



## Service Priorities and Programmes Electronic Presentations

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### **Be Alert !! Be Safe!!**

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### **Introduction**

Despite the advantages offered by the use of IPMOE, there is still inadequacy present. Upon the adoption of IPMOE, since June 2015, there were total of three medication incidents reported in Surgery department, which indicated for this CQI program

### **Objectives**

1. To reduce medication incident (MI) in ward
2. To promote medication safety by facilitation the workflow of administration of medication (AOM)
3. To enhance ward staff awareness in Medication Safety
4. To alert ward staff of IPMOE pitfalls

### **Methodology**

1. Reorganize the storage of medication trolley and Top-Up cupboards
2. Suggest specific improvements for the MIs by designing signage to alert ward staff. e.g. Posting of "warm reminder" for PRN drug administration cards besides IPMOE screens
3. Produce a flow chart of handling of brought in medication prescription
4. Produce a reminder card for brought in medication
5. Collect reports of recent medication incidents and perform root cause analysis related cases
6. Conduct sharing on new measures to prevent MI with ward staff, and review the measures regularly corresponding to the ward practice and feedbacks from staff
7. Share updated information at medication safety board
8. Conduct staff knowledge test

### **Result**

1. No of medication incidents reported has been reduced to 0 case in the year 2017
2. All staff has increased the awareness of administration of PRN drug. The average score of the post education of medication knowledge test has been increased by 25%