QUALITY INDICATORS IN AN UNITARY DOSE DRUG DISDENSATION SYSTEM: MEASUREMENT, ANALYSIS AND IMPROVEMENT



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BACKGROUND

Quality indicators (QIs) are measures of health care quality in order to achieve the planned results in a Quality Management System.

PURPOSE

To evaluate the results of some QIs in an **Unitary Dose Drug Dispensation System** (UDDDS) in a Hospital Pharmacy Department (HPD).

MATERIAL AND METHODS

Prospective observational 3-weeks study (September'14) performed in a second level hospital.

QIs and standard values (SV) to achieve maximum quality were established by a working group: 2 pharmacists and 1 nurse.

411 beds, 52.8% of them with UDDDS and manual transcription by nurses and validation by pharmacists.

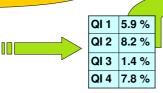


Three days a week a "pilot cart" (PC) was selected by a random method (extraction balls) and checked by a pharmacist. Data were recorded and analyzed, using a form designed for that purpose, Farmatools-Dominion® programme and Microsoft Office Excel®.

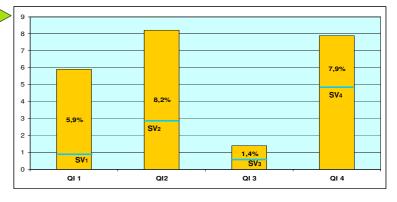
QI1: % Filling errors	[errors / number of dispensed drugs (nºDD)]*100	SV1 < 1%
QI2: % Transcription errors	[errors / number of prescription lines (nºPL)]*100	SV2 < 3%
QI3: % Validation errors	[errors / nº PL]*100	SV3 < 0.5%
QI4: % Returns	[returned drugs / nº DD]*100	SV4 < 5%

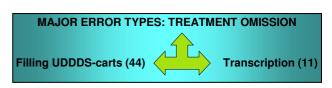
RESULTS

9 PC were checked 474 PL 1736 DD 207 PATIENTS



COMMON ERRORS		
102	Filling	- Omission 44 - Different amount 26 - Commision* 16 - Different dose/dosage form/drug 16
39	Transcription	- Omission 11 - Different dose/dosage regimen 14 - Incorrect drug/route of administration/duration 11 - Commision 3
7	Validation	- Different drug 2 - Different dose 2 - Commision 1 - Different route of administration 1 - Different dosage regimen 1
136	Returns	Not administered drug 88 Transfer/discharge 30 Finish treatment after cart distribution 16





* drug should be discontinued but remained in patient's treatment

Even though UDDDS may reduce medication errors, the QIs analyzed were superior to SV previously defined. The measurement of QIs showed noncompliance and required corrective actions to resolve mistakes in orden to improve patient security:

- ✓ regular training sessions for HPD staff;
- √instructive note for nursing;
- √technical instructions for nursing assistant;
- design of a specific form for returned drugs.

CONCLUSIONS

