



Service Priorities and Programmes Electronic Presentations

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Towards Safe Medication Practice by 7DOs

CHOA L, W C LAM, W Y HO, W F HO

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Introduction

Medication incident related to known drug allergy is one of the most common medication errors in HA. In the past several years, ward stock drug such as Paracetamol (Panadol) becoming known drug allergy being overlooked that leads to serious untoward events. In this connection, ensuring medication safety is a high priority goal for risk reduction in Cheshire Home, Chung Hom Kok.

Objectives

To develop multidisciplinary risk reduction strategies and to ensure staff compliance to safe medication practice.

Methodology

A multidisciplinary working group, consisting of medical and nursing staff as well as pharmacist, was set up to analyze medication incident related to known drug allergy via fish-bone approach. 2 main root causes were identified, namely (i) no instruction for faxing MAR to Pharmacy when ward stock drug was prescribed, (ii) failure to comply with HA Guidelines on Known Drug Allergy Checking.

Risk reduction strategies were devised through concerted effort of multidisciplinary members to reinforce staff's vigilance in checking patient's known drug allergy history. There were 7 DOs that staff has to perform:

1 DO: Nurses should make sure an orange color confidential cover with marking "Known Drug Allergy" is placed on the front page of MAR chart board to arouse staff's alertness.

2 DO: Medical staff has to fill in Drug Alert Warning (DAW) sheet which has to be faxed to pharmacy when patient has a history of known drug allergy and then put it on top of MARs. Medical staff and nurses should check it during drug prescription and administration.

3 DO: Nurses have to check patient's allergy/alert information on CMS and have a copy placed under DAW sheet.

4 DO: Patient with a history of known drug allergy should be put on a wrist band with two red clasps on admission. Nurses have to check patient's wrist band during drug administration.

5 DO: A signage of "Drug Allergy" should be posted up at patient's bed head end on admission and nurse should check it during drug administration.

6 DO: Nurses have to fax all MARs to pharmacy including MARs with ward-stock drugs for vetting.

7 DO: Medical and nursing staff should comply with HA Guideline on Safe Medication Management.

These important points were promulgated at staff meetings and newsletter of nursing department.

Result

An audit with 7DOs as criteria was conducted in 3Q16. The good compliance was reflected by 100% rate with 52 nursing staff involved. There has been no this kind of medication incident reported since strategies implemented.

Problem of medication error can be tackled by multidisciplinary approach in the development of risk reduction strategies. Dedicated leadership of senior staff with frontline staff involvement would be conducive towards successful safe medication management.