Introduction
Medication reconciliation safety is the first priority in PMH top risk. Based on reported incidents and near miss cases in AIRS, there are increasing trend of medication incidence on patient self-medications. Private medications management denotes special attention. In order to mitigate and standardize the difference practice among M&G wards in the handling, storage and documentation in private medication; a structured medication safety enhancement program was elaborated from September 2014 on patient private medication management. The effectiveness of the program was assessed by staff and patient satisfaction survey, clinical audits and retrospective review of MI via AIRS.

Objectives
1. To safeguard the medication reconciliation and strengthen staffs’ awareness of private drug management; 2. To emphasize effective communication among patient, caregiver and staffs; 3. To reinforce patient education on self-medications in order to prevent the incidences on drug overdose and omission of drugs; 4. To decrease medication errors related to patient self-medication by 50%.

Methodology
A validated questionnaire was distributed to nursing staffs and patients in order to reveal their level of knowledge, attitudes and practices among nurses and patients towards private medication management. Documentation review and site visit was implemented. Though reviewing the system, care process, clinical handover, staff and the environment factors, strategies were constructed. The workflow on the process of handling of private medication was standardized and nursing assessment checklist was revised to enhance more effective communication strategies among nurses, patient and carers. Colored private drug reminder cards are redesigned to alert staffs to return private drugs upon discharge or the usage if indicated. Standardize the
storage of private drugs in designated medication drawer with labeled plastic zip bag. To enhance effective supervision and education to patient and carers on private drugs resumption, information is promulgate via PA system, education pamphlets and individual coaching by named nurse.

**Result**

With improved awareness, filling of knowledge gap and standardization of self medication management; overall related incident decreased by 50%. Staffs compliance rate with the standard was 100%; staff satisfaction of the redesigned workflow was over 90% and patient’s understanding of the information was increased over 80%. Undoubtedly, cultivated personal alertness; effective communication and efficient workflow are the impulsive force to eliminate medication errors.