Service Priorities and Programmes

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Post-Implementation Reviews - the Pointing and Calling for checking high alert medication using infusion / syringe pump

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Introduction
The Pointing and Calling (P&C) originated from the “Zero Accident Campaign” in Japan has been proved its effectiveness to reduce human errors by enhancing one’s alertness and accuracy of operations. Since June 2016, the P&C has been implemented in the department of Medicine, Orthopaedics, Surgery, Obstetrics & Gynaecology, Ear, Nose & Throat, Psychiatrics, and Accident & Emergency to check high alert medication using infusion / syringe pump in United Christian Hospital (UCH) after nine-month preparation and promulgation.

Objectives
To review whether the P&C can reduce medication administration incident (MAI) related to high alert medication using infusion / syringe pump.

Methodology
An adapted post-implementation review guide developed by the department for business, innovation & skills, UK (2016) was used to guide the review of the post-implementation. The guide composes 7 areas including (1) the objectives of the method, (2) the evidence has informed the review, (3) what extent have the objectives been achieved, (4) the original assumptions, (5) any unintended consequences, and (6) any evidences identified any opportunities for reducing the burden on implementation.

Result
The MAIs related to high alert medication using infusion / syringe pump in 2014, 2015 and 2016 were 6, 3, and 4 respectively. Of these MAIs, there were 3, 2, and 1 reported in respective year related to wrong infusion rate setting. Since June 2016, there was no report related to infusion pump settings. It may be due to an audit effect that was carried out between September and November 2016. 709 nurses were audited and the compliance rate was ranged from 98.1% to 100% amongst 10 models

of pump. It proved that the P&C method can effectively to prevent wrong infusion rate setting along with diverse strategies. However, it still cannot solve the problem when a doctor prescribed or changed rate of the medication without notifying corresponding nurse or nurse is not aware of the change of prescription. Moreover, refresher training is required to ensure nurses understanding the application of the P&C for checking. Further action is required to address the communication between doctor and nurse in future.