

Service Priorities and Programmes Electronic Presentations

Convention ID: 101 Submitting author: Ms Jessica YIK Post title: Ward Manager, Princess Margaret Hospital, KWC

To sustain medication reconciliation in a world of change

Yik WMJ(1), Tang MKC(1), Wong SPA(1), Cheung HW(1), Medical and Geriatric Department, Princess Margaret Hospital

Keywords:

IPMOE Medication reconciliation

Introduction

In a rapid changing world, IT advancement is unavoidable and is the bible for the succession. As we can see that there are lots of new interventions in medication process like electronic dispensing system, electronic MAR or up to IPMOE. A series of workflow changes are foreseeable. Therefore it is necessary to sustain the medication reconciliation during the transient period so as to maintain patient safety and uphold the professional standard. The project intended to improve the efficiency and accuracy of the medication process in clinical areas and to keep up with the time for the advancement of IPMOE.

Objectives

~ To maintain patient safety ~To uphold the professional standard on medication process ~To minimize medication incident from human error ~To enhance communication among staff, wards and department by standard practice ~To provide continuity of quality of patient care

Methodology

Real Life Education: On top of classroom teaching, we arrange one for one hand on learning in real scene, so training is more interesting, more acceptable of complicated steps so as to overcome negative aspects with confident gained & stress reduced, Illustrated assessment checklist: return demonstration to ensure staff competency & identify the weakness for improvement. Illustrative quick guide: eye catching reminders for staff easy reference. It will quicken the adaption &minimize confusion. Equipment and environment: Tailor made cupboard to house IT devices enable easy access maintain of electricity supply & relived congested coiled electricity wires. Professional standard: To show proper regards for new changes, standardize & revised workflow developed to tackle foreseeable problems from current practices e.g. urgent drug request, verbal order, drug handover in transfer or special procedures.

<u>Result</u>

Evidently, the program significantly reduced the common medication incidents caused by human error such as wrong preset time, wrong patient identification, and so accuracy of medication administration ensured. The standard practice among different disciplines; wards and department greatly improve the continuity of care and communications among different aspect. Above all, magnitude of patient safety can be achieved and pave a good foundation for further advancement.