



# COMMITTEE FOR SAFE MEDICATION USE IN A SPANISH PHARMACY DEPARTMENT



De Andrés Morera S; R Ashok Natur R; Bilbao Gómez-Martino C; García-Trevijano Cabetas M; Gómez del Pulgar Carrillo E; Jiménez Núñez C; Jiménez Nacher I; Moreno Palomino M; Moro Agud M; Sobрино Jiménez C; Testillano Tarrero ML; Villamañán Bueno E; Herrero Ambrosio A.

Hospital Universitario La Paz - Madrid (Spain)



## What was done ?

A Committee for Safe Medication Use (CoSeMe) was created with pharmacists and technicians from the different areas of the Pharmacy Department (PD). This initiative was introduced in April-2019.

## Why was it done ?

The CoSeMe was created to contribute and improve patient safety.

The aim of this GPI was to constitute a Safe Medication Use working group within the PD and to define its structure and functions.



## How was it done ?

The working procedures of the Committee were defined, establishing: the frequency of meetings, the lines of effort and the activity monitoring through minutes accessible to all PD.



The meetings were structured as follows:

1. Identification of medication-related problems (MRP) based on different data sources;
2. Proposal of measures to be adopted in order to prevent/minimise the medicine's risks; and
3. Monitoring the implementation of risk minimisation measures.

## What has been achieved ?

### CoSeMe:

- ✓ Constituted in April-2019
- ✓ Composed of 12 people
- ✓ Frequency of established meetings: every two months.



The following **lines of effort** were defined:

1. Detection, notification and analysis of medication errors (ME);
2. Identification of MRP;
3. Development, implementation and monitoring of risk minimisation measures
4. Dissemination of drug-safety information.

From the analyses of the ME registered, 28 MRP were selected to be addressed, which were added to the 16 MPR identified from direct notifications and the 5 from safety bulletins. These 49 MRP were mainly involved in the "administration" and "prescription" stages of the medication process, being "dosing error" and "inappropriate drug selection" the main risks of ME. To address them, 76 risk minimisation measures were established.

## Results achieved

**49 MRP addressed**

**76 Minimisation measures established**

- ✓ 14 Training measures
- ✓ 13 Medication safety briefing notes
- ✓ 11 Measures for the storage of medicines
- ✓ 8 Measures for high-risk medicines identification
- ✓ 8 Medication administration aids
- ✓ 7 Electronic assisted prescribing aids
- ✓ 5 Tall Man Letters interventions
- ✓ 5 Protocolisation measures
- ✓ 3 Measures for hazardous medicines identification
- ✓ 2 Other measures

Good! Lot of recommended patient safety practices!

**72% fully implemented by June 2022**



## What's next ?

This GPI will help in the maintenance and **continuous improvement of the culture of safety** in the PD, including the minimisation of the risks associated with medicines. Moreover, the CoSeMe initiative is **easily implementable** in other healthcare centres, as well as **warmly welcomed and appreciated by other professionals**.