



Service Priorities and Programmes
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Nursing intervention can reduce medication error: an enhancement program to reduce medication incident in a medical ward

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Introduction

Drug administration is an inevitable treatment received by patients in medical wards. Medication errors can cause harm to our patients. In order to protect our patients and improve the quality of care, prompt measurement should be taken to improve medication safety. Thereby, a Quality Improvement Program to reduce oral and intravenous medication incident in a medical ward in UCH was initiated. The program commenced in October 2012.

Objectives

To enhance medication safety and prevent medication error in a medical ward in UCH. Measurable outcome: the number of medication error rate between two periods of time.

Methodology

Within the study period five months: 1. Review the existing administration of medication practice 2. Standardize drug administration time scheduling, according to department guideline 3. Affix a quick reference of drug administration time schedule to every drug trolley 4. Establish counter-checking system by two nurses for scheduling drug administration time on MAR 5. Share good practice of other ward among nursing staff 6. Alert ward staff about 'Near Miss' incidents

Result

The number of medication error rate from October 2011 - February 2012 and October 2012 - February 2013 were compared. By measuring the medication error rate between two periods of time. It was found that the medication error rate was reduced by 60%. Less medication errors occurred after the improvement program implement since October 2012. With a good initiative on service enhancement on patient care, refresher training and regular audit on administration of medication in order to increase medication safety alertness is necessary.