Service Priorities and Programmes

Electronic Presentations

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Revamp on medication record management in Psychiatric Day Hospital

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Introduction

Albeit the practice of medication management in Psychiatric Day Hospital (PDH) was different to in-patient, the praxis of keeping medication record in PDH was alike as in-patient. The prescribed medications were hand-written by medical staff on medication administration record (MAR). Both nursing and medical staffs usually referred the MAR as medication record. This practice unfolded plenty of drawbacks that exhausted staffs' energy on manual works, for instance, transcribing medication, checking MAR, signing the update or amendment, review and renewal of record. The most intractable problem was that medication records had to be kept in case files while those manual works needed to be simplified necessarily. The transcription process was time-consuming and rife with the possibilities for transcription errors, which in turn could result in medication errors. Ultimately, it was imperative to see into a best practice of managing medication record which was effective and viable in PDH.

Objectives

1. To simplify and save time from unnecessary manual procedures 2. To enhance efficiency on medication record management in the PDH 3. To minimize medication incidents by re-engineering the whole set of manual procedures 4. To enhance communication among care related parties by a consistent and agreed practice on medication record management in PDH 5. To maintain a tidy and integrated format of medication record in case file

Methodology

This was a multidisciplinary collaboration that both medical and nursing staff worked together with the ultimate aims of maintaining medication records with adopting a safe, agreed and effective practice. Both disciplines contributed their knowledge and explored ways of retrieving patient's medication record which were viable to PDH. The pilot was launched in August 2013 which was implemented incrementally from those newly admitted cases. The abandonment of MAR was put into practice in the first place that transcription could be avoided. Then the practice of printing out prescription sheets, the filing of medication records in case files were then followed thereafter. In order to maintain the whole set of practice related to medication record management consistently among all staffs, i) Flow chart on drug supervision in PDH, ii) Roadmap

on medication record management in PDH, iii) In-house guidelines on medication records in PDH, were developed for staff making quick reference.

Result

Both positive and negative feedbacks from medical and nursing staffs were collected. The positives were outweighed the negatives in terms of amount and importance. That was an outstanding collaboration of medical and nursing professionals moving on the same page. There were some hurdles encountered including inconsistent practice of individuals, unfamiliarity of retrieving the record printouts, doubts about its feasibility. The commonest negatives were the increase in paper use and loads of case files. All staff welcomed the medication records in case files were consistent with the printouts at patients' hands. They all found it time saving and the amount of manual procedures being grossly reduced. The records were more legible and informative, like the duration of drugs prescribed, the date of prescription. Staff also found the printouts allowing tidy and integrated format. Furthermore, this revamp allowed staffs to revisit the system and enhanced their knowing as well.