



**Service Priorities and Programmes**  
**Electronic Presentations**

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**Enhancement Program in Drug Administration by implement IPMOE system**

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**Keywords:**

Drug Administration

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**Introduction**

Medication safety is an important aspect in quality service provision. The majority of underlying causes of drug administration is the staff failure to comply with correct patient identification. IPMOE is a “close-loop” medication management system for in-patient care which supports drug prescription, dispensing and administration. Nurse scan the barcode on the wristband to verify the right patient and ask patient name for reconfirm the patient identity. Drug administration details will be documented automatically in the system. Therefore, the IPMOE system has roll out in NTWC since 2016 and schedule implemented in general ward on January 2018.

**Objectives**

1. To prepare the ward nurses in using IPMOE system for drug administration
2. To minimize the medication error from using IPMOE system

**Methodology**

1. Staff engagement: To provide the hospital based training to Nurses and Doctors for implement IPMOE
2. To procurement the appropriate medication Carts and installed Tough Pad, Mobile Scanner and Printer
3. To Installed the Drug Code on Drug package by pharmacists
4. To install the Wifi Access point by IT staff for strengthen the wireless connection quality
5. To review and streamline the delivery and drug administration process by hospital and departmental based IPMOE Workgroup members
6. To prepare or revise the documents, workflow and guidelines by hospital and departmental based IPMOE Workgroup members
7. To prepare the Conversion Team meetings and Production Drills for Live-run day of implement IPMOE

**Result**

The IPMOE has rolled out in general ward on January 2018. 4 Conversion Teams on

the Live-run day. 1 doctor with 3 nurse checkers per team. There were 32 numbers of patients and 329 number of order line for MAR conversion, and the conversion time 44 minutes.

After implemented IPMOE, all nurses have positive feedbacks, they have enhanced their alertness of drug administration. Medication errors are often preventable, Nurses are at the frontline in preventing the potentially errors and playing an important role.