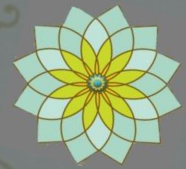
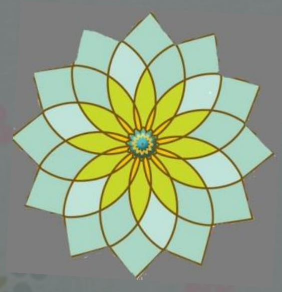
Safety Programme on Handling of High Risk Medication in M&G Dept. (PMH)





PMH M&G Dept.
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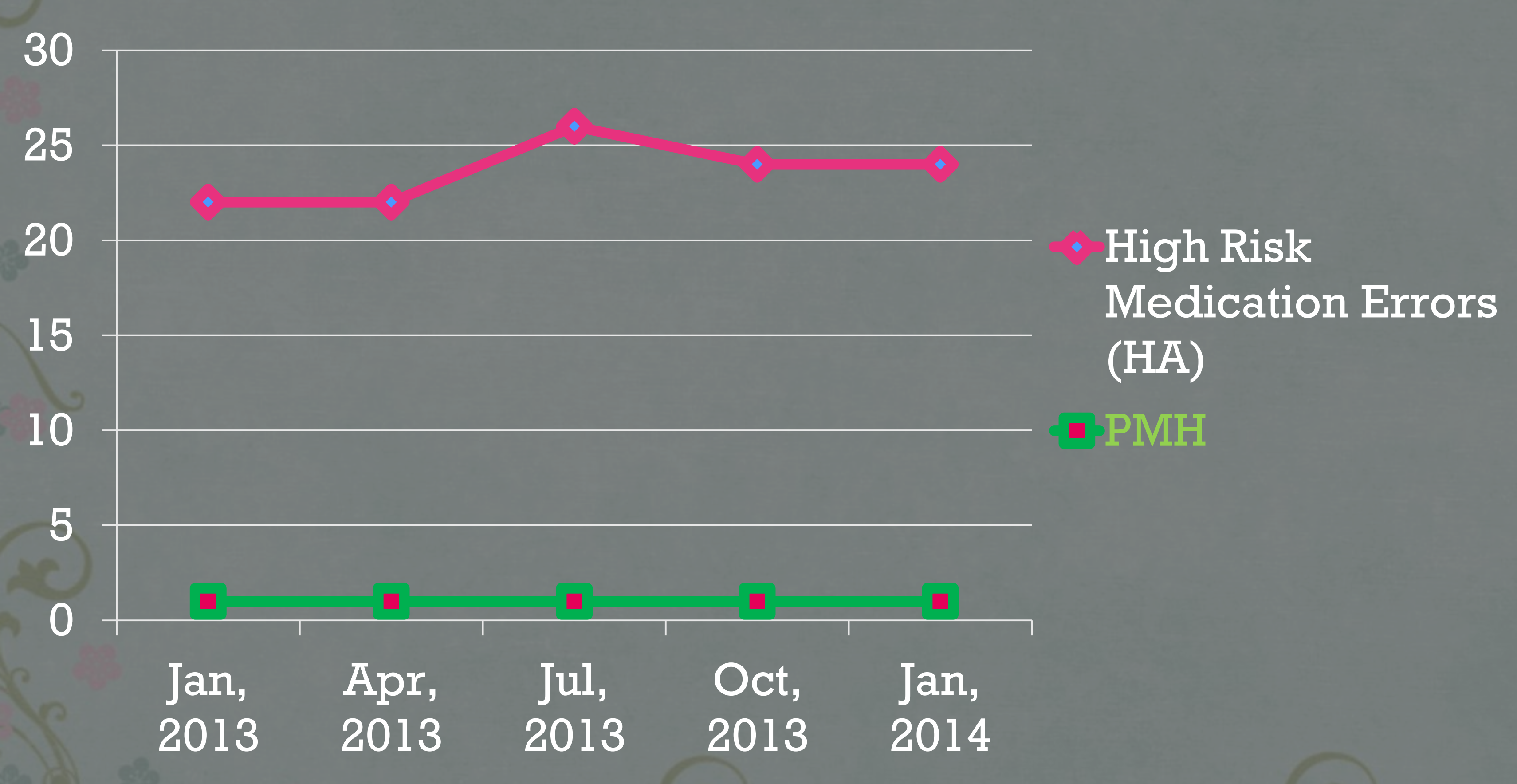
Introduction

High risk medications not only bring irreversible harm but can also be fatal to patients if they are used by mistakes. To prevent such hazardous incidents, a comprehensive safety programme was launched out for handling of high risk medication.

Risk Alert



Objectives

- To mitigate drug administration risk
- To put patient safety at first
- To provide competency- based education.

Methodology

1. Risk mitigation strategy;
2. Patient safety driven approach; and
3. Cognitive problem based learning

Risk mitigation strategy (1)

- The numbers and storage of high risk medications were minimised and centralised in designated place.

Risk mitigation strategy (2)

- Enclosed containers with warning label were also used to raise staff's alertness when picking up the drugs.

Risk mitigation strategy (3)

- Storage of insulin in individual drawer was unified and sharing of insulin among patients was abandoned.

Risk mitigation strategy (4)

- Drug stock under Dangerous Drugs Act (DDA) reviewed every half yearly
- Low utilisation items must be returned to Pharmacy.
- Separated partition for each DDA drugs with clear and colour signage was reinforced.

Patient safety driven approach (1)

Medication reconciliation:

- Starting from admission, medication reconciliation was improved with mandatory retrieval of medication record for checking.

Patient safety driven approach (1)

Medication reconciliation:

- Discharge medication checklists

(✓ the appropriate ☐ and * delete as appropriate)

Discharge medication

	Check patient's data Check discharge prescription vs MAR & ePR Summary
☐	Check the collected drugs vs discharge summary Collected drug handed over with drug advice to *Patient / Relatives / Carer / OAH / Portering staff / Others Name : ____________________
☐	Self collect medication (± drug advice given)
☐	Private drugs returned
☐	Print patient's drug allergy history from CMS and issue to patient upon discharge if patient do not have such information
☐	<u>**Out-patient Parenteral Antimicrobial Therapy (OPAT) referred:**</u> 1. Angiocath set within 24 hours prior to discharge, well secured & insertion date marked. 2. NS / Water for injection dispensed from pharmacy, <u>ONE</u> simple IV drip set and OPAT fact sheet given to patient. 3. Reconfirm CNS Tel 6468 1820 IV dose p.m. of the same day to be given in ward or by CNS at home on patient discharge. 4. Update last date/time of injection given during hospitalization in patient's HA 53 provided to patient for CNS / OPD reference.

Patient safety driven approach (2)

For drug allergy alertness:

- Red bracelet, and red signage posted on bed head

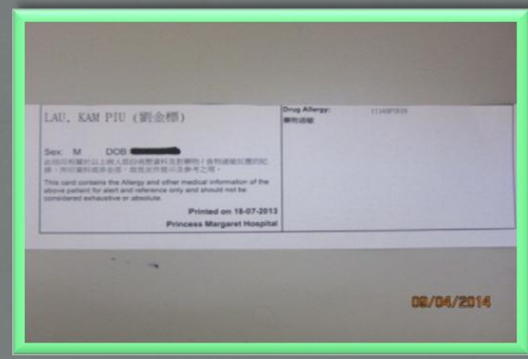
- Allergy card enlarged to A4 size

- Generic name and brand name added for more users' friendly effect were adopted as decision-support measures

Patient safety driven approach (3)

Enhancement of patient education:

- Provision of printed information sheet on drug allergy history upon discharge.



- Patient education on drug regime to enhance patient drug compliance and alert of side effects

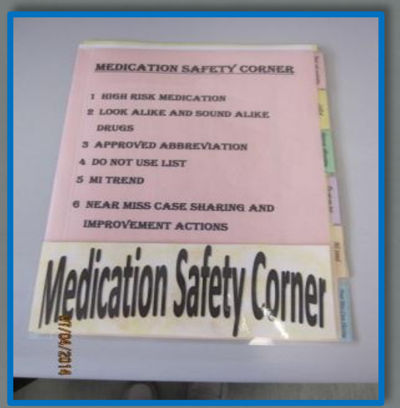
Patient safety driven approach (4)

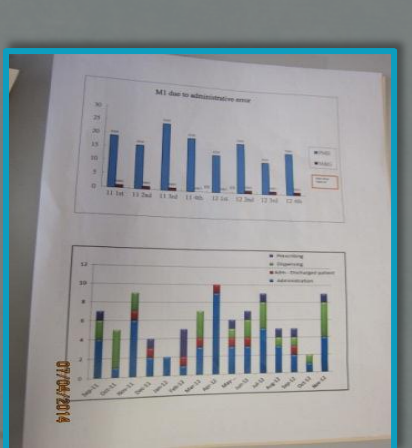
- Pioneer Inpatient Medication Order Entry (IPMOE) program was served as the most effective tool for prevention of known drug allergy.

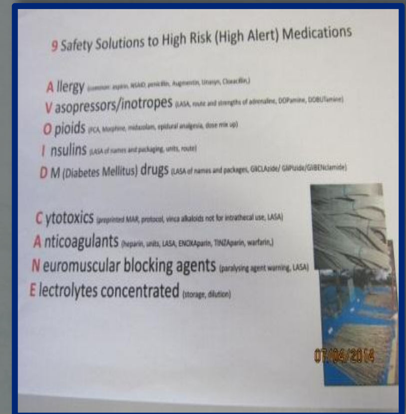
Cognitive problem based learning (1)

<u>*problem-based learning*</u>:

- Medication safety corner and
- Medication safety newsletter were initiated to update staffs' medication information







Cognitive problem based learning (2)

Improve staff competency and arouse staff sensitiveness, alertness on drug administration procedures:

- Lectures and web-based education related to handling of high risk medications
- Dynamic sharing of medication incidents

Staff training plan + assessment plan on medication in M&G Dept

June 2013

Staff	Content	Mandatory (M) Read and Sign (R&S)	Time/Period	Record
New graduate	Mentorship (one to one)	M	1st month	Duty roster
	Preceptorship	M	1st 2 year	Individual Training record
	One day orientation program (+ Infusion pump training)	M	Sept/year	Dept. training record
	Form A	M	1st month	Staff training /assessment file
	Form D	M	Dec/year	Staff training /assessment file
	Sharing of MI / Near Miss cases High risk medication AIRS reporting system	M	April/year	Dept. training Record
All Staff	Form A	M	Before Oct/year	Staff training /assessment file
	Form D	M	Before Dec/year	Staff training /assessment file
	Infusion pump operation assessment (by TTT)	M	2 yearly Sept 2013	Staff training /assessment file
	Sharing of MI / Near miss case (M&G Dept. nursing web site)	R&S	Quarterly Jan, Apr, June, Sept	System on Medication management
	HA/PMH guideline + standard (PMH nursing information mall)	R&S	According to review date	System on Medication management
	Medication related enhancement Measures (M&G Dept. nursing web site)	R&S	Accordingly	System on Medication management
	PMH – CND - Pharmacy talk (M&G Dept. nursing web site)	Individual	Accordingly	Individual training record
	PMH – Pharmacy Dept.-Pharmacy Talk (M&G Dept. nursing web site)	Individual	Accordingly	Individual training record

Results/Outcomes

- The programme was commenced since April 2013. Regular audits with medications safety round were performed.
- The compliance rate of the program was over 90%

Results/Outcomes

Increase reporting of near miss incidents with variety of enhancements.

Near Miss Cases related to MI in M&G Dept (Sept. 2013 to Nov. 2013)

Date	Brief description of the incident	Learning points	Improvement actions	Time completed
Sept. 2013 To Nov. 2013	Wrong IV label was found during counter check procedures	The name nurse was a new comer and not concentrate on the procedures	Strengthening of the supervision and coaching, as well as monitoring	-Continuous reinforcement
	MES was checked instead of Phensedyl (stopped by mentor)	The color of the two medications were very similar	Different placement of the two syrups Alert sign for staff awareness Advised the staffs must check the generic name	Sept 2013
	Syringe with NS (flush HB) was nearly mixed up with syringe with medication	It was difficult to differentiate the two syringes with the same volume	Preprint label for syringe with NS for flushing. Two different types of syringes for differentiation. e.g. 2 ml for NS and 5ml for medication	Sept 2013
	One new comer intended to crush the medication “Adalat Retard” for drug administration via RT	Staff drug knowledge was inadequate.	Improve staff knowledge Advised all new comers to access the drug information via PMH pharmacy website Reminder to alert all staff.	Lectures related to drug In Dec.13 Jan14. Photo guide completed in Feb 2014

Results/Outcomes

- As for the revamping lectures and medication incidence sharing sessions, 100% attendance rate for the new comers was achieved
- Related incident was zero

Results/ Outcomes

- Overall, the benefits of categorization approach for process-focused improvement are notable and regarded as a vital solution to traditional obstacles.

THANKS

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