Service Priorities and Programmes

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Building A Safer System for Medication Safety: Moving Towards Better Prevention

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Introduction

Following the call of action from the landmark study of Institute of Medicine in 2000, To Err Is Human, which highlighted the prevalence of medication-related errors in morbidity and mortality, an innovation to incorporate health information technology in the nodes of medication system has been made worldwide to reduce medication-related risks and enhance the safety and effectiveness of medication use. However, on a broader scale, efforts should continue be made to monitor the proper utilization of the technology and improve the performance of the many processes that are still prone to failure, resulting in harm to patients.

Objectives

To improve and increase the team's awareness in medication safety through building a safer surveillance and education system under a JUST culture.

Methodology

The Medication Safety Workgroup has been established for 5 years and has enhanced its efforts to reduce medication errors by collaborating several inter-correlating strategies. The first involves a quarterly meeting which critically reviews and analyzes medication incidents from surveillance and prevention perspectives and develops recommendations and prevention plans, including aligning frontline practice of proper documentations, providing a safer drug administration environment under a 5S system and designing eye-catching reminder cards containing important safety information that nurses need to be aware of before high-risk medication administration. The second involves a bi-monthly cross-wards Medication Safety Walk-rounds which primary initiative is to move towards staff's reflection on medication safety rather than inspection of specific areas. The third is staff education on safe medication practices. Competency of safe medication use of frontline nurses was assessed yearly. A series of educational sessions on medications, appropriate use of Inpatient Medication Order Entry (IPMOE), as well as sharings on medication incidents from UCH Medication Administration Monitoring Workgroup were organized regularly.

Result

Through the implementation of health information technology in medication safety, the incidence of medication errors has reduced dramatically. However, if it is applied

inappropriately, it can introduce risks that may lead to unsafe conditions, serious injury, or even mortality in patients. This surveillance and improvement system successfully increases staff awareness and engagement on safe medication practices, resulting in the mitigation on the risks of medication errors and thus enhancement on patient safety.