Healthcare Organization Commitment

Contact Details

Name
Manuel Alejandro Muñoz

Phone
5255 41605231

Email
malejandromunozs@imp.edu.mx

Position
Subdirector de Hospitalización Instituto Mexicano de Psiquiatría Ramón de la Fuente Muñiz

Organization Name
National Institute of Psychiatry Ramón de la Fuente Muñiz

Organization Address
Calzada México Xochimilco 101
Mexico City, CP 14370
MX

Commitment Details

Commitment Name
Medication Errors

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

Commitment Start Date
11/01/2017

How Many Hospitals Will This Commitment Represent
Commitment Summary
Reinforce the correct medication program with an improved and effective plan to search, register and correct the medication errors, adverse drug events and near misses in the inpatient Service of National Institute on Psychiatry (INPRFM), in the phases of medication: prescription, transcription, administration, registration and control.

Commitment Description & Detail
The Plan will take actions with the purpose to reduce medication errors and near misses and to identify the risk of adverse drug events and monitor and control the patients under these medications, during one year in the inpatient service of the Institute, with the vision of reinforcing the medication system.

The Plan will facilitate and improve communication with patients, nurses, medical residents, and physicians and reinforce continuous education, supervision, monitoring, and correction of errors and near misses and surveillance of adverse effects.

To accomplish this goal, it will include a process to identify risks in each phase of the medication system, to establish security barriers to prevent these risks, standardize medication labeling and information in the prescription and in the electronic file, instrument safety procedures in its distribution and administration and monitor the process of the medication system through measurable indicators.

It will ensure that clinicians have access to adequate information tools to support decision making.

Action Plan
The aim of the Action Plan is to promote team work among professionals in charge of each phase of the medication procedure, physicians, residents, nurses, pharmacists, hospital pharmacy, administrators and the quality of care team to ensure availability of medications with quality standards. It will include patients seen at the inpatient service, adults from 15 years of age and older, males and females, with a severe psychiatric condition.

1. Prepare and test an electronic database of the 2017 medication errors using standardized definitions.
2. Use of the standardized registration and follow up of formats of prescription.
3. Identify high risk medications and substances.
4. Train new staff and implement a refreshment course for nurses, residents and physicians.
5. Implement a supervision procedure on the correct prescription and use of prescription formats by residents and physicians. Supervise that therapeutic levels of lithium and anticonvulsants have been measured when prescribed.
6. Implement continuous supervision of nurses in the “7 correct moments” for drug administration.
7. Supervise the process of “double verification”.
8. Implement the use of a checklist for the correct prescription, transcription, registration and control of the medication process.
9. Supervise physician’s evaluation, on daily bases, of the correct dispensation of medication by nurses.
10. Register medication errors, adverse drug events, and near misses.
11. Register side effects.
12. Use as basal starting point the 2016 determination of medication errors in the inpatient service, to evaluate outcomes in 2017.
Commitment Timeline
Month - Activity 2-3 - Prepare and test an electronic database of the 2017 medication errors
2-3 - Train new staff and implement a refreshment course for nurses, residents and physicians. All - Use of the standardized registration and follow up of formats of prescription. All - Identify in a visible way high risk medications and substances All - Implement a supervision procedure and continuous monitoring of the correct prescription and use of prescription formats by residents and physicians. Supervise that therapeutic levels of lithium and anticonvulsants have been measured when prescribed. All - Implement continuous supervision of nurses in the “7 correct moments” for drug administration. All - Supervise the process of “double verification” All - Implement the use of a checklist for the correct prescription, transcription, registration and control of the medication process. All - Supervise physicians evaluate on a daily bases of the correct dispensation of medication by nurses. All - Register medication errors, adverse drug events, and near misses All Register side effects 12 - Use as basal the 2016 determination of medication errors in the inpatient service, to evaluate 2017 outcomes and report