumadin
Topical anaesthetics for teething infants
A mislabelling event with batched drugs: the unintended consequences of practice changes
Understanding and managing IV container overfill
Infusion pump with library from different hospital
Potential dose confusion with Spiriva (tiotropium)
Performing a cognitive check while working alone
Oral vaccine mistakenly given by injection
December 2013 (download)
Topics include:
Member Login
Member number
Password
LOGIN
Forgotten your login details?
Join SHPA
Buy online courses
News
SHPA acknowledges Anne Leversha's contribution to rural health care
SHPA reluctantly farewells Anne Leversha as its inaugural National Rural Adviser; a role she has filled for 18 years. As a champion of rural health, Anne has made a substantial contribution to rural health by supporting and educating rural practitioners for more


ISMP
Institute for Safe Medication Practices
A Nonprofit Organization Educating the Healthcare Community and Consumers About Safe Medication Practices
20 YEARS ADVANCING MEDICATION SAFETY
Home Support ISMP Newsletters Webinars Report Errors Educational Store Consulting FAQ Tools About Us Contact Us
Search
MEDICATION SAFETY TOOLS AND RESOURCES
The Institute for Safe Medication Practices (ISMP) offers a wide range of resources and information to help healthcare practitioners in a variety of healthcare settings prevent errors and ensure that medications are used safely. All of the ISMP tools listed below are free, downloadable, and easy to use.
In addition, ISMP offers teleconferences on timely topics in medication safety, educational symposia at leading healthcare meetings, and knowledgeable and articulate speakers from varied health disciplines who can provide expert advice and education on patient safety issues.
Healthcare practitioners can also browse ISMP's online product catalog for videos, books, and other resources.


ConsumerMedSafety.org
PROTECT YOURSELF FROM MEDICATION ERRORS
ISMP BROUGHT TO YOU BY Institute for Safe Medication Practices
ACCESSIBILITY
Like 304
Search site
SEARCH
Home Medication Safety Articles Tools and Resources Latest FDA Medication Alerts About Us Report a Medication Error
Please answer the questions as completely and accurately as possible. Your answers will help us to better understand the type of errors that are happening, where and why they are happening, and how to help those people being affected.
Required Information:
Please describe what happened or what could happen due to your safety concern or error. Please review such topics as What Should be Reported, Who Should Report and other links in this section.
1. Describe the error or adverse drug reaction. What went wrong?
2. Was this an actual medication error that happened to you or a loved one, or are you expressing concern about a potential error that was discovered before it reached the patient?
3. Type of practice site (hospital, private office, retail pharmacy, long-term care facility, etc).
4. The name of all drugs and/or medical products related to the error.
5. If known, the dosage form (capsule, tablet, injection, etc), concentration or strength, etc.
Report a Medication Error
Report a Medication Error
Why Report a Medication Error
What Should be Reported?
Who Should Report an Error?
What We Do With Your Report
How We Maintain Your Privacy
Other Ways to Report Errors
CHECK UP
MEDICATION SAFETY BLOG
philly.com



http://www.ismp.org/Tools/links.asp

Plan of action

1. Education and awareness campaign
2. Change or improvement in practice
3. Research
4. Revisit the present regulation and policy

Plan of action

Commitment to reduce harm

1. Reducing or eliminating the risk of error
2. Making error visible, and
3. Minimizing the consequences or error

Plan of action

Set of Policies

1. Provide direction on the appropriate, safe and effective use of medicines
2. Describe the key points that should be included in standard operating procedures (SOPs)
3. Policy pertains to all healthcare staff that prescribe, dispense, distribute and/or administer medications

Medication Management Cycle

Accountability in Healthcare Practice: Is it Important?

- Accountability is an essential component of professional care practice
- Accountability is also an important element of patient safety
- In all code of ethics for healthcare professionals, there is the component of accountability: "to be answerable to oneself and others for one's own actions"
- We are accountable to the patients and their family members, our colleagues, our workplace, and our profession.
- I wish to extend this term, meaning and responsibility to the universities, policymakers others

- Patient Safety First
- And Who is Next?
- Healthcare providers? Are you at risk?
- Do medications harm you?

Recommendations

1. Networking – are we working in silo? Should we be working in silo? It's vital that team members step out of their silos and start working together
2. Looking collectively at risk
3. Establish a successful medication safety program for the country
4. More researches are needed

Wrong vaccines send schoolgirl into coma

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Preventing medication errors and promoting medication safety are shared responsibility

We need to get away from the traditional culture of Blame and Shame

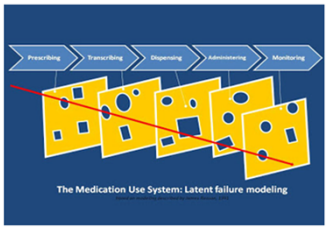
How can we as a team establish a hospital as a High Reliability Organization?

Defences

Barriers

Safeguards

Swiss cheese model



Lessons learned……

1. Medication safety is everyone's concern; not to blame and shame
2. National regulatory authorities need to be vigilanced within the supply chains
3. According to "Swiss Cheese model", faults happened in different layers of a system. Thus, we need a systems approach to handle the situation
4. Health institutions need a workable and effective policy and regulations