**REFERENCA**

1.World Health Organization. WHO Global Patient Safety Challenge: Medication without harm. Geneva: WHO; May 2017.

2.Assiri GA, Shebl NA, Mahmoud MA, et al. What is the epidemiology of medication errors, error-related adverse eventsand risk factors for errors in adults managed in community care contexts? A systematic review of the internationalliterature. BMJ Open 2018;8(5):e019101.

3.Krahenbuhl-Melcher A, Schlienger R, Lampert M, et al. Drug-related problems in hospitals: a review of the recentliterature. Drug Saf 2007;30(5):379–407.

4.Elliott R, 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 errors in the UK. PolicyResearch Unit in Economic Evaluation of Health and Care Interventions, Universities of Sheffield and York; 2018.

5.World Health Organization. Global campaign: Medication without harm. Geneva WHO. Available at:https://www.who.int/patientsafety/medication-safety/campaign/en/ (accessed 19 June 2020).

6.Council of Europe Committee of Experts on Management of Safety and Quality in Health Care: Expert group on safemedication practices. Glossary of terms related to patient and medication safety. Council of Europe; 2005.

7.Institute of Medicine. Patient safety: Achieving a new standard for care. Washington DC: National Academies Press;2004. Available at: https://doi.org/10.17226/10863 (accessed 19 June 2020).

8.Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: Building a safer health system. Washington DC:National Academies Press;2000.

9.Alliance for Health Policy and Systems research, World Healt Organization.WHO. Systems thinking for health systemsstrengthening. Geneva: WHO; 2009. Available at: http://www.who.int/alliance-hpsr/systemsthinking/en/index.html(accessed 19 June 2020).

10.STAKES. Potilas-ja lääkehoidon turvallisuussanasto [in Finnish]. Available at:https://www.julkari.fi/bitstream/handle/10024/75835/T28-2006-VERKKO.pdf (accessed 21 June 2020).

11.Huml RA. Pharmaceutical competitive intelligence for the regulatory affairs professional: New York: Springer; 2012.

12.Schepel L. Strategies for medication safety: An organization-based approach focusing on high-alert medications andclinical pharmacy services in Helsinki University Hospital. Helsinki: Helsingin yliopisto; 2018.

13.Nebeker J, Barach, P, Samore, MH. Clarifying adverse drug events: A clinician’s guide to terminology, documentation,and reporting. Ann Intern Med 2004 May 18;140(10):795–801.

14.Lotta S, Kirsi A, Kirsi K, et al. Strategies for improving medication safety in hospitals: Evolution of clinical pharmacyservices. Res Social Admin Pharm 2019;15(7):873–82.

15.Expert Group on Safe Medication Practices. Creation of a better medication safety culture in Europe: Building up safemedication practices. Council of Europe; 2006.

16.Inacio P, Cavaco A, Airaksinen M. The value of patient reporting to the pharmacovigilance system: a systematicreview. Br J Clin Pharmacol 2017;83(2):227–46.

17.Holmström A-R. Learning from medication errors in healthcare — How to make medication error reporting systemswork? [Academic dissertation]. University of Helsinki; 2017. Available at:https://researchportal.helsinki.fi/en/publications/learning-from-medication-errors-in-healthcare-how-to-make-medicat (accessed 21 June 2020).

18.Cheng L, Sun N, Li Y, Zhang Z, et al. International comparative analyses of incidents reporting systems for healthcarerisk management. J Evid Based Med 2011;4(1):32–47.

19.National Coordinating Council for Medication Error Reporting and Prevention. Taxonomy of medication errors. NCCMERP; 1998.

20.Bates DW, Boyle DL, Vander Vliet MB, et al. Relationship between medication errors and adverse drug events. J GenIntern Med 1995 Apr;10(4):199–205.

21.Council of Europe Committee of Ministers. Recommendation Rec (2006)7 of the Committee of Ministers to memberstates on management of patient safety and prevention of adverse events in health care. Council of Europe; 2006.Available from: https://search.coe.int/cm/Pages/result\_details.aspx?ObjectID=09000016805ae8b5 (accessed 19 June2020).

22.World Health Organization. Patient safety. Available at: https://www.who.int/patientsafety/en/ (accessed 19 June2020).

23.Sheikh A, Rudan I, Cresswell K, et al. Agreeing on global research priorities for medication safety: an internationalprioritisation exercise. J Global Health 2019;9(1):010422.

24.World Health Organization. Clean care is safer care. Available at: https://www.who.int/gpsc/background/en/(accessed 19 June 2020).

25.World Health Organization. Safe surgery. Available at: https://www.who.int/patientsafety/safesurgery/en/ (accessed19 June 2020)

26.World Health Organization. Medication safety in high-risk situations. Geneva: WHO; 2019.

27.World Health Organization. Medication safety in polypharmacy. Geneva: WHO; 2019.

28.World Health Organization. Medication safety in transitions of care. Geneva: WHO; 2019.

29.Panesar SS, deSilva D, Carson-Stevens A, et al. How safe is primary care? A systematic review. BMJ Qual Safe2016;25(7):544–53.

30.World Health Organization & WHO Patient Safety. Patient safety curriculum guide: multi-professional edition. Geneva:WHO; 2011.

31.Holmström A, Airaksinen M, Laaksonen R. Introducing basic principles of medication safety: Development of a three-day continuing education course for healthcare professionals. Currents in Pharmacy Teaching and Learning.2015;7(5):716–23.

32.Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. AJHP 1990;47(3):533–43.

33.International Pharmaceutical Federation/World Heath Organization. Joint guidelines on good pharmacy practice:standards for quality of pharmacy services. The Hague/Geneva: FIP/WHO; 2011.

34.World Health Organization. Good pharmacy practice in community and hospital pharmacy settings. Geneva: WHO;1996.

35.International Pharmaceutical Federation/World Heath Organization. Joint guidelines on good pharmacy practice:standards for quality of pharmacy services. The Hague/Geneva: FIP/WHO; 2011.

36.Jeddah Declaration on Patient Safety. Jeddah; 2019. Available at:https://spsc.gov.sa/English/Summit/Documents/JeddahDeclaration-En.pdf (accessed 19 June 2020).

37.World Health Organization. The Fourth Global Ministerial Summit on Patient Safety, 2–3 March 2019. Available at:https://www.who.int/news-room/events/detail/2019/03/02/default-calendar/global-ministerial-summit-on-patient-safety (accessed 19 June 2020).

38.International pharmaceutical Federation. Intervention on provisional agenda item 12.5 Patient Safety — Global actionon patient safety, World Health Assembly, 2019. Available at: https://www.fip.org/files/content/news/2019/FIP-intervention-1251-Patient-Safety.pdf (accessed 19 June 2020).

39.Patient Safety Network. Glossary. Available at: https://psnet.ahrq.gov/glossary (accessed 19 June 2020).

40.World Health Organization Regional Office for Europe. Patient safety. Available at:http://www.euro.who.int/en/health-topics/Health-systems/patient-safety (accessed 19 June 2020).

41.Institute for Safe Medication Practices Canada. Definitions of terms. Available at: https://www.ismp-canada.org/definitions.htm (accessed 19 June 2020).

42.Polnariev A. The Medication Error Prioritization System (MEPS): A novel tool in medication safety. P&T2014;39(6):443–7.

43.Sexton JB, Helmreich RL, Neilands TB, et al. The Safety Attitudes Questionnaire: psychometric properties,benchmarking data, and emerging research. BMC Health Serv Res 2006;6(1):44.

44.Paradiso L, Sweeney N. Just culture: It's more than policy. Nurs Manage 2019;50(6):38–45.

45.Runciman WB. Shared meanings: preferred terms and definitions for safety and quality concepts. Med J Australia2006;184(10 Suppl):S41–3.

46.Phillips DP, Bredder CC. Morbidity and mortality from medical errors: An increasingly serious public health problem.Ann Rev Public Health 2002;23:135–50.

47.Phillips DP, Bredder CC. Morbidity and mortality from medical errors: An increasingly serious public health problem.Ann Rev Public Health 2002(23):135–50.

48.Duckers M, Faber M, Cruijsberg J, et al. Safety and risk management interventions in hospitals: a systematic review ofthe literature. Med Care Res Review 2009;66(6 Suppl):90s–119s.

49.Reason J. Human error: models and management. BMJ Clin Res 2000;320(7237):768–70.

50.Weick KE. Organizational culture as a source of high reliability. California Manage Rev 1987;29(2):112–27.

51.Weick KE, Sutcliffe KM, Obstfeld D. Organizing for high reliability: Processes of collective mindfulness. In: Sutton RI,Staw BM (editors), Research in organizational behaviour Vol 2. Elsevier Science/JAI Press; 1999.

52.Reason J. The contribution of latent human failures to the breakdown of complex systems. Philos Trans R Soc of LondB Biol Sci 1990;327(1241):475–84.

53.Reason J. Human errors: models and management. BMJ 2000;320:768–70.

54.Cheung KC, van den Bemt PM, Torringa ML, et al. Erroneous exchange of asparaginase forms in the treatment of acutelymphoblastic leukemia. J Pediatr Hematol/Oncol 2011;33(3):e109–13.

Self-reported uptake of recommendations after dissemination of medicationincident alerts. BMJ Qual Saf 2012;21(12):1009–18.

56.Cheung KC, van den Bemt PM, Bouvy ML, et al. Relevance of foreign alerts and newsletters for the medication errorsreporting programme in the Netherlands: an explorative retrospective study. Drug Saf 2014;37(11):981–7.

57.DiCuccio MH. The relationship between patient safety culture and patient outcomes: A systematic review. J PatientSaf 2015;11(3):135–42.

58.Morello RT, Lowthian JA, Barker AL, et al. Strategies for improving patient safety culture in hospitals: a systematicreview. BMJ Qual Saf 2013;22(1):11–8.

59.Institute of Medicine Committee on Quality of Health Care in America. Crossing the quality chasm: A new healthsystem for the 21st century. Washington DC: National Academies Press;2001.

60.Nieva VF, Sorra J. Safety culture assessment: a tool for improving patient safety in healthcare organizations. Qual SafHealth Care 2003;12(Suppl 2):ii17–23.

61.Gershon RR, Stone PW, Bakken S, et al. Measurement of organizational culture and climate in healthcare. J NursingAdmin 2004;34(1):33–40.

62.Phipps DL, De Bie J, Herborg H, et al. Evaluation of the Pharmacy Safety Climate Questionnaire in Europeancommunity pharmacies. Int J Qual Health Care 2012;24(1):16–22.

63.Meyer-Massetti C, Cheng CM, Schwappach DL, et al. Systematic review of medication safety assessment methods.AJHP 2011;68(3):227–40.

64.Blegen MA, Pepper GA, Rosse J. Safety climate on hospital units: A new measure. In: Henriksen K, Battles JB, Marks ES,et al, editors. Advances in patient safety: From research to implementation (Volume 4: Programs, tools, andproducts). Rockville, Maryland: Agency for Healthcare Research and Quality; 2005.

65.Classen DC, Metzger J. Improving medication safety: the measurement conundrum and where to start. Int J QualHealth Care 2003;15(Suppl 1):i41–7.

66.Singla AK, Kitch BT, Weissman JS, et al. Assessing patient safety culture: a review and synthesis of the measurementtools. J Patient Saf 2006;2:105–15.

67.Kotter J. The 8-step process for leading change. Available at: https://www.kotterinc.com/8-steps-process-for-leading-change/ (accessed 19 July 2020)

68.Sivanandy P, Maharajan MK, Rajiah K, et al. Evaluation of patient safety culture among Malaysian retail pharmacists:results of a self-reported survey. Patient Prefer Adherence 2016;10:1317–25.

69.Chui MA, Look KA, Mott DA. The association of subjective workload dimensions on quality of care and pharmacistquality of work life. Res Soc Admin Pharm 2014;10(2):328–40.

70.Mekonnen AB, McLachlan AJ, Brien JE, et al. Barriers and facilitators to hospital pharmacists’ engagement inmedication safety activities: a qualitative study using the theoretical domains framework. J Pharm Policy Pract2018;11:2.

71.Lalor DJ, Chen TF, Walpola R, et al. An exploration of Australian hospital pharmacists’ attitudes to patient safety. Int JPharm Pract 2015;23(1):67–76.

72.Acheampong F, Bruce E, Anto BP. Medication safety activities of hospital pharmacists in Ghana; challenges andperceived impact on patient care. The International journal of risk & safety in medicine. 2015;27(1):1-10.

73.Acheampong F, Anto BP. Perceived barriers to pharmacist engagement in adverse drug event prevention activities inGhana using semi-structured interview. BMC Health Serv Res 2015;15:361.

74.Jia PL, Zhang LH, Zhang MM, et al. Safety culture in a pharmacy setting using a pharmacy survey on patient safetyculture: a cross-sectional study in China. BMJ Open 2014;4(6):e004904.

75.Magalhães GF, Santos GN, Rosa MB, et al. Medication reconciliation in patients hospitalized in a cardiology unit. PloSOne 2014;9(12):e115491.

76.Surugue J, Vulto AG. The hospital pharmacist: your stakeholder for in-hospital medication safety. EJHP Practice; 2006.Available at: https://ec.europa.eu/health/archive/ph\_systems/docs/ev\_20080617\_rd03\_en.pdf (accessed 19 June2020).

77.Holmstrom AR, Airaksinen M, Weiss M, et al. National and local medication error reporting systems: a survey ofpractices in 16 countries. J Patient Saf 2012;8(4):165–76.

78.Pharmacy Council of India. PCI introduction. Available at: http://www.pci.nic.in/GenInfo\_About\_Introduction.html(accessed 20 June 2020).

79.Ghana Pharmacy Council. Health Professions Regulatory Bodies Act, 2013 Act 857. Part 4 — Pharmacy Council, Section78-114. Available at: https://www.pcghana.org/wp-content/uploads/2017/02/Health-Professions-Regulatory-Bodies-Act.pdf (accessed 20 June 2020).

80.Benton D, Thomas K, Damgaard G, et al. Exploring the differences between regulatory bodies, professionalassociations, and trade unions: An integrative review. J Nursing Reg 2017;8(3):4–11.

81.US Food Drug Administration. Safety considerations for product design to minimize medication errors: Guidance forindustry. Available at: https://www.fda.gov/media/84903/download (accessed 20 June 2020).

82. Institute of Medicine. Preventing medication errors. Washington DC: National Academies Press; 2007.

83.Sustersic M, Gauchet A, Foote A, et al. How best to use and evaluate patient information leaflets given during aconsultation: a systematic review of literature reviews. Health Expectations 2017;20(4):531\_42.

84.European Medicines Agency. Recommendations on medication errors. Available at:https://www.ema.europa.eu/en/human-regulatory/post-authorisation/pharmacovigilance/medication-errors/recommendations-medication-errors (accessed 20 June 2020).

85.McCoy LK. Look-alike, sound-alike drugs review: include look-alike packaging as an additional safety check. Jt Comm JQual Patient Saf 2005;31(1):47–53.

86.Hoffman JM, Proulx SM. Medication errors caused by confusion of drug names. Drug Saf 2003;26(7):445–52.

87.Gam V. Safe drug dispensing. Presentation delivered 4 July 2007 in a Seminar on Safe Dispensing in Private Clinicsorganised by Community Network led by Yau Tsim Mong from The Hong Kong Medical Association.

88.WHO Collaborating Centre for Patient Safety Solutions. Look-alike, sound-alike medication names Available at:https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution1.pdf (accessed 20 June 2020).

89.Vogt EM, Robinson DC, Chambers-Fox SL. Educating for safety in the pharmacy curriculum. Am J Pharm Educ2011;75(7):140.

90.World Health Organization. Patient safety research — A guide for developing training programmes. Available at:https://www.who.int/patientsafety/topics/research/developing\_research\_training\_programmes/en/ (accessed 20June 2020).

91.International Pharmaceutical Federation. FIP Education initiatives — Pharmacy education taskforce: A globalcompetency framework. The Hague: FIP; 2012.

92. Kilroy RA, Iafrate RP. Provision of pharmaceutical care in the intensive care unit. Crit Care Nurs Clin N Am 1993;5:221-225

93. Bootman JL, Johnson JA. Drug Related Morbidity and Mortality. A cost of illness model.Arch Intern Med 1995;155:1949-56

94. Bond C, Raehl C, Franke T. Clinical Pharmacy Services, Hospital Pharmacy Staffing, and Medication Errors in the United States Hospitals. Pharmacotherapy 2002; 22:134-47

95. Kaushal R, Bates DW, Landrigan C, et al. Medication errors and adverse drug events inpediatric inpatients. JAMA 2001;285:2114-2120

96. Scarsi KK, Fotis MA, Noskin GA. Pharmacist Participation in Medical Rounds Reduces Medication Errors. Am J Health-Syst Pharm 2002; 59(21):2089-2092

97. Kucukarslan SN, Peters M, Mulnarek M, Nafziger DA. Pharmacists on rounding teams reduce preventable adverse drug events in hospital general medicine units. Arch Intern Med 2003; 163:2014-2018

98. Fortescue EB, Kaushal R, Landrigan CP, et al. Prioritizing strategies for preventing medication errors and adverse drug events in pediatric inpatients. Pediatrics 2003;111(4):722-729

99. Canadian Society of Hospital Pharmacists. An Information Paper on Pharmacist Prescribing Within a Health Care Facility. Can J Hosp Pharm 2002;55(1):56-62

100. To EK, Pearson GJ. Implementation and Evaluation of a Pharmacist-Assisted Warfarin Dosing Program. Canadian Journal of Hospital Pharmacy 1997;50(4):169-175

101. Leong W. Outpatient DVT Treatment. Hospital Pharmacy Practice 1998;6(2):1-31

102. Chenella FC, Klotz TA, Gill MA, Kern JW et al. Comparison of Physician and Pharmacist Management of Anticoagulant Therapy of Patients . American Journal of Health-system Pharmacy 1993;40:1642-1645

103. Chiquette E, Amato MG, Bussey HI. Comparison of an anticoagulant clinic with usual medical care. Archives of Internal Medicine 1998;158:1641-1647

104. Bungard TJ, Ackman ML, Ho G, Tsuyuki RT. Adequacy of anticoagulation in patients with atrial fibrillation coming to a hospital. Pharmacotherapy 2000;20:1060-1065

105. Dager WE, Branch JM, King JH et al. Optimization of inpatient warfarin therapy: impact of daily consultation by a pharmacist-managed anticoagulant service. Annals of Pharmacotherapy 2000;34:567-572

106. Institute for Safe Medication Practices. A Call to Action: Eliminate Handwritten Prescriptions Within 3 Years! 2000 <http://www.ismp.org/MSAarticles/Whitepaper1.html> (accessed Nov, 2003)

107. 2001/2002 Annual Report: Hospital Pharmacy in Canada Survey http://www.lillyhospitalsurvey.ca/hpc2/content/Rep2002.pdf (accessed Nov, 2003)

108.American Pharmacists Association. Oath of a Pharmacist. Available at: *http://www.pharmacist.*

 *com/oath-pharmacist.* Accessed February 3, 2016.

 109.Ho MP, Bryson CL, Rumsfeld JS. Medication adherence: its importance in cardiovascular outcomes.

 *Circulation*. 2009;119:3028–35.

 110.American Pharmacists Association. APhA Policy: Pharmacists Role in Promoting Medication Adherence.

 2015. Available at: <http://www.pharmacist.com/policy/pharmacists-rolepromoting-> *medication-adherence.*

Accessed February 3, 2016.