Service Priorities and Programmes

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Submitting author: Miss Pui Ha CHENG
Post title: Ward Manager, Hong Kong Buddhist Hospital

Enhancement Program on Safe and Secure Handling of Dangerous Drugs in Integrated Palliative Care Unit

Cheng PH (1), Pi SS (1), Chan MY (1), Lo WC (1), Ng KL (1),
Chan CW (2)
(1) Integrated Palliative Care Unit, Hong Kong Buddhist Hospital
(2) Pharmacy, Hong Kong Buddhist Hospital

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Introduction

Opioids are the primary pharmacological treatment for cancer pain and, in the palliative care setting, are routinely used to manage symptoms at the end of life. They are one of the most frequently reported drug classes in medication errors causing patient harm. The acronym LASA (look-alike sound-alike) denotes the problem of confusing similar- looking and/or sounding drugs accidentally. Enhancing medication safety is pivotal in quality patient care. Integrated Palliative Care Unit (IPCU) in Hong Kong Buddhist Hospital is providing service for cancer patients which is well-known using multi-faceted Dangerous Drugs (DD) for pain and symptoms control. The safeguards of DD storage and administration continue to be a significant concern in the unit. The ultimate aim of assuring safe administration of DD and minimizing medication incidents or errors would be intentionally achieved.

Objectives

To enhance medication safety in Integrated Palliative Care Unit in Hong Kong Buddhist Hospital which is well-known using multi-faceted Dangerous Drugs (DD) for pain and symptoms control. The safeguards of DD storage and administration continue to be a significant concern.

Methodology

The enhancement project planned to:1) minimize ward stock by returning the drugs which had not been used in the past one year; 2) set up a new sequence (non-alphabetical order) of placing DD in the cupboard with Tall man lettering, numerical coding and colour coding, 3) set up an index for all DD; 4) design a DD Location Plan and change the drug location every 3 months; 5) check all DD by Ward

Nurse-In-Charge every month in terms of correct quantity and expiry date; 6) set up a Drugs Notice Board which included Drug Allergy Reference Table, Drugs Update and Standard Abbreviations; 7) place a weight reference table to foster MHO practice; 8) assess staff competence on the recognition of “LASA” DD by using a quiz.

Result

1) Minimum stocks were kept; 2) Staff provided positive feedback on the new sequence which might alert them to differentiate the look alike sound alike drugs; 3) Staff provided positive feedback on the index, location plan, numerical coding and colour coding which facilitated them to look for the drugs with caution; 4) The weight reference alerted the staff on MHO concerns when taking out the morphine bottle and DD Ledger from the top and second shelves; 5) Updated drugs knowledge could be easily accessible. 6) 100% nursing staff were assessed and they all passed the quiz with average score of 100%.