**MEDICATION WITHOUT HARM**

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The three key actions of the 3rd WHO Global Patient Safety Challenge are: 1. Polypharmacy 2. High risk situations 3. Transitions of care

The strategic framework involves the following:

### 1. Patients and public

- **1.1 Public awareness and medication literacy**
  - Patient Campaign

- **1.2 Patient reporting**
  - Medicines SIDE EFFECT REPORT FORM (FOR CONSUMERS)

- **1.3 Patient engagement**
  - Program management: AFFORDABILITY SOLUTONS
  - Ongoing patient education & support
  - Patient satisfaction survey

- **1.4 Involvement of Patients organization**
  - CUSTOM LABELS

### 2. Medicines

- **2.1 Product quality and safety**
  - Formulation & Quality control
  - Manufacturing process

- **2.2 Storage and safe disposal**
  - Place in a container
  - Scratch and discard information

- **2.3 Naming, labelling and packaging**
  - Create your own CUSTOM LABELS

- **2.4 Right product at point of care**
  - Right Patient

### 3. Healthcare professionals

- **3.1 Education and training**

- **3.2 Capability at point of care**

- **3.3 Communication and teamwork**

- **3.4 Incident reporting and learning**

### 4. Systems and practices of medications

- **4.1 Leadership and Governance**

- **4.2 Administration and patient monitoring**

- **4.3 Prescribing, preparation and dispensing**

- **4.4 Monitoring and evaluation**

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**The Case Study - Medication Error**

A 62 years old male patient of post bilateral pulmonary embolism and was prescribed anticoagulant Coumadin (warfarin) 5mg daily. He came for weekly follow up with report of INR 8.

#### Importance

- No extra-warfarin
- No recent alcohol intake
- New prescription medication
- New symptoms of bruising/bleeding

#### Further questioning

New medication started 5 days earlier – Xarelto 2mg (Rivaroxaban)

#### Enquiry

- Clinic staff had asked to discontinue Xarelto. Prescription for Xarelto had been sent to his retail pharmacy to inquire about the cost of the medication with his insurance plan.
- The retail pharmacy kept it on hold rather than discontinuation and filled and dispensed it.
- Patient was not counseled about the same and assumed that it was prescribed for neuropathy.

#### Action

Xarelto was discontinued and warfarin dose gradually reduced until INR was within range.

#### Medication reconciliation

The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medications.

- It ensures that a hospital patient’s medication list is as up-to-date as possible.
- This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors or drug interactions.