Service Priorities and Programmes

Electronic Presentations

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To Err Is Human? Medication Safety by Facing At-Risk Behaviour Squarely

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Introduction
According to 2017 annual report of Sentinel and Serious Untoward Events (SUE) of Hospital Authority, medication incidents remain the majority of SUE. Human always trend to shortcut way on tasks, but may lead to at-risk Behaviour and in turn, resulting in error. Thus, an medication safety related at-risk Behaviour exploration was done in ward-9B of United Christian Hospital.

Objectives
Identify and correct current at-risk Behaviour regarding to medication handling

Methodology
A continuous proactive assessment initiated at 1Q2017: (A) Environment risks: 1 Look-alike IVF placed beside another Action: Separate with clear labelling 2 Seldom used ward-keeping medication were excessively stored in medication trolley Action: Streamline medications list 3 Discharged patients' medication left in medication trolley Action: A daily scheduled time was set for checking 4 Similar labelling of cupboard storing Potassium containing IVF Action: Tall-man-labelling with different easily recognizing color (B) Human risks: 1 Entirely relied on barcode scanning without manual checking of patient identity during Administration of Medication (AOM) Action: Importance of manual and technology-assisted checking was reminded 2 Unfamiliar with newly introduced infusion pump Action: i: Proper training by qualified person ii: Counter-checking of infusion pump setting iii: 'Pointing & Calling' concept reinforced 3 Staffs disturbed during AOM Action: i: "Do-not-disturb" labelling on medication trolley to remind visitors ii: Staffs were reminded to start over '3 checks 5 rights' if disturbed 4 Unfamiliar with dosage/rate conversions Action: Reference posters of common conversion were available 5 Unfamiliar with guideline of AOM Action: References of IV medications which can be administrated by nurse AND items must be counter-checked was shown conspicuously 6 Insufficient pharmacology knowledge Action: Proper training of pharmacology in-service arranged 7 Inadequate medication reconciliation standard Action: Medication reconciliation checklist developed with lecture service (C) Hardware risks and actions taken: 1 Failure to input administration

record to IPMOE Action: i: Connectivity of equipment and proper data transfer reinforced to nurses ii: Report weak connectivity to IT department

Result

1. The incident rate decreased from 5 at 1Q2017 to 0 at 3Q2017 2. At-risk Behaviour were recognized by nurses 3. A safety enhancing culture was introduced to new colleagues to maintain sustainability 4. All nurses agreed it is ulmost important to uncover the conditions under which they occur.