**Improvement of professional nursing service and care delivery by preventing incidence of medication**

Yue SS, Poon LH, Chau SW

*Department of Medicine and Geriatrics, United Christian Hospital*

**Keywords:**
medication safety

**Introduction**
Administration of medication is one of the most important aspects in professional nursing service that must be correct in terms of medication, dose, route, time and patient. Although everyone is trying to follow the guideline of administration of oral and intravenous medication, there were still four incidents of medication error during a half year period (from April to October, 2014) in our ward. Fortunately, these four incidents did not cause any adverse effect on the patients. In order to improve the quality of our professional nursing service and effectiveness of care delivery, there is an urgent need to optimize the systems of medication management and monitoring.

**Objectives**
The objective of this project is to optimize the systems of drug management and monitoring through distribution of a “Reminder of medication safety procedure” and implementation of “an in-house checking system” to prevent any incidents of medication error in the future.

**Methodology**
After revision of more than twenty five procedures and guidelines of Pharmacy Department of United Christian Hospital, a 4-page “Reminder medication safety procedure” was written which includes all the commonly used procedure of administration of medication in our ward. This 4-page reminder was posted on broad, uploaded to the share point of Department of Medicine and Geriatrics, and distribute to every nurse in our ward for daily reminder. An inter-team checking system was also implemented, in which the prescription and recording sheet of every new admission case and randomly picked old cases were checked by another team to improve the quality professional service. In addition an internal annual administration of medication audit for all nurses would be performed. In this audit, every nurse has to correctly demonstrate the procedure of administration of medication to the auditor.
**Result**
The 4-page reminder have been posted and uploaded since 1 November 2014 and read by every nurse in our ward. There was no mistake found in any team among 720 times checking over a three-month period. Totally, 24 nurses had passed the internal audit by 14 November 2015. There was no incident of medication error over a 3-month assessing period (from 1 Nov 2014 to 31 Jan 2015). The professional service of nursing was successfully improved through our team work and committed staff.