Service Priorities and Programmes
Electronic Presentations

Convention ID: 336
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Service Improvement: Procedure in handling amendment on CGAT/CVMO Rx in Haven of Hope Hospital
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Keywords:
Medication safety

Introduction
There are two types of prescription Rx generated from CGAT clinical activities to be processed by HHH pharmacy (CGAT SOPD outreach vs. VMO). Both handwritten and MOE Rx are actively in use. Despite continuous efforts by both physician and pharmacy, prescribing errors still arise. Hence amendment, clarification and confirmation to multiple parties are needed. For example: poor handwriting, incorrect drug name, incorrect dosage and unavailable drugs due to suspension of supply when change to an alternative drug is needed. In the past, when pharmacy staff identified a problem on the CGAT/CVMO Rx, the staff would contact the responsible CGAT/CVMO doctor for clarification. After confirming with the responsible doctor, if there is any amendment on the drug regimen, the staff would mark on the finalized regimen, dispense the correct formulary items and just notify the OAH nurse through telephone. There was no formal documentation for those changes on the progress and the consultation record of the OAH and CGAT record. As a result, it may induce prescription or dispensing error on both sides: 1. Risk of medication incidents. OAH nurses may administer medications according to the original consultation notes instead of the instructions on the amended prescription. 2. Communication breakdown between OAH nurses and with the CGAT office. With staffs rotating on shifts, not all OAH nurses would aware of or recall the changes in the drug regimen finalized on phone contact. 3. Risk of repeating the errors from old Rx (esp. for handwritten Rx) by doctor when he/she prescribe again in the future ( which most of the time is referring from the earlier prescription) Therefore, the aim of the service is to improve the communication through a proper, convenient and formal documentation for prescription amendment on CGAT/CVMO Rx was proposed. An improvement on the procedure in handling amendment on CAGT Rx by HHH pharmacy staff was designed

Objectives
To minimize the risk of medication incidents caused by changing in regimens/poor handwriting on CGAT/CVMO Rx.

Methodology
When there are unclear drug regimens/problems identified, after phone clarification/confirmation with doctors, if there is amendment in drug regimen, pharmacy staff will:

- Contact OAH nurses by phone
- Fax a copy of amended Rx having a red chop with details of amendment to CGAT office for documentation
- CGAT Rx filed in patient’s chart profile
- CVMO Rx filed in designated folder

Send a copy of amended Rx with red chop to OAH nurse together with dispensed medications. OAH nurse will be asked to keep the amended Rx in patient’s chart profile

Primary Outcome: (1) No. of interventions (2) No. of interventions required change in drug regimens

Result
Before the start of this service improvement, from Oct 2013 to Sep 2014, there were total 68 prescriptions (2%) with problems identified and 81 interventions had been done in which 38 (47%) interventions required change in regimens. Most of the interventions were due to unclear drug regimens (53%) which required clarification with doctors on the dose, frequency and route. Starting from October 2014, total 12 out of 840 (1.3%) CGAT/CVMO Rx with problems have been identified and 13 interventions have been done in which 9 of the interventions required change in regimens. Eight (62%) interventions were related to inappropriate dose/frequency or requiring clarification on drug name/dose. Until now, no prescribing error has repeatedly been found. Analysis of data: Since the usual prescribing duration of CGAT Rx is about 16-24 weeks, it is expected to start to see the effect of this service improvement until February 2015. Therefore, it is planning to observe and measure the prescribing errors of CGAT/CVMO Rx identified from February to September 2015 to see if there is any reduction in the no. of interventions/prescribing errors.