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# Supporting the World Health Organisation Medication Without Harm Challenge

Unsafe medication practices and medication errors are a leading cause of injury and avoidable harm in healthcare systems across the world.[1] It has been estimated that 66 million potentially clinically significant errors occur per year with 71.0% of these occurring in primary care.[2]

This bulletin provides an overview of the 3rd World Health Organisation (WHO) global patient safety challenge entitled Medication Without Harm[1] and outlines additional supporting materials that are available to assist with its implementation.

This is one of a series of bulletins which support the implementation of WHO Medication Without Harm projects. The supporting bulletins are aimed at improving the safety of prescribing of four groups of medication:

- Insulins
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Sodium valproate
- Dependence forming medicines including opioids, benzodiazepines, Z-drugs, gabapentin and pregabalin

The aim of the WHO Global Patient Safety Challenge, launched on 29 March 2017, is to reduce severe avoidable medication-related harm by 50%, globally over five years.[1]

## Recommendations

- Review patients prescribed medicines with a higher potential risk of harm and implement appropriate measures to improve their safety.
- Focus medication safety projects on the four high-risk groups of medicines for implementation in primary care. Namely: insulins, NSAIDs, sodium valproate and dependency forming medicines.
- Use the guidance and support materials for organisations when considering reviewing prescribing medicines at higher risk of causing harm as a QIPP project. These are available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/
- Any change in treatment should aim to improve medication safety for the individual patient and be tailored to the individual.

## Safety

The three priority areas of medication safety that most affect patients are:

- High-risk situations
- Polypharmacy
- Transitions of care

Each area is associated with a substantial burden of harm and therefore, if appropriately managed, could reduce the risk of harm to many patients. WHO has produced a series of three technical reports on these topics to facilitate early priority actions and planning to address each of these areas.[3]

The World Health Organisation (WHO) Global Patient Safety Challenge on Medication Safety, launched on 29 March 2017, focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication-related harm. The aim is to reduce severe, avoidable medication-related harm by 50% in the next five years, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems.[1]

Medicines that pose a higher risk of severe adverse events with any error, such as in the key areas identified above, are a good place to start.

An Australian patient safety program has put together a list of medicines and groups of medicines that have been identified as universally high risk: anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy, and heparin and other anticoagulants. These medicines are represented by the acronym 'A PINCH'.[4]

## Patient factors

The call for action of the global campaign is "KNOW. CHECK. ASK." This encourages and empowers both patients and their caregivers and healthcare professionals (for example nurses, prescribers, pharmacists) to take an active role in ensuring safer medication practices and medication use processes including prescription, preparation, dispensing, administration and monitoring.[1]

Patient resources will assist in making sure that patients are also involved in knowing their medication, checking they know how to take it and asking a healthcare professional if they are unsure or need any additional information. These are available at https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

## Cost

The estimated NHS costs of definitely avoidable adverse drug reactions are £98.5 million per year, consuming 181,626 bed days, causing 712 deaths, and contributing to 1,708 deaths. This may even be an underestimate.[2]

Reducing severe avoidable medication-related harm by 50% in the next five years in line with the WHO Medication Without Harm challenge would save lives and reduce NHS costs.

## Summary

The World Health Organisation (WHO) Global Patient Safety Challenge on Medication Safety aims to reduce severe, avoidable medication-related harm by 50% in the next five years. We have identified four key areas for implementation in primary care with medicines that pose a risk of severe harm if any errors occur, namely: insulins, NSAIDs, sodium valproate and dependency forming medicines. Additional implementation resources are available to support medicines optimisation projects on these topics.

## Supporting resources

PrescQIPP Medication Without Harm resources on the topic of insulins. Available at https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

PrescQIPP Medication Without Harm resources on the topic of NSAIDs. Available at https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

PrescQIPP Medication Without Harm resources on the topic of sodium valproate. Available at https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

PrescQIPP Medication Without Harm resources on the topic of dependency forming medicines. Available at https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

## Additional resources:

PrescQIPP resources on Anticoagulation. Bulletin 183. October 2017. Available at: https://www.prescqipp.info/our-resources/bulletins/bulletin-183-anticoagulation/

# References


1. World Health Organisation (WHO). Global Patient Safety Challenge: Medication Without Harm, 2017. Available at: https://www.who.int/patientsafety/medication-safety/en/ Last accessed 12/06/19.
2. Elliott RA, Camacho E, Campbell F et al. Prevalence and Economic Burden of Medication Errors in The NHS in England: Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK. Policy Research Unit in Economic Evaluation of Health and Care Interventions (EEPRU). Published 22/02/18. Available at: https://pure.york.ac.uk/portal/en/publications/prevalence-and-economic-burden-of-medication-errors-in-the-nhs-in-england(dfaa1403-5ac8-4a35-85c9-b10dd2e8668f).html Last accessed 12/06/19.
3. World Health Organisation (WHO). Medication Safety in Key Action Areas. June 2019. Available at: https://www.who.int/patientsafety/medication-safety/technical-reports/en/ Last accessed 27/06/19.
4. Clinical Excellence Commission. New South Wales Government. High risk medicines: A PINCH. August 2015. Available at: http://www.cec.health.nsw.gov.au/patient-safety-programs/medication-safety/high-risk-medicines/A-PINCH Last accessed 27/06/19.


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| Briefing | https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/ |
| Implementation tools | |

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