



Service Priorities and Programmes
Electronic Presentations

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Clonazepam Bookmark for Correct Dose Drug Administration in Alice Ho Miu Ling Nethersole Hospital and Tai Po Hospital

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Introduction

Nearly 10 incidents related to wrong dose administration of Clonazepam were revealed since the implementation of monthly pharmacy check of the dangerous drug (DD) ledgers in AHNH and TPH in Dec 2016. Investigation showed wrong dosage of Clonazepam was retrieved for drug administration despite 2 nurses independent checking. The preparation of the drug was the odd 0.5mg/tablet or 2 mg/tablet. There was no other strength of Clonazepam in the market. Medication incidents occurred in wards where Clonazepam is not frequently used.

Objectives

Provide an easy reference tool to help ward nurses confirm the calculation of the quantity of clonazepam tablets required when they retrieve the drug from the DD cupboard

Methodology

A bookmark for Clonazepam was proposed by the user. Common prescribed dosages were solicited from the nurses and pharmacy. The number and combination of different strengths of tablets against the prescribed dosages are illustrated pictorially. The bookmark is kept in the respective section for Clonazepam in the DD ledger for easy reference. It was trial used in AHNH Medicine and TPH Medicine & Geriatrics and Psychiatry.

Result

Positive comments on its usefulness and clarity were received from the participating departments and the HAHO Medication Safety Committee when they visited TPH at that time. It is also regarded a good teaching tool for new comers and students. The bookmark was then endorsed by the Hospital Medication Safety Committee and has been rolled out hospital wide in 4 Q 2017. Medication incident of wrong dose administration of Clonazepam has dropped to zero.