Preventing Wrong Administration of Drug Due to Inappropriate Storage of Drug in Ward

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Introduction
The storage of drug products is one of the key elements of the medication-use process. A well-organized drug-storage system can reduce the risk of medication incident. Break down in the storage of medications can contribute to drug product mix-ups. To ensure safe administration and proper storage of drugs, a working group was developed to evaluate the current ward practice and to eliminate weakness so as to target of zero medication error due to inappropriate storage of drug in ward.

Objectives
1. To review current ward practice and seek for improvement
2. To evaluate weakness and to implement corrective action
3. To share good practice among wards
4. As guide to standardize storage system

Methodology
4 Medication Inspection Rounds were scheduled in quarterly basis. Checklists were developed according to the HAHO and Princess Margaret Hospital drug administration guidelines. Medication Safety Board was posted up in ward for medication safety promotion. Post Inspection Round’s recommendation was shared with ward nurses by responsible NO/APN to enhance their awareness

Result
The project was successfully rolled out from September 2015 through September 2016. Overall compliance rate was 92.4%. Zero medication incident was found related to inappropriate storage of drug in Lai King Building of Princess Margaret Hospital since September 2015.

Recommendations and key improvements were implemented after the Inspection
Round:
(a) Standardize content of Medication Safety Board
(b) Look Alike and Sound Alike infusion solution not place in close vicinity
(C) Medication in individual cabinet of Injection Trolley place according to individual patient instead of by type of medication
(d) Alert label attached on Pre-mixed KCL solution and different kind of Pre-mixed KCL solution stored physically separate from each other
(e) Standardize Medication Fridge Labeling with appropriate function check of Medication Fridge and well documented
(f) Posting of updated reference of “Injectable Dilution Table and PMH Guideline on Preparing Drug for IV Administration with Infusion/Syringe Pump” over Injection Trolley for staff reference