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

Sir Liam Donaldson
WHO Envoy for Patient Safety

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First story of medication-related harm
External Inquiry into the adverse incident that occurred at Queen’s Medical Centre, Nottingham, 4th January 2001

by

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The seeds of destruction
Pre-filled syringe containing Vincristine illustrating the warning written in blue text
Everything ok?
Vincristine: The trail continues
Safe vincristine use in Switzerland: Still a long way to go?

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Abstract
Background: Different international organizations recommend safety measures for the use of vincristine to prevent wrong route administration. 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 chemotherapy in Switzerland.

Methods: We conducted a written survey among hospital pharmacies of all general care and pediatric hospitals in Switzerland (n = 110). 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 60%), 27 have a hospital pharmacy preparing parenteral chemotherapy. All of those hospitals prepared vincristine in 2017, while 21 also prepared intrathecal chemotherapy. Of those 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 measure was labeling for vincristine and special delivery for intrathecal drugs. Of hospitals preparing vincristine syringes and intrathecal chemotherapy, those reported to have a policy for vincristine are still widespread, while 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

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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. Invariably patients die or suffer considerable morbidity. The reasons why these errors happen are not always known. In a literature review, Gilbert et al identified the following possible reasons:

1. Improper labeling for intended intrathecal medication, resulting in syringes and intravenous drug (i.e. vincristine) being mixed up.
2. Inexperienced medical staff, patient not treated in a specialist unit, treatment given outside of normal hours, administration order not checked and an insufficient warning label.

Different organizations such as the World Health Organization (WHO), the Institute for Safe Medication Practice (ISMP), the International Patient Safety Program, and the Swiss Patent Safety Foundation, Zurich, Switzerland have provided recommendations for the prevention of such errors.
Second story of medication-related harm
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
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
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*
## Shaping the Challenge: the Strategic Framework

<table>
<thead>
<tr>
<th>Patients</th>
<th>Medicines</th>
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<tr>
<td>Health professionals</td>
<td>Systems</td>
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Domain 1: Health care Professionals
Domain 2: Medicines
Domain 3: Systems and Practices of Medication
Domain 4: Patients and the Public
The 4 Domains of the Strategic Framework
Key Actions Areas

- High-risk situations
- Polypharmacy
- Transitions of Care
• **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
Early Priority Action – Technical reports
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
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

World Health Organization