# **Reducing** medication incident rate in Outram Community Hospital (OCH)



Bright Vision • Outram • Sengkang

# Singapore Healthcare Management 2022

<sup>1</sup>Dr Loo Yu Xian, <sup>2</sup>Chan Tsui Pik, <sup>1</sup>Dr Clarence Chiang, <sup>2</sup>Diana Ting, <sup>3</sup>Shaifullah, <sup>3</sup>Phyllis Wong, <sup>4</sup>Dong Minyan and <sup>5</sup>Wang Xuan Wei <sup>1</sup>PACC, <sup>2</sup>Pharmacy, <sup>3</sup>Nursing, <sup>4</sup>QI Project Facilitation and <sup>5</sup>Clinical Governance Office

## BACKGROUND

OCH medication rate was 1.4 per 1000 patient days from Nov 19 to Jun 20. SCH management team expressed concerns over the high medication incident rate at OCH and had requested for QI project to be conducted to establish appropriate interventions to reduce medication rate and ensure patient safety within a year.

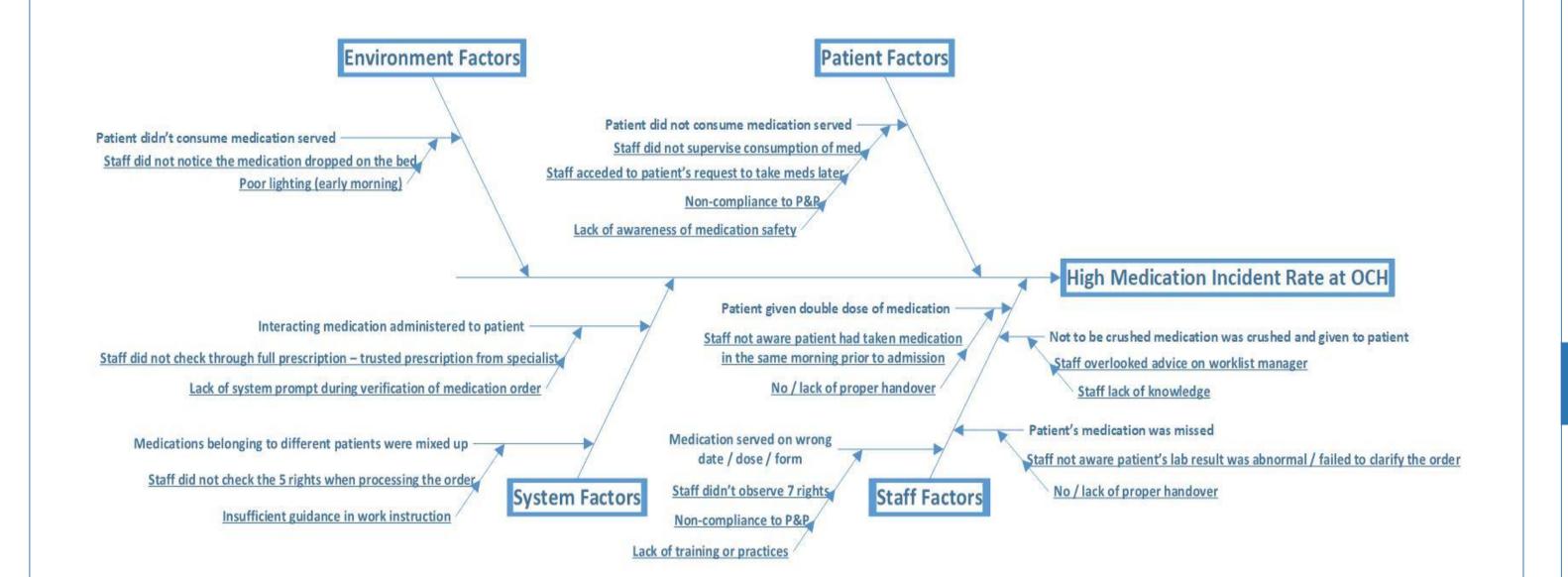
# **INTERVENTIONS / INITIATIVES**

The project team brainstormed and came out with the following interventions:

#### **MISSION STATEMENT**

To reduce medication incident rate at OCH by 50% within 6 months, and further reduce to below 0.3 per 1,000 patient days 3 months thereafter.

# ANALYSIS OF PROBLEM



1. A medication safety workgroup was formed to look into all medication safety related issues. Incidents were discussed with root cause analysis and corrective actions were proposed at workgroup level.

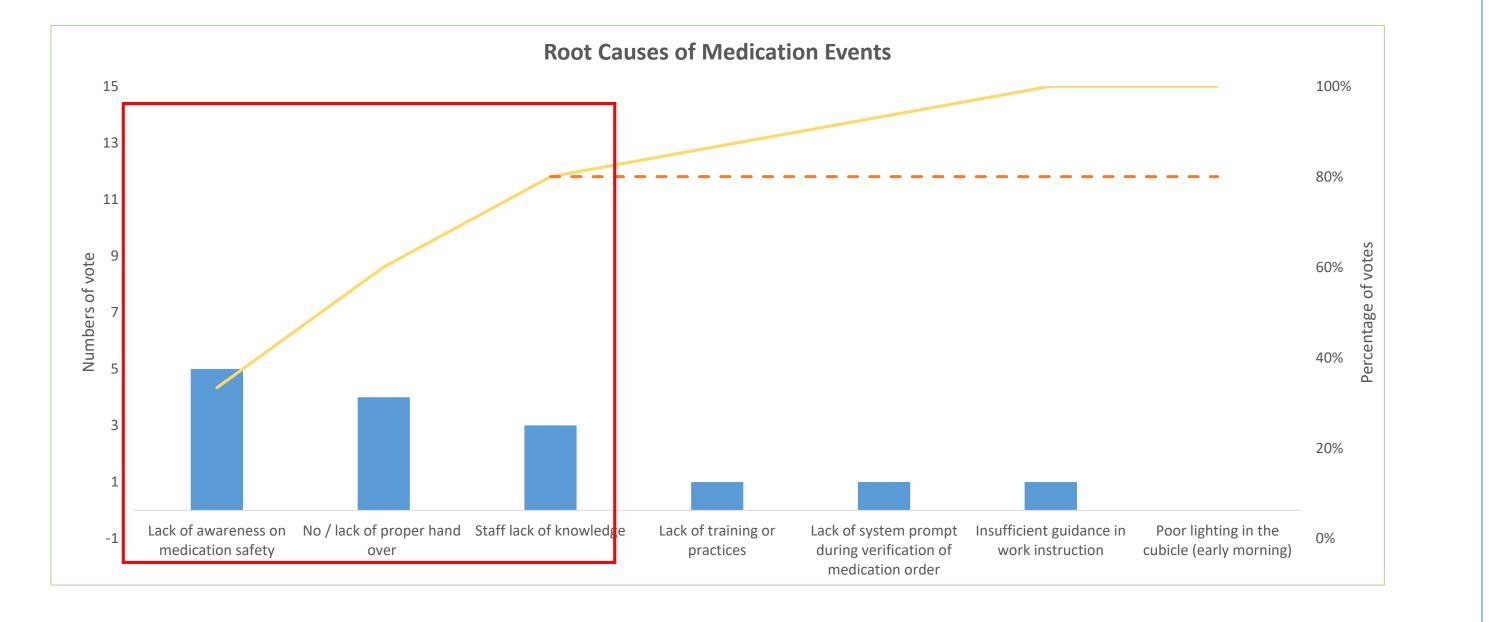
2. SCH monthly medication safety bulletin has been published to share best practices and correct procedures to ensure medication safety.

3. Medication safety vest was piloted in selected OCH wards with the aim to reduce disruptions during medication administration. The intervention was not implemented due to unsatisfactory pilot results.

4. To implement the "status board" in SCM as a "live" board to keep staff updated on the list of tasks for Patients.

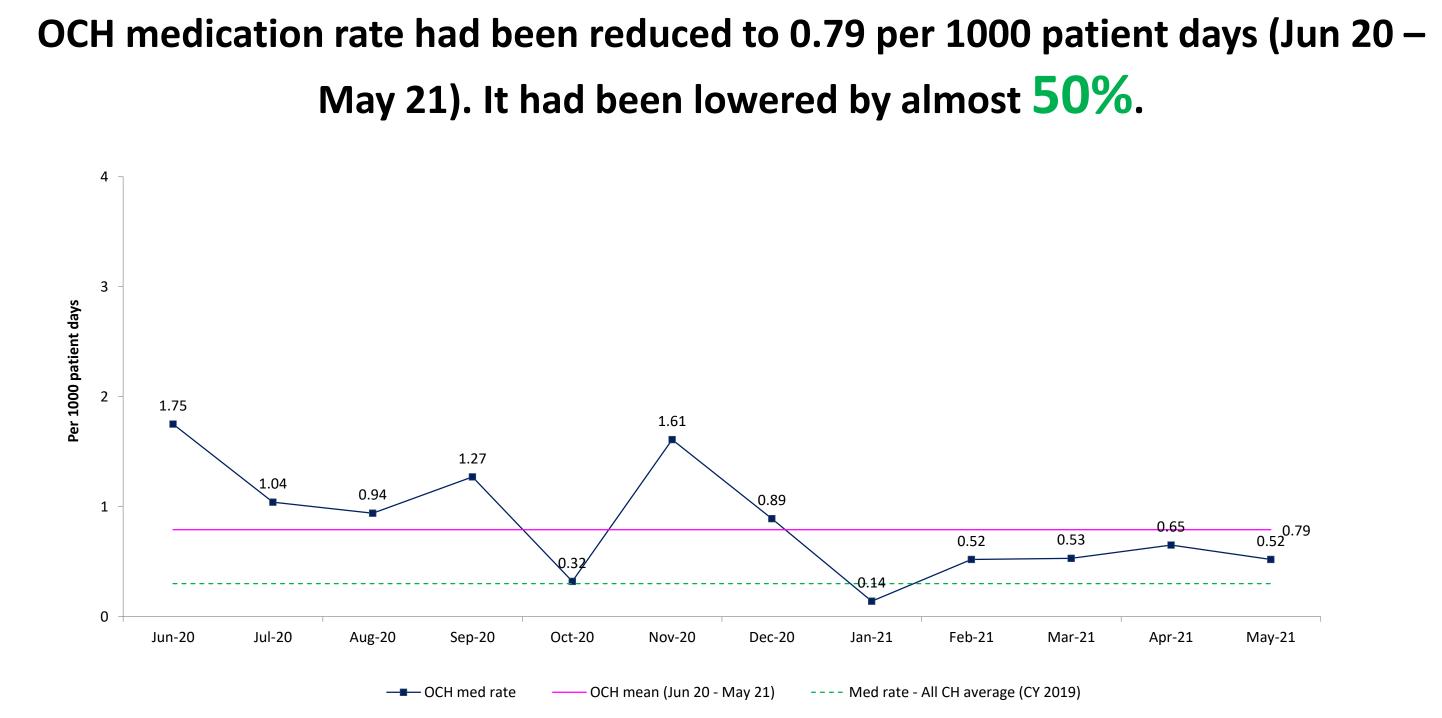
5. Medication safety champions at each ward were identified to further reduce the risk of medication incidents. The champions will reinforce the correct procedures to ground staff and create awareness. At the same time, they will communicate with their colleagues on new medication practices if any.

6. Complicated medications scheduling in SCM will be scheduled by medical team, which will then be verified by pharmacist prior to nursing



administration.

## RESULTS



#### SUSTAINABILITY AND SPREAD

The workgroup conducted root cause analysis and identified the following root causes to focus on:

- 1. Lack of awareness on medication safety
- 2. Lack of proper handover between nurses with regards to medication
- 3. Staff's lack of knowledge regarding certain medications.

The medication safety champions in individual ward are able to reinforce medication safety practices to their colleagues. Staff will comply with medication administration process when the correct practices have been consistently highlighted to them.

The monthly SCH medication bulletins have been sharing the correct medication safety practices with all staff. Group Comms have adapted one of the SCH bulletins to an article for HealthXchange on the topic of "Do Not Crush medications". It can enhance the cross learning at SingHealth.