Healthcare Organization Commitment

Contact Details

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Commitment Details

Commitment Name
Medication Errors

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

Commitment Start Date
01/01/2017

How Many Hospitals Will This Commitment Represent
1
**Commitment Summary**
Establishing an effective plan to search, register and correct the medication errors in the Internal Medicine Service of the Hospital Juárez de México, by a multidisciplinary team in the phases of “medication”: prescription, preparation, storage, administration, registration and follow up.

**Commitment Description & Detail**
The plan will take actions with the purpose to reduce medication errors during a year in Internal Medicine Service of the hospital and save lives of patients, with the vision of establishing the correct plan in all the hospital services, to reduce costs and optimize the medication resources of the hospital.

**Action Plan**
Create the multidisciplinary team with physicians, nurses, pharmacists, epidemiology officer, investigation, patient safety team and hospital pharmacy. The patient sample will be patients of the Internal Medicine Service, adults from 20 to 60 years of age, both genders, with problems of metabolic syndrome or its complications, with special reference of this drugs*: opioids, sedatives, IV and oral anticoagulants, antibiotics, oral, subcutaneous or IV anti-diabetic drugs and concentrated electrolytes. •Design of the registration tool for the information •Review the knowledge of nurses of the service about intravenous infusion pumps. •Implement a refreshment course of training in infusion pumps for the nurses of the service. •Establish a continuous supervision in the nurses of the “7 correct moments” for administration of drugs. •Supervision of the process of “double verification” •Implement checklists for correct use of infusion pumps. •Measurement of the knowledge of the residents about correct and timely medication administration and good medical practices in this field. •Implement a course of correct medication administration for residents. •Implement a checklist to measure in a daily way the correct medication process. •Implement a standard order set in the medical record. •Implement the unique dosage of medication through the hospital pharmacy. •Make a basal determination of medication errors in the Internal Medicine Service, taking in account the correct drug, dosing considerations, interval of administration, registration in the medical record and collateral effects. •Measure daily by the multidisciplinary team the correct medication administration and detect the medication errors. •Make an electronic database of the medication errors. •In special cases the development of pharmacologic profile With the acquisition of experience in correct medication process and medication errors, design good practices for all the hospital with the objective of saving lives.

**Commitment Timeline**
Annex No. 1

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*Note: This is a hypothetical example to illustrate the structure. Actual content may vary.*