Service Priorities and Programmes

Electronic Presentations

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Back to "basic", away from "chaotic". Improve pharmaceutical care in KH through new repackaging system and technology

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Introduction

Repackaging of medications, on one hand, is essential in pharmacy service as it speeds up dispensing process at the front end and reduces patients' waiting time for collection of medications. On the other hand, repackaging is a high risk procedure and a small unintentional error may lead to a group incident with serious consequence. This project improved medication safety through focusing on the basic repackaging steps. We also introduced system enhancement and additional risk management components into the existing system to minimize risks and chaos.

Objectives

1) Improve pharmaceutical care through new repackaging system and technology 2) Improve efficiency and avoid chaos during drug recall with the new system

Methodology

1. Review existing system and identify potential chaos producing steps with reference to HA Guidelines on Medication Management 2. Prepare computer and other technical hardware for the project 3. Discuss with QEH pharmacy for assistance on computer program and software 4. Introduce maximum/minimum stock management method to control stock levels 5. Make adjustment to the existing color coding system with risk management concept in mind 6. Restructure the stock movement and documentation system so that patient impact can be minimized during drug recall 7. Introduce the new system to all concerned staff.

Result

The medication repackaging system is greatly improved in Kowloon Hospital. All repackaging record, history and statistics can be stored in a cluster-based program which facilitates data analysis. With the new repackaging procedures, stock management system and adjustment of color coding system, repackaging related

chaos are further reduced. Full documentation of the whole process also minimizes patient impact during medication recall. Repackaging of medications is one of the basic procedures in daily dispensing. This is a repetitive process, and its importance is easily neglected in the medication management flow. One unintentional error in repackaging may lead to a chaotic situation. To ensure medication safety, one should re-examine the risky steps in our work and