Healthcare Organization Commitment

Contact Details

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APSS

What Patient Safety Challenge does your Commitment address?
Challenge 3D - Pediatric Adverse Drug Events

Commitment Name
Reducing Pediatric Adverse Drug Events - Update - 12.30.2019
**How many hospitals are represented in this commitment?**

<table>
<thead>
<tr>
<th>Last Report</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
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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

**Self Assessment Tool**

**Create an action plan**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Create a multidisciplinary team specialized in neonatal and pediatric medicine, nursing, and pharmacy that reports regularly to executive leadership</td>
<td>Yes</td>
</tr>
<tr>
<td>Use a software program to identify, detect, and report pediatric adverse drug events (pADEs) with analysis of the incidence and characteristics of pADEs and the near-misses</td>
<td>Yes</td>
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<tr>
<td>Set up a closed loop medicine administration system with an electronic medication administration record (eMAR) and barcoding, or other technology with computerized provider order entry (CPOE)</td>
<td>Yes</td>
</tr>
<tr>
<td>Collaborate in pADE reduction among all hospital systems during inpatient care and transitions of care</td>
<td>Yes</td>
</tr>
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**Ensure best patient care**

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</tr>
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<tr>
<td>Standardize order sets and protocols for each admitting diagnosis</td>
<td>Yes</td>
</tr>
<tr>
<td>Use a CPOE with decision support systems (DSS) including medicine reconciliation, allergy checking, interaction checking, and dose range checking with alerts</td>
<td>Yes</td>
</tr>
<tr>
<td>Use a double-check process of medicine verification before dispensing high-risk medicines</td>
<td>Yes</td>
</tr>
<tr>
<td>Ensure open communication and standardize medicine handoffs between healthcare teams at shift changes</td>
<td>Yes</td>
</tr>
<tr>
<td>Use ‘smart’ drug infusion pumps with drug libraries that include pediatric standardized medicine amounts for all weight ranges</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Engage staff and use data to find areas for improvement**

| Use pediatric-specific technologies such as eBroselow (or equivalent) to assure that basic resources to treat acutely ill or injured children are present 24/7 | Yes |
| Ensure that the healthcare team reviews and understands the FDA Safety Communication: “Syringe Pump Problems with Fluid Flow Continuity at Low Infusion Rates Can Result in Serious Clinical Consequences” | Yes |
| Use Continuous Quality Improvement (CQI) software from infusion pump manufacturers to routinely monitor drug library parameters and report the frequency of command overrides and alerts | Yes |
| Use patient stories – in written and video form – to teach and inspire change in your staff | No |

**Boxes Marked Yes:**
12

**Your Score:**
92%

**Commitment Details**

**Commitment Update**
The strategies described in the action plan of the initial commitment have been implemented, which has allowed us to improve the detection processes. Actions that will be reinforced to reduce adverse events in pediatric patients include:

1. Increase the notification of adverse events related to medication in pediatric patients by health personnel as part of one of the strategic objectives of the service.
2. Continue with safety barriers such as high-risk drug alerts, detection of allergic reactions to medications with suspension and replacement with another
medication, use of barcode equipment and dose verification systems during medication administration. 3. Integrate patient stories related to pediatric adverse drug events as a way to reinforce culture of safety in the personnel.

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome.
- The importance of having control procedures and guides that allow staff to have updated information based on good practices as a safety barrier to reduce the risk of errors. - The reinforcement with the staff of the importance of implementing highly effective measures without lowering the quality of care controls that allow reducing the risks of errors with patients.

Action Plan

Impact Details

Lives Saved

Next, make a prediction (goal) of your lives saved in the next 12 months. We’ll give you the opportunity to update us next year on the actuals:
2

Lives Saved:
2

Methodology for Determining Lives Saved:
We are using the metric to measure of adverse drug in pediatric events based on the formula of Number of reported adverse drug events with harm by class or medication in the Pediatric Unit/Number of doses administered (by medicine or class of medicines) in the Pediatric Unit.

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.