

DEVELOPING A PROJECT FOR BROADCASTING INFORMATION ABOUT MEDICATION ERRORS

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What was done?

Two hospital pharmacy specialists from two Spanish hospitals created a project based on web 2.0 to broadcast information about medication errors and how to prevent them

Why was it done?

Currently, with the extended use of social-networks (SN), information related to medication errors can be disseminated quickly and directly, and also provide interaction with professionals enhancing the information. This is very important to promote safety culture among health professionals to prevent medication errors.



How it was done?

- **1st step** was to create a **website** in which we could post information related to **medication errors** (www.stoperroresdemedicacion.org). The main part of the website is the blog, where we develop all information that we consider interesting. The website also has other sections containing useful resources: photo gallery with examples of look/sound-alike drugs, infographics, educational information, information about the authors and a section where readers can share content with the authors.
- **2nd step** was to create accounts on SN to spread the information posted in the website and also for sharing original content. We chose **Twitter®** and **Facebook®** as ideal SN. Twitter allows sharing information quickly and concisely and also is used by a different groups of healthcare providers by allowing us a wide spread. On the other hand, Facebook allows us to reach to a different audience, especially patients.

What has been achieved?

- Because of the multiple warnings that we have carried out about **Look-Alike/Sound-Alike** drugs, some pharmaceutical companies have considered changing the packaging of their drugs.
- We have achieved more than 72.000 signatures on **change.org** website requesting Spanish healthcare authorities to develop guidelines for the proper packaging and labeling of drugs. Because of this initiative, the Spanish press became interested in this problem and our project and the problem of drug packaging was mentioned in multiple media.



What is next?

Currently, we have included another pharmacist in our project in order to enhance the quality and periodicity of our publications. On the other hand, we are trying to work together with institutions dedicated to preventing medication errors to carry out joint projects in order to improve patient safety.