Medication Safety Use in Colombia: The view of the ACQFH

Asociación Colombiana de Químicos Farmacéuticos Hospitalarios

Claudia L. Pulido Ismael Basto Annual IMSN Meeting 2023 October 24

www.acqfh.org.co

National background

National Patient Safety Policy • 2008 Health Services basic standards

• 2013

National Accreditation Process

• Voluntary process

International accreditation

• By JCI



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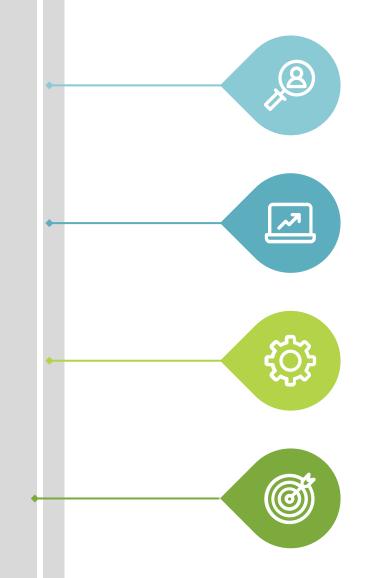
Evolution during the past 9 years



Actual situation for Hospital Pharmacy

Compuonding	Unit Dose System	High Risk	Controlled substances
100% Medications should be compound by Pharmacy	100% Hospitals must have a Unit Dose Program	100% Hospitals must have a high risk medication list.	Effort on 0% losses of controlled substances
Good Compounding Practices	Electronic Prescription and labeling	Medication use proceesses risk assesstment	Staff education and control

Pharmaceutical Industry challenges



Moves towards regional harmonization of labels

Lack of knowledge on regulatory authorities about safer labeling strategies

 Tall-man lettering is not allowed in Chile
 Difficulties to state safer strength

expression in Central America

Shortages: "Vital not available"

Few ready to use medications available

Some medication errors: case 1



Uso seguro de medicamentos

New evidence on safer labeling

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Research Article Estimating the impact of label design on reducing the risk of medication errors by applying HEART in drug administration	99 Cite Cite Status: Under Review Springer	Download PDF
	European Journal of Clinical Pharmacology	
This is a preprint; it has not been peer reviewed by a journal. https://doi.org/10.21203/rs.3.rs-3250873/v1 This work is licensed under a CC BY 4.0 License	Version 1 posted 17 Aug, 2023	~
Abstract	 Reviews received at journal Reviewers agreed at journal 	27 Sep, 2023 22 Sep, 2023
Medication errors are one of the biggest problems in healthcare. The medicines ' poor labelling design (i.e., Look-Alike labels) is a well-recognised risk for potential confusion, wrong administration, and patient damage. Human Factors and Ergonomics (HFE)	 Reviewers invited by journal Submission checks completed at journal 	28 Aug, 2023 10 Aug, 2023
encourages the human-centred design of system elements, which might reduce medication errors and improve people's well-being and system performance.	n Editor assigned by journal First submitted to journal	10 Aug, 2023 10 Aug, 2023

https://www.researchsquare.com/article/rs-3250873/v1

Research Article

Aim: To estimate impact of a Human-Centred Design (HCD) labels on medication administration compared to a Look-Alike (LA) labels.

Method: Modified Human Error Assessment and Reduction Technique (HEART) version to analyse a medication administration task in a simulated NICU scenario (Ergonomics – Human Factors).

Results: Human Error Probability was reduced by up to 56%, and the percentage of contribution to the unreliability of label design was consistently reduced by at least 40% in all the scenarios when the HCD label was evaluated.





ACQFH MEDICATION SAFETY USE CHAPTER



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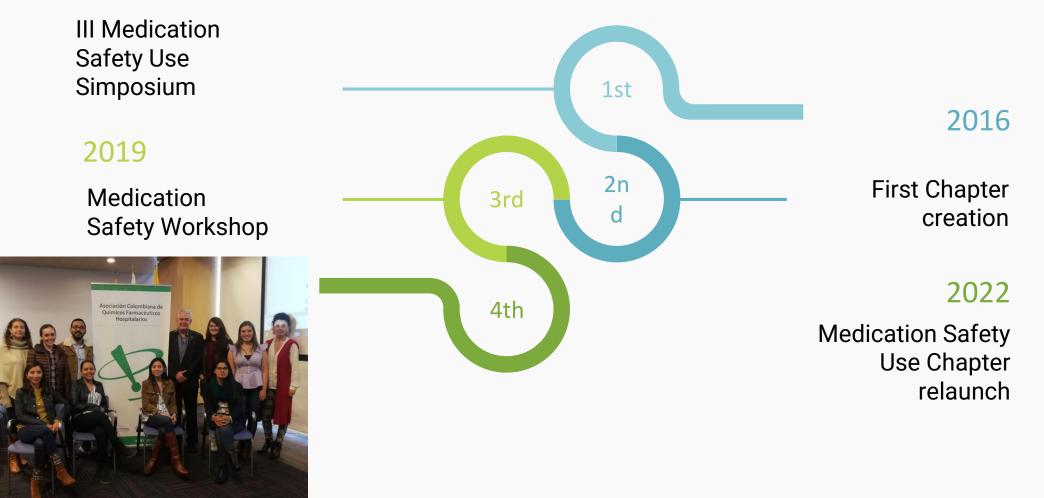
MAIN OBJECTIVE

To stablish a working team belonging to the ACQFH responsible for identifying, promoting and managing the Safe Use of Medicines in Colombia, and acting as a national and international reference.



HISTORY OF MEDICATION SAFETY USE CHAPTER

2015



OUR TEAM



Viviana A. Pinzón HUSI



Claudia Pulido C.Country/ ACQFH



Paula Moreno HPTU



Carol Muñoz Los Cobos/ ACQFH



Andrés Valencia HPTU



Karen Charria C.Country



Luis A. Cárdenas HOMI









Tatiana Perdomo C. Marly

rly Sandra Fuentes H. MEDERI



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STRATEGIC GOALS



Establish a comprehensive overview of safe medication use at national level.



To lead consensus relating to safe medication use, and to offer technical support to the healthcare system in this field



To propose and disseminate strategies for medication safety use, and define local implementation models



To maintain a permanent relationship with international medication safety networks in a two-way approach.



MAIN ACHIEVEMENTS



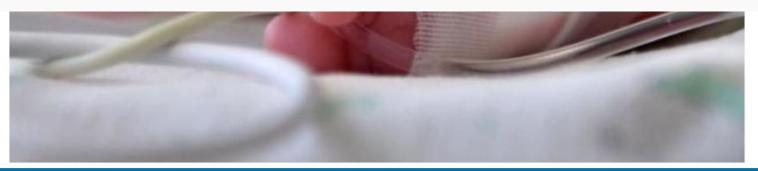


Medication safety use chapter relaunch



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Some medication errors: case 2



Bebé de nueve meses, con pronóstico

reservado por error con

medicamento

Le habrían suministrado 33 veces más la cantidad del fármaco que requería para tratar la dermatitis.



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contributing factors

Improvement actions



Lack of availability of commercially pediatric drugs

Calculation errors for pediatric doses.

Administration in emergency department.

Delegating medication ad ministration activity



Increase in the preparation of standard pediatric doses in pharmacy compounding area



Education and training



Update available information and protocols



Share lessons learned



MAIN ACHIEVEMENTS



Position paper: Recommendations for safe drug preparation in hospitals





KEY CHALLENGES







PUBLIC HOSPITALS MEMBERS

RELATIONSHIP WITH ACADEMY

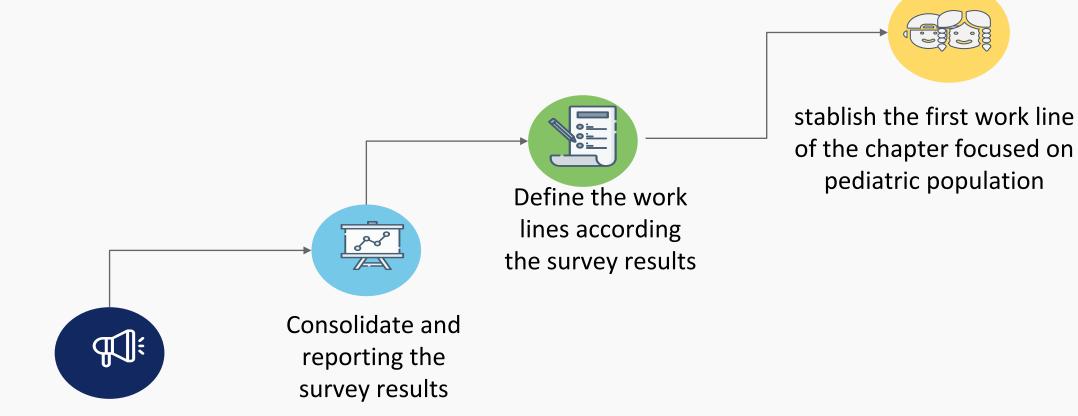
NATIONAL POLICY

To Increase the number of chapter members including those from public hospitals.

To Stablish an ongoing relationship to support research initiatives and publications. To Build a national policy of safe use of medications at the government level.



NEXT STEPS



Continue the position paper disclosure activities









SAVE THE DATE!!!!!!



