EVALUATION OF INTERRUPTIONS DURING UNIT DOSE DRUG DISTRIBUTION SYSTEM IN AN HOSPITAL PHARMACY

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BACKGROUND
To improve quality and safety of care, multidisciplinary meetings are regularly conducted in order to retrospectively analyse undesirable events in care system. During one of these experience feedback committees, daily mistakes by pharmacists’ assistants (PhA) when filling the trolleys with drugs were reported. We formulated the hypothesis that disruptions in the work load may have led to them. In fact, many studies about interruptions (ITs) in nursing care are published. They indicate that interruptions are commonplace and lead to medication errors, particularly during medication administration. However, we noted that studies about its are limited in pharmacy.

OBJECTIVES
1. To evaluate quantity of PhA’s IT during daily dispensation in unit-dose drug distribution system (UDDS). 2. To understand the causes of ITs to avoid them better. 3. To know PhA feeling’s of ITs.

MATERIALS AND METHODS
We observed 6 out of 12 PhA for 20 hours of UDDS. We established an observation grid (one for each PhA observed) then, we collected PhA opinion through an anonymous questionnaire in order to know their feeling about ITs. PhA had been informed and asked for their consent. Note that the grid was tested twice and then modified.

RESULTS
The first cause of disturbance was PhA themselves (41%), initiating conversations. De facto, colleagues (30%) were the second cause due to proximity, then nurses and calls from medical staff (23%). Same types of IT were observed in nursing stations because of patient’s relatives.

The increase of ITs observed in nurse stations (6.7 to 7.6 IT/h). The frequency of IT observed (7 IT/h) was similar with the numerous IT described in nurse stations (6.7 to 7.6 IT/h).

CONCLUSION
- Task interruptions are numerous but seemed to be justified by the necessity of relationship with medical staff.
- This study allowed the pharmacists and pharmacist’s assistants to be aware of ITs and to be made sensitive at the risk of error leads by these.
- The following work will focused on the improvement of the resumption of a current activity. We can lean on the guide of the HAS (tool for securing and self-assessment of interruptions) as well as on the collected data.