Safety Programme on Handling of High Risk Medication in M&G Dept. (PMH)

PMH  M&G Dept.
APN Chan Wai Lan, Fanny
High risk medications not only bring irreversible harm but can also be fatal to patients if they are used by mistakes. To prevent such hazardous incidents, a comprehensive safety programme was launched out for handling of high risk medication.
Risk Alert

High Risk Medication Errors (HA)

PMH

Objectives

- To mitigate drug administration risk
- To put patient safety at first
- To provide competency-based education.
Methodology

1. Risk mitigation strategy;
2. Patient safety driven approach; and
3. Cognitive problem based learning
The numbers and storage of high risk medications were minimised and centralised in designated place.
Enclosed containers with warning label were also used to raise staff’s alertness when picking up the drugs.
Storage of insulin in individual drawer was unified and sharing of insulin among patients was abandoned.
Risk mitigation strategy (4)

- Drug stock under Dangerous Drugs Act (DDA) reviewed every half yearly

- Low utilisation items must be returned to Pharmacy.

- Separated partition for each DDA drugs with clear and colour signage was reinforced.
Medication reconciliation:

- Starting from admission, medication reconciliation was improved with mandatory retrieval of medication record for checking.
Patient safety driven approach (1)

Medication reconciliation:

- Discharge medication checklists

| Discharge medication | | |
|-----------------------|-------------|
|                      | (✓ the appropriate □ and * delete as appropriate ) |
| Check patient’s data | Check discharge prescription vs MAR & ePR Summary |
|                      | Check the collected drugs vs discharge summary |
|                      | Collected drug handed over with drug advice to |
|                      | *Patient / Relatives / Carer / OAH / Portering staff / Others |
|                      | Name: ____________________________ |
|                      | Self collect medication (± drug advice given) |
|                      | Private drugs returned |
|                      | Print patient’s drug allergy history from CMS and issue to patient upon discharge if patient do not have such information |

**Out-patient Parenteral Antimicrobial Therapy (OPAT) referred:**

1. Angiocath set within 24 hours prior to discharge, well secured & insertion date marked.
2. NS / Water for injection dispensed from pharmacy, **ONE** simple IV drip set and OPAT fact sheet given to patient.
3. Reconfirm CNS Tel 6468 1820 IV dose p.m. of the same day to be given in ward or by CNS at home on patient discharge.
4. Update last date/time of injection given during hospitalization in patient’s HA 53 provided to patient for CNS / OPD reference.
For drug allergy alertness:

- Red bracelet, and red signage posted on bed head
- Allergy card enlarged to A4 size
- Generic name and brand name added for more users’ friendly effect were adopted as decision-support measures
Enhancement of patient education:

- Provision of printed information sheet on drug allergy history upon discharge.
- Patient education on drug regime to enhance patient drug compliance and alert of side effects.
Patient safety driven approach (4)

- Pioneer Inpatient Medication Order Entry (IPMOE) program was served as the most effective tool for prevention of known drug allergy.
Cognitive problem based learning (1)

**problem-based learning:**

- Medication safety corner and
- Medication safety newsletter were initiated to update staffs’ medication information
Improve staff competency and arouse staff sensitiveness, alertness on drug administration procedures:

- Lectures and web-based education related to handling of high risk medications
- Dynamic sharing of medication incidents
Results/Outcomes

- The programme was commenced since April 2013. Regular audits with medications safety round were performed.
- The compliance rate of the program was over 90%
Increase reporting of near miss incidents with variety of enhancements.

<table>
<thead>
<tr>
<th>Date</th>
<th>Brief description of the incident</th>
<th>Learning points</th>
<th>Improvement actions</th>
<th>Time completed</th>
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</thead>
<tbody>
<tr>
<td>Sept. 2013</td>
<td>Wrong IV label was found during counter check procedures</td>
<td>The name nurse was a new comer and not concentrate on the procedures</td>
<td>Strengthening of the supervision and coaching, as well as monitoring</td>
<td>-Continuous reinforcement</td>
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<td>MES was checked instead of Phensedyl (stopped by mentor)</td>
<td>The color of the two medications were very similar</td>
<td>Different placement of the two syrups Alert sign for staff awareness Advised the staffs must check the generic name</td>
<td>Sept 2013</td>
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<td></td>
<td>Syringe with NS (flush HB) was nearly mixed up with syringe with medication</td>
<td>It was difficult to differentiate the two syringes with the same volume</td>
<td>Preprint label for syringe with NS for flushing</td>
<td>Sept 2013</td>
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<td>One new comer intended to crush the medication “Adalat Retard” for drug administration via RT</td>
<td>Staff drug knowledge was inadequate.</td>
<td>Improve staff knowledge Advised all new comers to access the drug information via PMH pharmacy website Reminder to alert all staff.</td>
<td>Lectures related to drug in Dec. 13 Jan 14. Photo guide completed in Feb 2014</td>
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As for the revamping lectures and medication incidence sharing sessions, 100% attendance rate for the new comers was achieved.

Related incident was zero
Overall, the benefits of categorization approach for process-focused improvement are notable and regarded as a vital solution to traditional obstacles.
THANKS

DOM M&G Dept. PMH
Ms Candic Tang

WM EF1 M&G Dept. PMH
Ms Alice Wong

Team Members:
RN EF1 M&G Dept. PMH
Ms Cheong Yee Mei &
Ms Carrie Chan