HIGH-ALERT MEDICATIONS, A STEP FORWARD TO IMPROVE PATIENT SAFETY

B. Bonaga Serrano[1], M. Gimeno Gracia[1], A.J. Frutos Pérez-Surio[1], T. Salvador Gómez[1], M.A. Allende Bandrés[1], B. Abad Bañuelos[1], F.J. Campos Montellano[1], V. Compaired Turlán[1], I. Puértolas Tena[1], M.J. Cumbraos Sánchez[1].

[1] Pharmacy Service, Hospital Clínico Universitario Lozano Blesa. Zaragoza, Spain.

WHAT WAS DONE?

A program for identifying and handle high-alert medications in a terciary hospital has been implemented.

WHY WAS IT DONE?

The implementation of safe medication practices plays a key role to prevent medication errors (ME) in the hospital setting. High-alert medications (HAMs) are those that bear a heightened risk of causing significant patient harm when they are used in error. Institutions such as the Joint Commission requires that hospitals define institution-specific HAMs and implement good processes.
Our objective was to ensure safe medication hospital practices and to eliminate medication errors that may cause harm, which is a priority to achieve patient´s safety goals.

HOW WAS IT DONE?

The project was carried out in different stages:
-First of all, it was consulted the updated list (published in 2012) by the Institute for Safe Medication Practices. Therefore, a total of 186 drugs were HAMs.
-The second step was identified them using auxiliary red colour labels to warn health professionals of their potential danger.
-Finally, we defined general and specific strategies to take up with HAMs. In general strategies, plant kits were reviewed to remove unnecessary stock and limiting access to HAMs. It was also standardized HAM handling practices. In this way, specific strategies focused on: methotrexate, insulin and heparin. Regarding methotrexate administered orally, it was distributed a fact sheet indicating rules to promote it proper administration. Regarding insulin, a working group was formed to determine the available presentations, reserving the insulin pen for diabetic debuts. For the unfractionated heparin, a procedure for standardized dilution of 5% heparin was performed being the 1% heparin restricted to certain services.

WHAT HAS BEEN ACHIEVED?

A total of 186 medications were identified as HAMs and different strategies to prevent ME with those was defined.

The main objective we have accomplished is becoming aware of their potential danger in case of error.

WHAT NEXT?

In the near future, our main objectives are asses the long-term impact of the implemented strategies, monitor ME involving HAMs and reassess the current list of HAMs to promote a safety culture in the hospital setting.

Keywords: Clinical pharmacy, Drug safety, Patient safety

Acknowledgements to all of the Pharmacy staff of Hospital Clínico Universitario Lozano Blesa for their dedication and total commitment

GPI Nº: PSQ5038