BACKGROUND AND OBJECTIVES

The Unit Dose System (UDS) of medication distribution is a pharmacy-coordinated method of dispensing and controlling medication in organized health care settings. In our hospital, medications contained in single unit package are delivered for 24h-period; however, many drugs are requested and returned to the pharmacy store.

Our goal is to identify the reasons for requested and returned drugs dispensed by the UDS.

METHODS

Prospective study over a 6 month-period, in which drugs dispensed-returned from various clinical units were analyzed. The study presented two stages:

➢ The first one, a medication cart was randomly selected once a week and double-checked before dispensing; the medication errors were recorded and corrected before it was taken to the pertinent hospital ward.

➢ The second step was to monitor the medication cart during 24 hours after delivering. The out of the circuit request of medication and the return to the Pharmacy Department (PD) from the clinical unit selected were recorded and analyzed with the nursing staff.

RESULTS

During the study, twenty-four medication carts were assessed, including 3766 medication lines and 6796 unit doses, corresponding to 572 patients. Thirty-eight medication lines errors (1%) were detected at the PD. The most frequent error was dose duplication, seventeen cases were registered (50%) and its main cause was the lack of attention, thirteen records (73.6%). 144 out of the circuit medication request, which correspond to 204 unit doses, were registered. 1127 unit doses (16.58%) were returned to the PD.

- Requested medication
- Returned medication
  - Treatment modification/new prescription
  - New hospitalized patients
  - Others

CONCLUSIONS

This study has allowed to identify the main cause errors of the medication dispensing process. Knowing the failures of the UDS will allow us to design the dispensing circuit to increase their efficiency.

REFERENCES