NHG-AWWA Medication Safety Project

[1] Clarice Woon, Central Regional Health Office, NHG [2] Chong Yunn Ling, AWWA Community Home
[3] Deborah Ee, Quality Resources & Management , NHG [September 2015 – January 2016]

AWWA

National Healthcare Group
Adding years of healthy life

Mission Statement

To build awareness and improve safe practices for medication packing, dispensing and storage in the AWWA Community Home.

Key outcomes:
- 1-page summary of current meds which residents bring along when they visit Polyclinics and GPs
- Reduced 40% (from 25 to 15 mins) in medication packing time per resident; this accounted for 10 hr/week for 60 residents
- Achieved zero errors in medication safety in Jan 16 & in Jun 16.

This project contributed to AWWA's medication safety practices via timely, accurate medication packing & administration as well as using standardized medication records.

Core Team Members

Name	Designation	Department
Clarice Woon Alison Yeo	Dy. Director Executive	Regional Health, NHG
Deborah Ee	Director	QRM, NHG
Chong Yunn Ling Khin	Nurse Manager Registered Nurse	AWWA Community Home

Evidence for a Problem worth solving

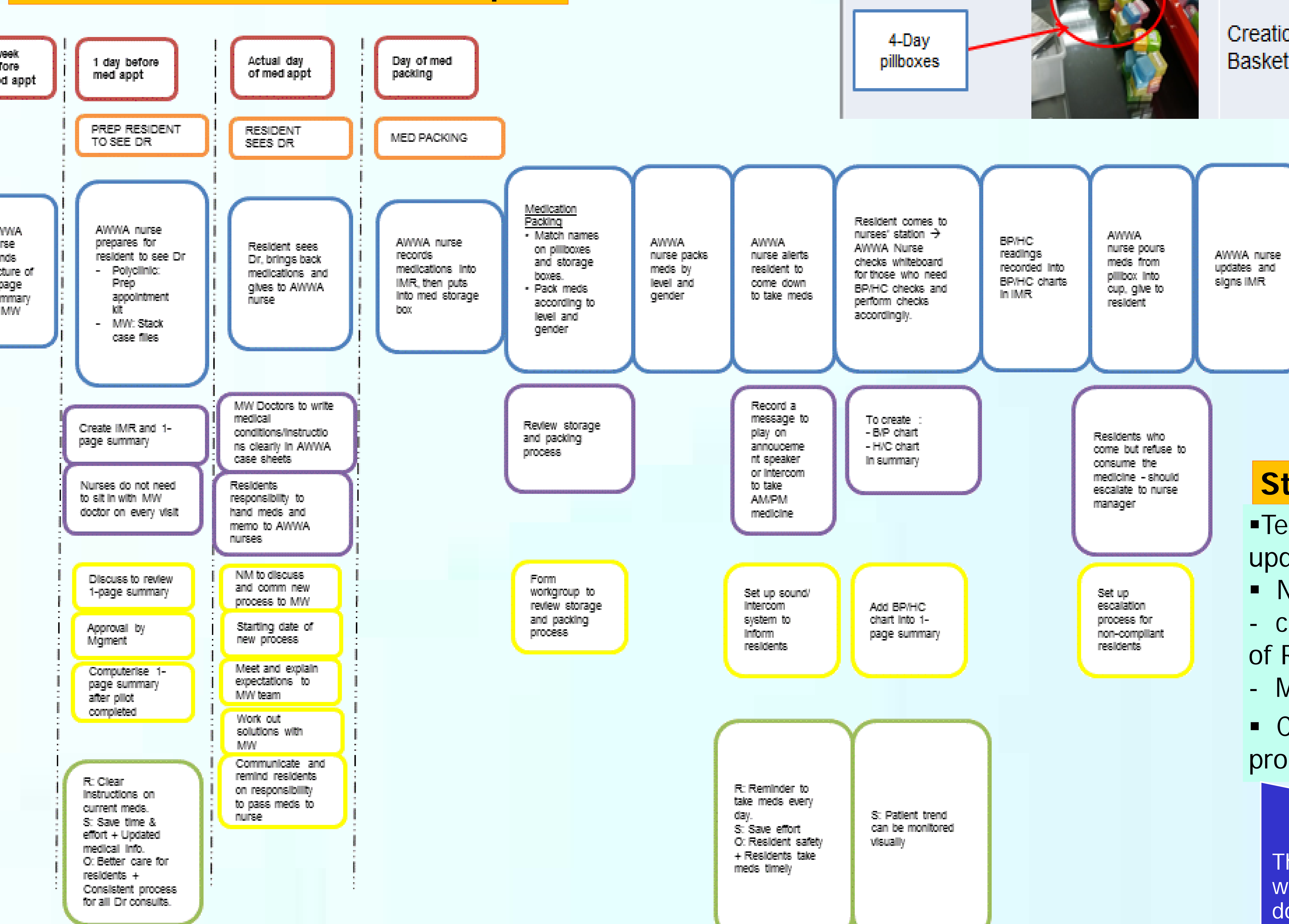
AWWA identified safe medication practices as a key improvement area:
- A medication safety audit on packing medication was conducted by NHG Pharmacy on 21 July 2015.
- Recommendations on safe documentation practices were made
- Reinforced staff training on drug storage and medication management

Current Performance of a Process

Average medication packing time for ONE resident: 15 – 25 minutes

- Resident medication drawers not arranged by floor, alphabetical or any other order .
- No clear demarcation of storage areas in the cabinet
- Labelling of resident drawers by colour as visual cues for gender (Red: Female; Blue: Male) not strictly enforced.
- Medication packing done once every 4 days.
- No one single summary for medications
- Many actions performed based off memory and not written down

Future-State Value-Stream Map



Cause & Effect

Issues	R/Causes	Issues	R /Causes
▪ Discharge summary from hospital/polyclinic does not have specific meds, but these meds are prescribed. ▪ AWWA sent memo to Hospital informing meds discontinued, but meds still prescribed to resident. ▪ Medication Distribution Form not updated regularly	▪ No one single summary for medications	▪ Hospital staff asked to Community Home to monitor patient without proper instructions ▪ No point-of-contact to confirm instructions at Hospital end.	Hospital staff not aware that AWWA Community Home is not a Nursing Home, instructions to Community Home staff not clearly articulated
▪ No indication of whose medications need to be packed by days or by weeks. ▪ Pill-box may contain wrong number of medications.	▪ Staff familiarity & recognition of resident takes precedence, not written down ▪ Residents with similar names ▪ Medication storage not methodical	▪ No proper acknowledgement of injection administered by GP nurse. ▪ GP gives injection to AWWA nurse to administer without clear directions/ dosage	GP documentation not aligned with Community Home processes

Solutions, Results & Cost Savings

Before	After
Labelling of resident drawers by colour as visual cues for gender not strictly enforced.	Drawers relabelled to enforce visual cues usage. Red: Female Blue: Male
Packing was done once every 4 days. 4-Day pillboxes	Packing is done once every 7 days (on Tuesday). 7-Day pillboxes Creation of Tuesday Basket

- 40% Reduction (from 25 to 15 mins.) in meds packing time per resident
- Total savings of 10 hours per week for 60 residents

1-page Summary of Current Meds
- Enabled clear communication with Drs. during Hospital and Polyclinic visits
- Achieved zero medication errors in Community Home

AWWA RESIDENT MEDICATION RECORD

Strategies to Sustain

- Team Leader (Registered Nurse) monitors, audits & update Nurse Manager on weekly meds error rates
- Nurse Manager creates standard work to:
  - communicate new process and alignment on usage of Resident Medication Record
  - Medication Packing process
- Creation of AWWA Sustaining Board to promote responsibility for assigned tasks

The staff are much happier with guidance on what to do, and they now have more awareness on the importance of proper medication management.
- AWWA Nurse Manager

This has been a very educational experience.
I feel like I know how to do things better. I learnt a lot.
- AWWA Enrolled Nurse