PHARMACEUTICAL CARE NETWORK EUROPE

Working Conference 2013 – Abstract

Collaborative pharmaceutical care in research and practice

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The above mentioned participant in the PCNE WC 2013 wishes to submit following abstract for a poster or oral communication. If accepted and presented, the abstract will be published in the International Journal of Clinical Pharmacy. Please make sure the abstract is no longer than 350 words, excl. author-details.

Title

An automated dose dispensing system that supports patient safety

Author(s)

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Type of abstract

☐ **Research** ☐ Practice development ☐ Practice implementation

Aim of project/study

To identify risk factors in the ADD process that compromise patient safety and to identify measures to achieve a safer and more effective ADD system. The ADD process included all steps in the medication use process such as prescribing, packaging, administration and monitoring of ADD medicines.

Method

We conducted four preliminary studies on implementation of ADD and experienced medication errors (MEs). A cross-sectional analysis identified the most frequent ME types and important risk factors. Results were presented to a multidisciplinary expert group of health care professionals having practical experience with ADD and a member of the Danish Rheumatism Association representing the patient perspective. Through an appreciative inquiry process followed by three consecutive consensus rounds, the expert group agreed on measures to improve safety and efficiency of the ADD system.

Result(s)

The most frequent MEs experienced by health care professionals were inadequate coordination of ADD, errors when administering medicines in nursing homes/home care, and errors at hospital admission or discharge.

Important risk factors were the ADD regulatory framework being an unsuitable add-on to existing regulations, health care professionals' attitudes, knowledge, coordination and implementation of ADD, unsupportive IT systems, economic concerns causing safety issues and hindering problem solving, and errors in home-based use of ADD

being largely unknown.
The expert group agreed on 40 recommendations for a safer and more effective ADD system. The recommendations mainly concerned development of the existing IT systems and the regulatory framework. The expert group also developed a best practice model for safe ADD implementation.

ADD has contributed to safer and more efficient packaging of medicines and should continue. A safer and more efficient ADD system can be achieved by implementing the developed national best practice model. To really enhance patient safety, it is necessary to revise the ADD system with specific attention to safety and efficiency. The expert group prepared recommendations for revision of the ADD system with that objective.

+++ NB: PhD students still pay the early bird fee for their abstract if their abstract is accepted ++++