Be Alert !! Be Safe!!
Szeto SM, Chan SC, Luk KM, Chan MK, Ng LK, Chan WT
Department of surgery, Ruttonjee and Tang Shiu Kin Hospitals

Keywords:
Mediation safety
staff awareness
alert staff
medication incident

Introduction
Despite the advantages offered by the use of IMPOE, 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 MIIs 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 to0 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%