Healthcare Organization Commitment

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Commitment Details

Commitment Name
Reduction in Anesthetic Medication Errors

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

How Many Hospitals Will This Commitment Represent
1

Commitment Summary
Department of Anesthesiology at our university hospital has a critical incident reporting mechanism in place since 1996. Empty forms are available in all the operating rooms of the hospital. These are filled on a voluntary basis by the medical and paramedical staff anonymously and are periodically reviewed and presented in academic meetings to educate, to increase awareness and to standardize and formulate guidelines.

We categorize these errors in different category and make action plans separately. Medication error is one of these categories. A medication error is ‘a failure in the treatment process that leads to, or has the potential to lead to, harm to the patient’. Medication errors can be classified as knowledge-based mistakes, rule-based mistakes, action-based slips, and memory-based lapses.

Commitment Description & Detail
We will retrieve medication error data for first six months; further make a subset of these errors. A list of action plans will be made and implement accordingly. We will tabulate data of medication error for the next six months and will look in to any repetition of same error. And then we can compare data of 2017 with 2018.

Action Plan
Action Plan: Standardization of prescription, specific labels, medication audits, e-mail alert, sharing of information at meetings of consultants and trainees, anaesthesia and surgical technicians.

Commitment Timeline
July 2017 to July 2020.