Service Priorities and Programmes

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Service Improvement: Procedure in handling amendment on CGAT/CVMO prescriptions in Haven of Hope Hospital

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Introduction

Prescriptions generated by Community Geriatric Assessment Team (CGAT) and Community Visiting Medical Officers (CVMO) are processed by Haven of Hope Hospital (HHH) pharmacy. In the past, when a problem was identified on a CGAT/CVMO prescription, pharmacy staff would contact the responsible doctor for clarification, mark any amendment on the prescription and inform old aged home (OAH) nurse through telephone without formal documentation on the patient's consultation records. This could induce repeated prescribing or administration errors. Therefore, a service improvement procedure aiming to enhance communication and documentation for amendments on CGAT/CVMO prescriptions was proposed.

Objectives

To minimize the risk of medication incidents associated with CGAT/CVMO prescriptions.

Methodology

When problems were identified on CGAT/CVMO prescriptions, doctors would be contacted on the phone for clarification/confirmation. If amendment was required, pharmacy staff would: -Contact OAH nurses by phone -Fax the amended prescription having a red stamp with amendment details to CGAT office for documentation -Send a copy of the amended prescription with red stamp to OAH for filing in patient's profile This procedure commenced in October 2014. Data regarding prescribing problems on CGAT/CVMO prescriptions after implementation of the procedure were collected and compared to the period before it began. Primary Outcomes: -Percentage of CGAT/CVMO prescriptions with problems identified -Frequency of pharmacy interventions -Frequency of prescribing errors or problems repeated from previous prescriptions

Result

Before the service improvement began, problems were identified in 2% of prescriptions (0.03 intervention per prescription). The major causes of interventions included: -Unclear drug regimens (51%) -Inappropriate dose/frequency (18%) -Unavailable items selected (9%) Repeated prescribing errors were found in 6.2% of

the prescriptions with problems identified. After implementation of the procedure, prescribing problems were reduced to 1.1% of prescriptions (45% reduction). There was 0.01 intervention per prescription (67% reduction). The main causes of interventions included: -Inappropriate dose/frequency (37%) -Inappropriate route prescribed (20%) -Unavailable items prescribed (13%) No prescribing error has repeatedly been found in the same patient. In conclusion, the service improvement procedure has been effective in reducing problems identified on CGAT/CVMO prescriptions. Through enhanced communication among multiple healthcare disciplines, the level of medication safety in OAH residents is expected to further improve.