NEW MEDICATION-USE PROCESS IMPLEMENTED IN THE PERIOPERATIVE SETTING

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What was done?

We re-engineered the process of medication use in the perioperative setting, from pre-admission to discharge. We implemented safety practices to improve safe medication use in the daily practice.

Why was it done?

High prevalence of medication errors in the perioperative setting→ need of practices to ensure safe medication use:

- 2020: multidisciplinary team coordinated by the management was formed
- 2021: FMEA → 25 failure modes
- 2021: bibliographic review

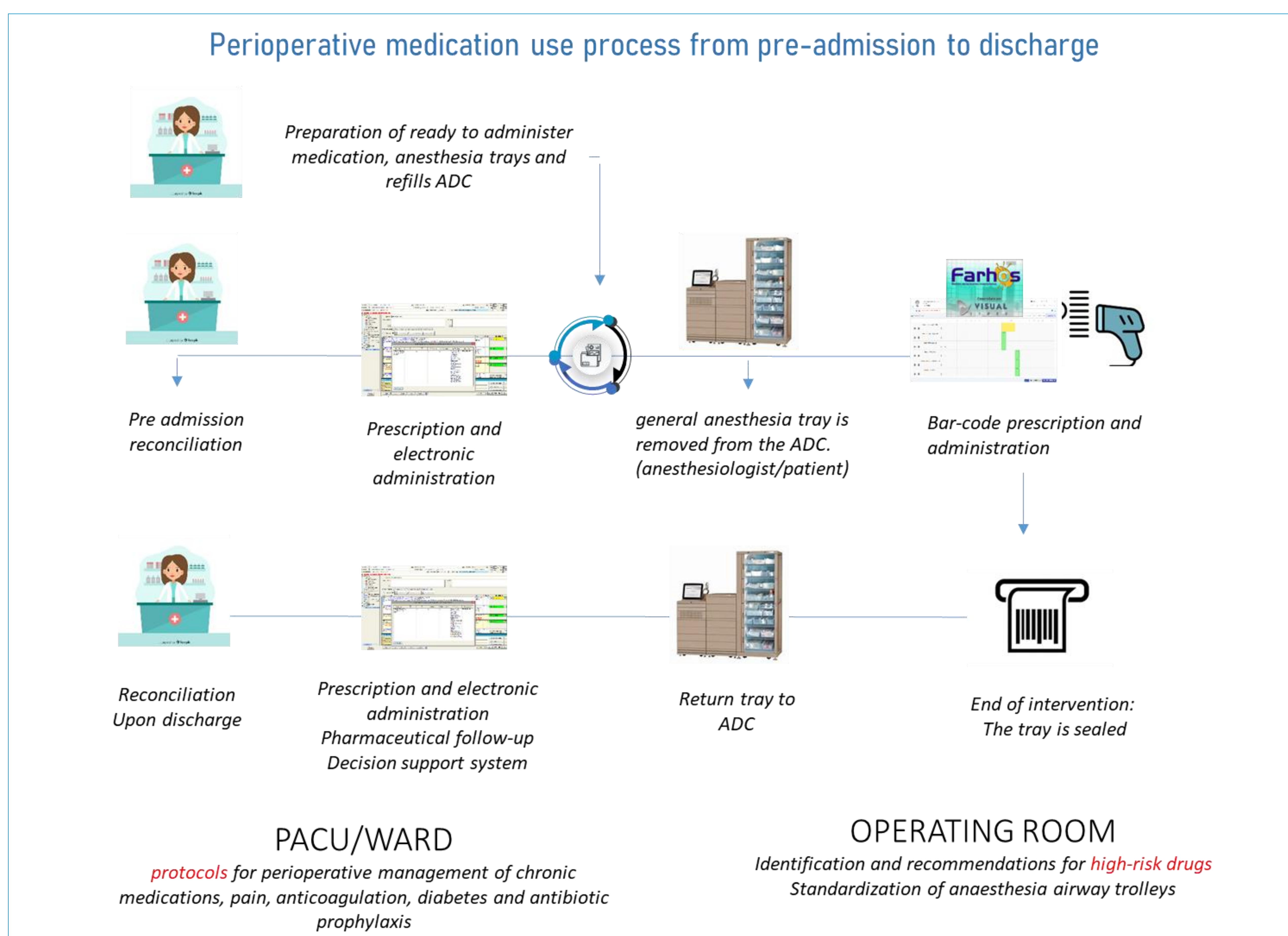
How was it done?

Obstacles were overcome as a result of the multidisciplinary teamwork, management support and the safety culture. We listened to health professionals' opinion, provided monthly information sessions in the Anaesthesia and Pharmacist Department in 2022 and disseminated information through the hospital website.

What has been achieved?

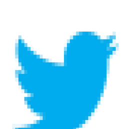
43% do not remember anesthesia recomendations
334 medication errors >=E

0,2% Cancelled surgeries due to incorrect chronic drug management (2,4% 2020)



What next?

We present a practical and real approach to promote perioperative patient safety in the daily practice.
Transfer into other centres is achievable.
There is a need to assess the impact and evaluate these safety practices to ensure ongoing improvement.



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