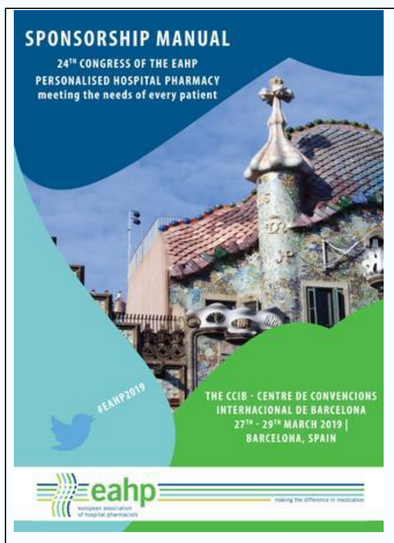

PREVENTING MEDICATION ERRORS REGARDING HIGH-ALERT MEDICATION

5PSQ-117

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OBJECTIVES

To make action protocols to minimize possible errors arising from the use of high alert medications and implanting them in a second level hospital through the pharmacy service.

METHODS

- The high alert medication list was obtained through the ISMP (Institute for the safe use of medicines).
- We analyzed the drugs included in it and we selected those that were reasons for doubt and by those who called more frequently to the hospital pharmacy service to clarify doses, routes of administration... In general, those that caused failures in the process of using them. We also tried to analyze the circumstances that could motivate these doubts or errors.
- These drugs were: oral anticoagulant, heparin, insulins, intravenous potassium chloride and oral methotrexate.

RESULTS AND DISCUSSION

High alert medication	Error o reason of doubt	Protocol of action
Oral anticoagulants	Lack of knowledge of dose and dosage schedule.	Transcription of the hematology guideline by the pharmacy service and dispensation the right dose for each day. Establish INR monitoring protocols.
Heparin	Confusion between doses and concentration. Possible confusion with Insulins when dosed also in units.	Reduce the variety of available presentations and indicate that heparin should be separated from insulin as well as from other drugs that are prescribed in units.
Insulins	Confusion between the different types, marks and concentrations.	Prescription by trade mark, decrease the number of presentations in the hospital.
Intravenous Potassium chloride	Storage of the solutions concentrated in the kits.	Remove potassium vials from care units and use pre-mixed potassium prepared by industry or pharmacy service.
Oral metrotexate	Daily administration instead of weekly.	Treatments conciliation (dosage and frequency of administration) to avoid overdosing.

CONCLUSIONS

The implantation of specific practices, including packaging, labelling, storage, prescription, preparation, etc., as well as the establishment of standardized protocols of action in the hospital will help to reduce the errors of medication.