Healthcare Organization Commitment

Contact Details

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Position
Chief Quality Officer

Organization Name
Hospital Español

APSS

What Patient Safety Challenge does your Commitment address?
Challenge 3A - Medication errors

Commitment Name
Reducing the Risk of Medication Errors - Update - 12.28.2019

How many hospitals are represented in this commitment?

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<th>Last Report</th>
<th>Current</th>
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Did you download and use the APSS in tandem with your action plan?
Yes
If yes, was the APSS valuable?
Yes

Commitment Details

Commitment Update
The initial commitment actions have been continued based on a medication system that involves safe, technology and metric processes that help keep track of the strategies. This year as part of the actions that the hospital will add to reduce the risks of medication-related errors are: 1. Implement a system based on QR codes that allows monitoring of medications from the moment they enter the organization until they are administered to the patient. 2. Continue with safety barriers such as high-risk medication alerts, detection of allergic reactions to medications with suspension and replacement by another medication, use of bar code equipment and dose verification systems during medication administration. 3. Unify the electronic system in the medication section throughout the organization. 4. Integrate patient stories related to medication errors to the personnel as a mechanism of sensibilization and improving the culture of safety in the hospital.

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome.
- As part of the experience that has been acquired over the years in the Medication System we have learned the great help that technology provides in the control of medications to reduce the risks of error, as well as to achieve efficient use and control of the resources. - The importance of having control procedures and guides that allow staff to have updated information based on good practices such as safety barriers within the system. - Implementation of different safety barriers (conciliation, suitability, identification of LASA products, high risk, double verification, etc.) during the entire medication process as a mechanism to reduce the risk of errors.

Action Plan

Impact Details

Lives Saved

Predicted Lives Spared Harm
9.499999999999998

For reporting purposes, the number has been rounded up to the nearest whole number. Predicted Lives Spared Harm
10
Acknowledgement
Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.