Senior Pharmacy Assistant Ward Based Medication Safety Support Activity

Leiuanna Rowe, Tasma Wagner, Amy Flavell, Emma Bartlett

Pharmacy Department, The Port Augusta Hospital, Port Augusta, SA Pharmacy, South Australia

Background

Unit-of-use medicine supply systems in small regional hospital wards are prevalent

Daily oversight of meds in bedside lockers is a foundational element for effective clinical pharmacy service

Incorrect or absent meds contribute to treatment delays, un-necessary consequent costs and failure to meet patient expectations

Methods

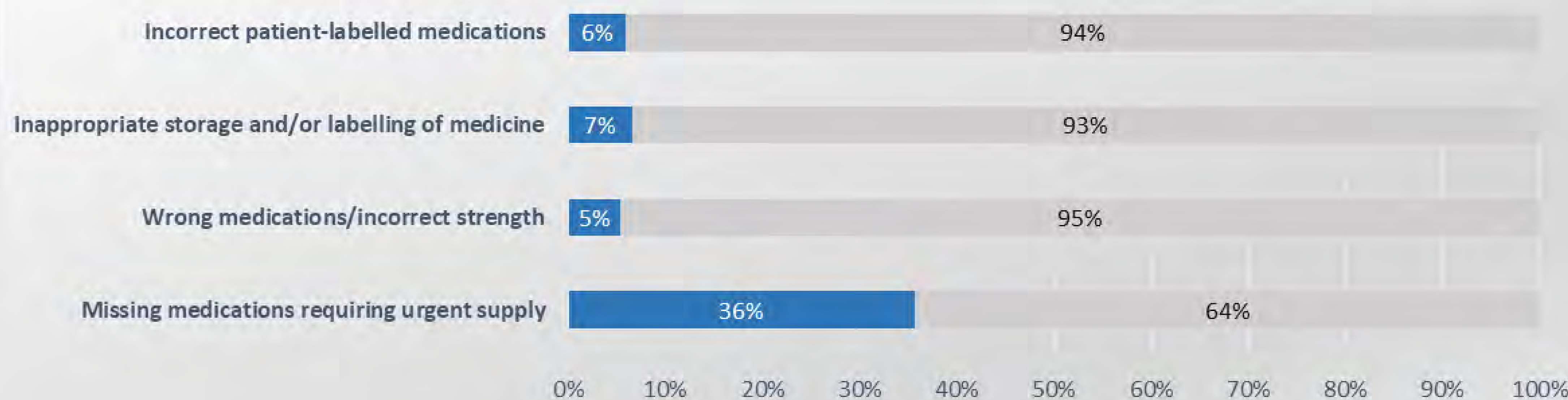
Each weekday for a month, all medicines in bedside lockers of one medical ward were reviewed by a Pharmacy Assistant

Locker contents were reviewed against an up-to-date electronic medication administration record

A daily patient-list summary report with potential medication supply or safety issues identified was prepared by the Pharmacy Assistant

Each day, the report was discussed with the responsible clinical pharmacist

Results



Outcomes over a One-Month Period:

- Medication identified as incorrect or ceased were removed and discussed with the clinical pharmacist (26/168)
- Newly admitted patients overnight with identified medication problems were flagged for the clinical pharmacist (62/168)
- Required non-imprest medication were supplied prior to dose due times reducing missed or delayed doses
- Appropriate storage was arranged for patient's own medications (11/168)
- Single patient use medication (eg. Inhalers) were reviewed for appropriate labelling

Conclusion

Daily Pharmacy Assistant review of ward medicine logistics in unit-of-use medicine supply systems provides invaluable support and credibility for advanced clinical pharmacy practice in small regional hospitals

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