Use of a pro-active systematic approach in minimizing medication error---the Pharmacy Medication Safety Working Group

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Introduction
Currently medication errors (MI) or near-missed medication errors were identified retrospectively and spontaneously. Medication safety improvement measures were adopted on an as-needed basis. This might lead to a delay in MI identification thus prevention of future MIs, eventually impairing patient care. The need of a regular, proactive and systematic approach towards minimizing medication errors was recognized.

Objectives
To establish a pro-active Pharmacy Medication Safety Working Group to minimize medication error by formulating structural strategies to regularly identify potential error, review current practice and prevent future error in all steps of patient care.

Methodology
A Pharmacy Medication Safety Working Group comprising members from all grades of pharmacy staff was established. Regular meetings were held to report any near-miss medication errors, review and suggest improvements to prevent future incidents. Bulletins targeting both pharmacy and ward staffs were published as educational measures to alert staff on recent medication errors and update staff on any recent prevention strategies.

Result
From April 2014 to Jan 2015, a total of 14 bulletins were published, quarterly meetings and monthly short talks were held. Numerous preventive measures and interventions were made to improve both the pharmacy environment and staff awareness towards medication errors. A pro-active systematic approach is effective in minimizing MIs, by improving the efficiency in identifying and refining procedures high in MI risk periodically and systematically.