A Patient Safety Initiative in Improving Medication Safety of Controlled Drugs

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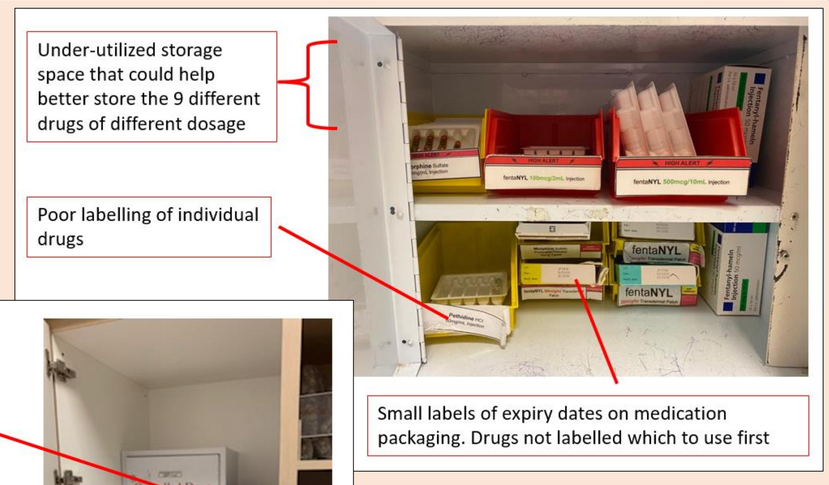
Introduction

Ward 43 is a Gynaecology Oncology ward; with a complex patient acuity. The ward stores multiple types and dosages of Controlled Drugs (CD) which includes patient's own controlled medications. In addition, there is a seasonal influx of palliative patients with their own poly pharmacy consisting of different types of CD. The similar name, similar packaging and different dosages kept in the current metal cabinet posed a risks for Medication Error. The expected error was foreseen as the nurse inability to differentiate when retrieving the required drug and dosage due to poorly labelled containers and space constraint of the current metal cabinet.



Aim(s)

The aim of the project is to:

- Mitigate risk for medication error with a well organized CD cabinet
- Reduce CD wastage by ensuring First Expiry First Out (FEFO)
- Improve staff satisfaction by ease of retrieving the correct CD

Methodology

A workgroup was formed in August 2019; with Ward 43 nurses, Principal Pharmacist and Facility Management (FM).

The following problem were identified by the team:

- Space constraint of existing CD cabinet
- Protocol breach in placement of CD for look-alike sound-alike (LASA)
- Excessive procurement of CD stock
- Worn-out CD labels

A revamp of the CD cabinet with Pharmacy, Ward Nursing Team and FM input to create compartments and storage for individual CD. Our pharmacist reviewed the CD placement to ensure that LASA drugs are spaced apart from each other. New CD drug labels were printed and replaced the worn out labels using "tall men lettering". The "To Use First" labels onto CD with shorter shelf-live was initiated to ensure First Expiry First Out (FEFO).

The CD usage needs of patients in this ward changed from time to time due to the needs of different individual palliative patient. Hence, the project team will monitor and adjust the CD quantity procured accordingly. This would ensure sufficient CD required by the ward is kept to meet patients' urgent needs but not in excess which may result in unnecessary write-offs.

Timeline of events

1st Aug 2020
When there is an influx in palliative patients, cabinet becomes too full to be locked and some CD drugs need be kept in the outer cabinet and double locked

4th Aug 2020
Consulted Pharmacist Wu Peiru and received feedback that according to previous Policy & Procedure (P&P), double lock was needed on doors. The current cabinet is old, doors need to be refurbished as it is ajar most of the time from worn out hinges.

6th Aug 2020
Site Visit to Ward 56 – Adopt practices
Wooden cabinets built to specifications replaced the old metal cabinets and provided additional space to add shelves and an inner door.

1st Sep 2020
Cabinet quotation was reviewed and approved according to P&P and to standardize practice with newly renovated wards

12th Sep 2020
Cabinet installation completed by FM Mr. Darren Lee

16th Sep 2020
Reviewed by DD Ms Teo, we decided to put in a 2nd lock on the outer door as a back-up should inner lock become faulty

25th Sep 2020
Cabinet reviewed by Pharmacist, Ms Wu Peiru & Ms. Gan Mee Ling and all drug labels were replaced according to LASA

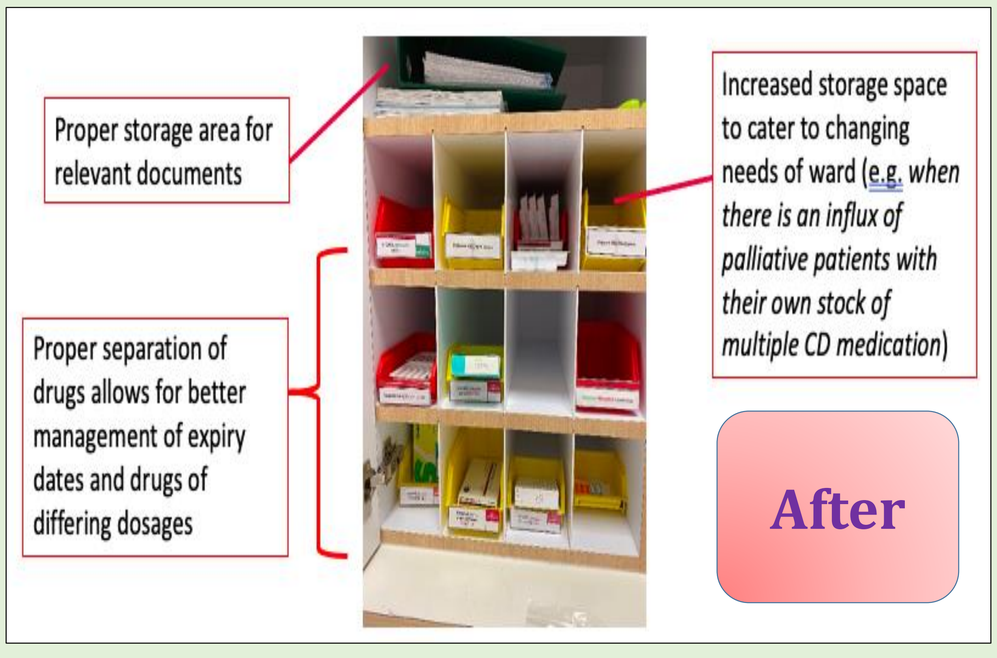
Result

We achieved all three (3) aims of the project as stated above.

Implementation of the project has improved patient's safety by mitigating the risk for medication error.

With the individual compartments, clear separation using LASA and clear labels using "tall men lettering", staffs are able to locate the correct type and dosage of CD.

Staff needs, satisfaction and most importantly patient and staff safety has been met.



Conclusion

The enhancement of the CD cabinet was initiated by the nurses who identified a safety concern; this initiative is vital and essential in maintaining the hospital's quality and safety standards for our patients. The nurses and pharmacist collaborative effort strived for better patient care and amplified our hospital's goal of **"TARGET ZERO HARM".**

PATIENTS AT THE HEART OF ALL WE DO