Introduction to the WHO Technical Report
“Medication Safety in transitions of care”

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Medication Without Harm

• Reduce serious, avoidable medication-related harm by 50% over 5 years
People at greater risk of harm...

...and the priorities for improvement

• Polypharmacy

• Transitions of care

• High-risk medication (A PINCH)
  • Antimicrobials, Potassium/electrolytes IV, Insulins, Narcotics (opioids), Chemotherapy including methotrexate, Heparins and anticoagulants; Diuretics?, NSAIDs?

• High-risk patients (e.g. renal impairment, age, critically ill, cognitive impairment...)

Bejer HJ et al. Pharm World Sci 2002; 24: 46-54
Rodríguez-Mongioi R et al Pharmacoeconomics 2003; 21: 623-50
Lazarou J, Pomeranz BH, Corey PN. JAMA 1998; 279: 1200-5

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Large burden of discrepancies and harm

- **Unintentional discrepancies for 62% of patients**
- **25-80% of patients have discrepancies**
- **0.3 potentially harmful discrepancies per patient**
- **Discrepancies in 3.4-97% of patients and 22-72.3% of paediatric patients**
- **Harm: 0.16 potentially harmful discrepancies per patient**
- **10-14 days after discharge**
  - discrepancies persisted in 69%
  - 8% had additional error(s)
- **25-80% of patients have discrepancies**
- **Unintentional discrepancies for 62% of patients**

**References**
- Lehnbom Ann Pharmacother 2014
- Salanitro BMC Health Services Research 2013
- O’Riordan Int J Clin Pharm 2016
What needs to be done?

1. Leadership commitment and planning
   - Strategy, governance, resources, research, collaboration

2. Quality improvement programme
   - Goals, measures, key elements

3. Key components
   1. Partnering with patients, families and caregivers
   2. Medication reconciliation capacity and capability
   3. Information quality and availability at care transitions

4. Measurement
Partnering with patients, families and caregivers

• The patient is the one constant in their healthcare
• Patient knowledge and patient-held information hugely aids safe transitions

• Partnering between patients, families and health care professionals to
  • discuss proposed medication and changes and help patients manage safely
  • have an up-to-date medication list, app or smart card and bring it to healthcare appointments and pharmacy
BEFORE YOU TAKE IT...

KNOW your medication
CHECK the dose and time
ASK your health care professional

BEFORE YOU GIVE IT...

KNOW your medication
CHECK you have the right patient, medicine, route, dose, time
ASK your patient if they understand
Introducing Mobile Application on 5 Moments for Medication Safety

WHO medsafe app
Will guide you through the 5 key moments where your action can reduce the risk of medication-related harm.

Ask your health care professional important questions, keep the answers in a structured way to better manage your medications. Stay Healthy!

5 Moments for Medication

Starting a medication
- What is the name of this medication and what is it for?
- What are the risks and possible side-effects?

Taking my medication
- When should I take this medication and how much should I take each time?
- What should I do if I have side-effects?

Adding a medication
- Do I really need any other medication?
- Can this medication interact with my other medications?

Reviewing my medication
- How long should I take each medication?
- Am I taking any medications I no longer need?

Stopping my medication
- When should I stop each medication?
- If I have to stop my medication due to an unwanted effect, where should I report this?
Medication reconciliation

• Formal structured process
• Collaborative – medical, nursing and pharmacy
  • Agreed roles and responsibilities – evidence for pharmacy-led
  • Supported by tools and technology but not a replacement
• Where staffing is inadequate
  • Plan and invest in increased workforce capacity and capability, including under- and post-graduate education and training
  • Prioritize patients at higher risk of medication-related harm
Medication reconciliation

1. Build the Best Possible Medication History
   - Patient interview
   - Verify with at least one **reliable** information source
   - Back to patient
2. Reconcile and update list
3. Adjust medication in line with new patient conditions and experience with medication (adverse drug events, adherence)
4. Communicate about changes with **patient** and future healthcare providers

Figure adapted from Fernandes OA. Medication reconciliation. Pharmacy Practice. 2009;25:26
Measurement

Percentage of patients with at least one outstanding unintentional discrepancy

\[ \frac{\text{Number of patients with at least one outstanding unintentional discrepancy}}{\text{Number of eligible* patients}} \times 100 \]

Percentage of patients receiving medication reconciliation

\[ \frac{\text{Number of eligible* patients receiving medication reconciliation}}{\text{Number of eligible* patients admitted}} \times 100 \]

Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

- [ ] Yes, completely
- [ ] Yes, to some extent
- [ ] No
- [ ] I did not need an explanation
- [ ] I had no medicines
Take home

• Unintended medication discrepancies affect nearly every patient that moves across transitions of care.

• We can and must change this.
Join us in achieving...

Medication Without Harm

World Health Organization