PATIENT SAFETY: INTERVENTIONS TO REDUCE RISKS IN MEDICATION USE PROCESSES

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What?

Development and implementation of measures to improve patient's safety from purchase to drug prescription and administration.When we switch to a new provider maybe forced by drug shortage, we perform a review to avoid medication errors in all dosage forms.If needed, we elaborated alerts (pharmalerts) and newsletters. We applied Tall Man letters (TML) method to manage look-alike and sound-alike drugs, and to reduce prescription errors we elaborated a "Best practices on drug prescription" validated by Commission of pharmacy.

Why?

The confusion between drug names represents a common cause of medication errors due to similarities between trade names and active ingredients or vice versa. Very new drugs coexisting with others that are very well known can easily induce errors in wards, unclear prescription may lead to misunderstanding of prescription.
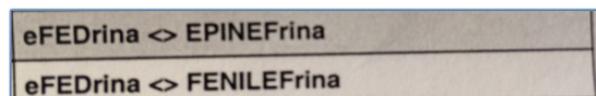
How?

We prepared a *formulary online* on the intranet where pharmacist introduces *relevant drug information* as composition (i.e, excipients, contents latex or not, etc.), dilution, stability, source of errors (name, brand name,etc) among others.

We compare them with existing ones to take an action, if necessary, that will be spread to all professionals.

To implement *TML method*

we followed the *ISMP recommendations*.

| eFEDrina <> EPINEFrina |
| eFEDrina <> FENILEFrina |

First, we selected 3 antibiotics: cef**OTAX**ime, cef**AZO**Lin, cefT**RIAX**one. We changed these names in the prescription program so that the differentiation is reflected when drugs are prescribed, dispensed and administered.
The implementation was explained to pharmacy, nursery and medical staff.After a month, we evaluated its acceptance.

What was achieved?

We reviewed 61 new products:
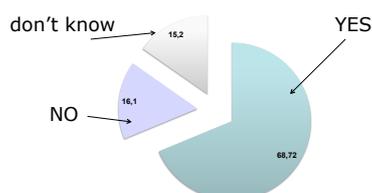- ✓ 50 trademarks,
- ✓ 14 new drugs and
- ✓ 7 dosage forms.

70.48% of products, acquired temporally or permanently, were new trademarks; 19.71% new drugs and 9.81% new dosage forms.
The review is a good tool for a safe use of drugs and improves communication between healthcare providers.

240 **questionnaires** were completed to evaluate **TML implementation** :

Acceptance was *92.05%* (nursery and *medical staff).*
91.17% thought that it *is possible* to make *a mistake with look-alike or sound-alike drugs* and

don't know 15,2   YES

NO 16,1

68,72

68.72% that *TML is useful* to minimise medication errors.

Next?

The huge acceptance of TML encorages us to select other drugs from ISMP list. We have 6 pairs of drugs. We are plannig to extend its use to storage shelves on wards