Background:
In 2014 we participated in the study EMOPEM through the observation technique for detecting drug administration errors.

Purpose:
Describe the corrective measures implemented after participating in the Project EMOPEM.

Material and methods
He was held for a week including holidays and weekdays and three nursing shifts. They were selected four floors of hospitalization representative of a general hospital. After entering the data into the national database we obtained the following results: 306 observations, 201 (65.7%) with error (considering time and patient information). Regardless of patient information (24.51%). The distribution of errors regardless of patient information was: omission (38%), error time (16%), speed incorrect administration (12%), wrong dose excess (8%), failure to register (8 %) and erroneous preparation plant (8%), others (10%). These results were presented in the Functional Unit Risk (UFR).

The following measures were implemented:
Change management and description of drugs active ingredient, in addition to identifying in describing possible routes of drug administration. Multidisciplinary working group on drug safety consisting of nurses, doctors, Quality Unit and Pharmacy. this group was established has generated a Guidesafe medication administration, where an update on antibiotics table, annexes published on parenteral administration or subcutaneous administration, regulations for high-risk medications, proper administration of heparins of low molecular weight is included. Within the newsletter edited by the Pharmacy Department a section on Safety and prevention of medication errors is included. The Program Electronic Health Record it has created a portal Information Pharmacy Services including Program Therapeutic Equivalents (PET) and a part with information regarding medication administration accessible to all medical personnel. As for the errors of omission detected, it has been analyzed that there were no differences in turn and affected several therapeutic groups, whose causality can come because nurses have fixed computers in control, distant patient and site of administration, so that has been raised to pilot the use of tablet.

Conclusions:
The EMOPEM, as indicated by its objectives, has served to obtain an error rate, to identify and implement corrective measures to help reduce medication administration errors. The pharmacist must be proactive and lead this process.