

Enhancing Medication Safety: **Insights into Medication Errors** Reporting and Handling by the Saudi Food and **Drug Authority (SFDA)**

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Outline

- Saudi Vigilance Reporting system
- Draft Guidance on Medication Errors Reporting
- Medication Error Reports Handling





Saudi Vigilance

Report Forms



Report Forms

How to Report

- Access the Reporting Service
- Choose a model
- Filling out the form
- Sending the Report to specialists



















Medication Error Reporting

- Introductory Statement
- Contact Information
- Trade and Generic Name
- Strength
- Dosage Form
- Description of the medication error
- Images?



About

Search for Product Report F

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Medication Error Report



Reporting Purpose			
		the naming, labeling, packaging, and design that a nay cause or lead to a medication error, to drive s	
Contact Information			
Email	Email	Mobile	9665xxxxxxxx
Request Information			
Trade Name	Trade Name in English		
Generic Name	Generic Name		
Strength	Strength		
	Select	•	
Dosage Form	Select		~
Batch Number	Batch Number		
Is this report to inform about similarity between medication names, products, inappropriate, or missing and misleading information in packaging and labeling	○ Yes ● No		



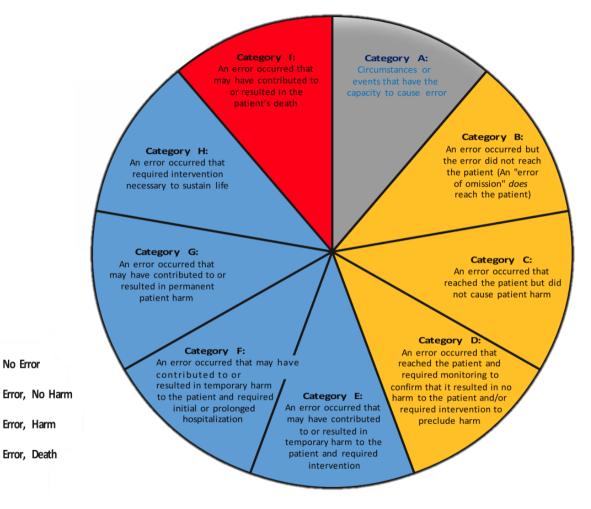
Medication Error Definition

"A medication error is any **preventable** event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use."

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)

NCC MERP Index for Categorizing Medication **Errors**

No Error





Contributing Factors?

4 Drug name, label, packaging problem?
 (e.g., look-/sound-alike names, look-alike packaging, unclear/absent labeling, faulty drug identification)





Types of Medication Errors

Product-related Medication Errors

Name Similarity
Look-alike / Sound-alike

Unclear labels

Lack of Critical Information on products packaging

Strength Expression

Discrepancies (translation/

packaging and labeling)

Design similarity
Unified themes
Look-alike
Packaging





Guidance for Medication Error Reporting

- Draft was released for public comments on July 23, 2023 for two (2) months
- Explains the importance of Med error reporting
- Steps to follow when reporting through the Saudi vigilance reporting system



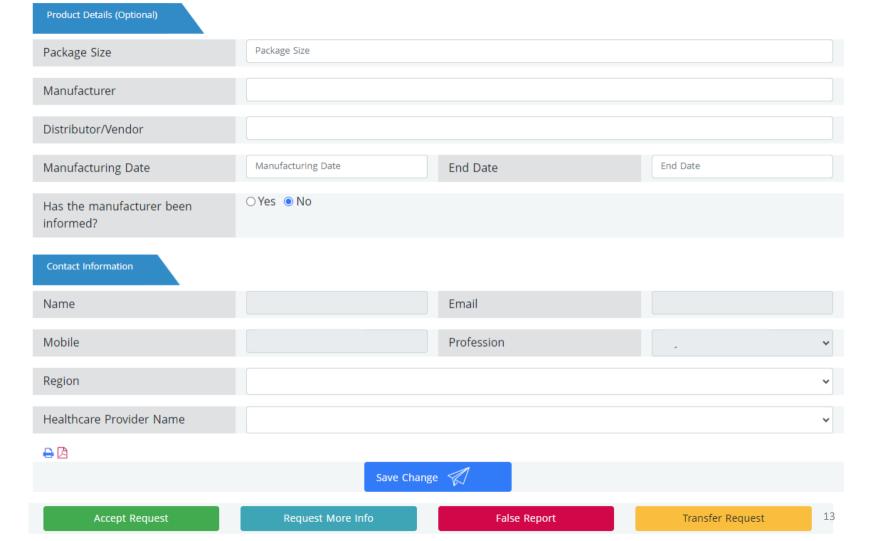


Medication Error Reporting Impact





Med Error Report Handling





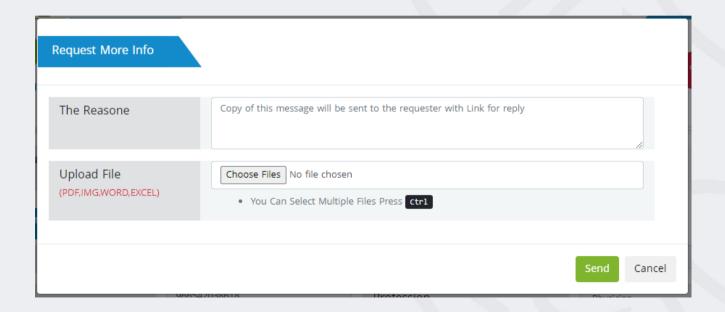


Accepted Request

Feedback to Report Submitter



Request More Info





Interactions with Qualified Person Responsible for Pharmacovigilance (QPPV)

- Med.drug@sfda.gov.sa
- Event description with images
- Recommendations
 - Product Modification (Trade name & artwork amendments)
 - Dear Health Care Provider Letter (DHCL)
 - Patient Education Materials
- Submit Variation Request



Examples



What's Wrong?







Dear Pharco Pharmaceuticals QPPV,

A medication error report was received through the Saudi Vigilance System (تيقظ) with the concern of strength discrepancy between the outer package labeling (carton label) and inner package labeling of Farcolin (salbutamol sulfate) 0.5% Respirator Solution — attached

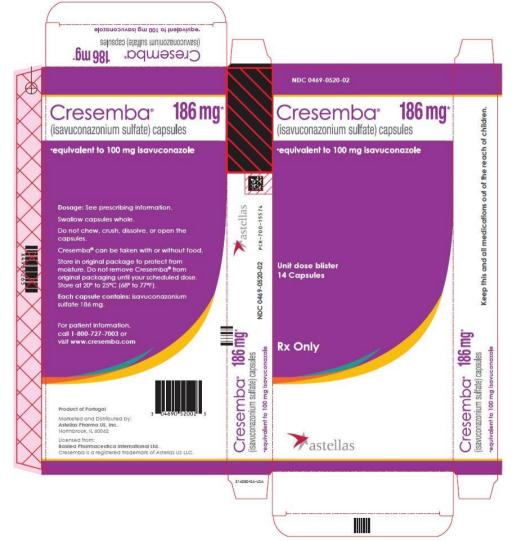
While currently used strength expression on outer package is matching the intended concentration of 0.5%, the inner package label does not. Calculating the amount of drug per mL using the information provided on outer package will result in the following concertation (5 mg/mL) which is different from the result of calculating amount per mL strength using inner label data (120 mg (0.121 g)/ 20 mL \rightarrow 6.05 mg/mL)

However, using any of the currently present strength expressions are discouraged, as they are confusing and require healthcare providers to calculate the dose upon prescribing which is subject to medication error.

Use of a common expression for Salbutamol nebulization solution as 0.5% accompanied by the amount per mL (5 mg/mL) is advised; to follow the innovator (Ventolin°) and since it matches usual prescribed doses of Salbutamol nebulization solution.

Kindly ensure using consistent strength expression across product packaging and labeling (primary and secondary packaging label, SPC, PIL,...etc.) in accordance to aforementioned recommendations, and availability of all critical information on principal display panel of outer packaging label to avoid any medication errors.

Regards,





Salt/Prodrug (Isavuconazonium sulfate) Vs. active moiety (Isavuconazole)





GTIN: 06285101003868 Batch No.: Mfg date.: Exp. date:



200 mg

I Vial

















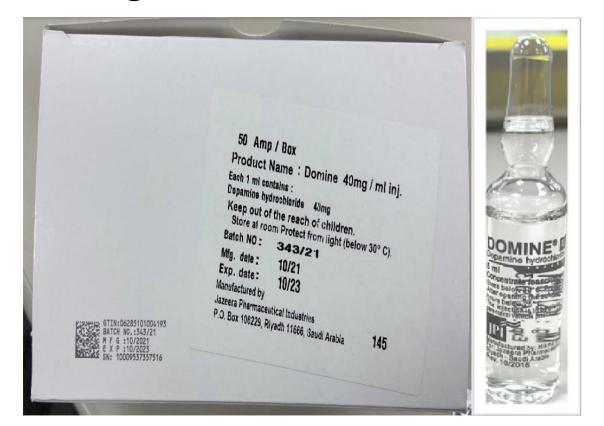
uydrocnioride







What's Wrong?



Good Day!

SFDA

We have received report of possible mix-ups between Domine (Dopamine Hydrochloride) 200 mg/ 5 mL (40 mg/mL) concentrate for solution for infusion ampoule with products from different manufacturers which typically occur with small containers — refer to the attached image

As per the SFDA Guidance for Graphic Design of Medication Packaging, the following amendments have to be considered to better differentiate various products and avoid any medication errors:

- 1. Use paper labeling where possible, and ensure that the label does not wrap completely around the ampoule to allow for inspection of contents. If clear plastic labeling must be used, highlight key information by inverting the text color.
- 2. Eliminate the overlapping text by keeping the information to minimum, as follow: proprietary name, nonproprietary name, strength, route(s) of administration, warnings or cautionary statements (if any), batch number, expiry date, and MAH.
- 3. Change the text orientation for the pharmaceutical information presented on the ampoule to be positioned longitudinally (vertically), along the length of the ampoule
- 4. The quantity per total volume should be the primary and prominent expression, followed in close proximity by quantity per milliliter enclosed by parentheses "i.e., 200 mg/5 mL (40 mg/mL)".

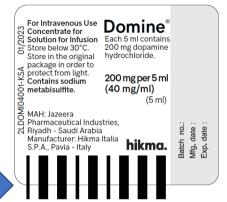
Kindly acknowledge receipt of this email and submit variation request with the new proposed artworks, ensuring the aforementioned recommendations are applied.



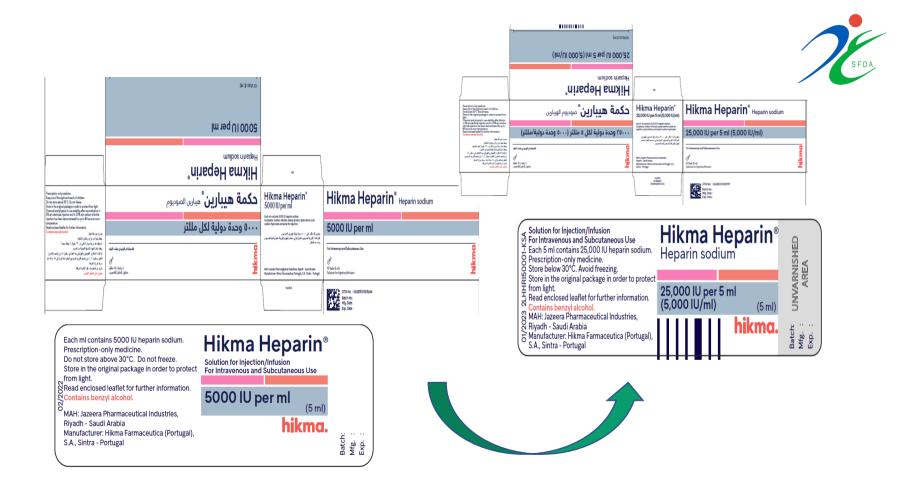




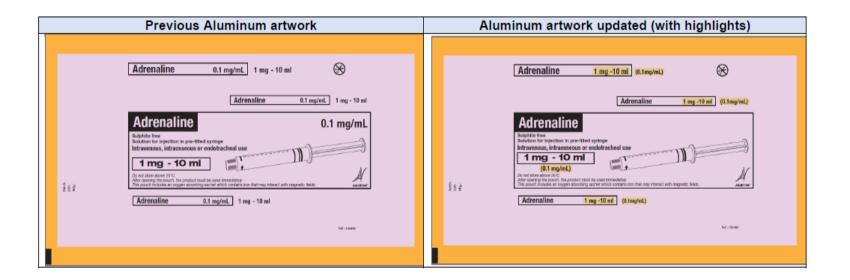






















The way Forward!

- Awareness about Medication Error Reporting
- Optional → Mandatory requirements!
- National Collaborations (CBAHI, SPSC)
- International Collaborations (IMSN)









Contact Us

Med.drug@sfda.gov.sa



Thank You