

# REDUCE RECORMON DISPENSING ERRORS AT OUTPATIENT PHARMACY (OP) LEVEL 2

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## Define Problem, Set Aim

### Problem Statement

In January 2024, three separate incidents occurred where patients were incorrectly dispensed Recormon 4000 IU instead of the prescribed Recormon 2000 IU at Level 2 Outpatient Pharmacy. The recurrence of this specific error within a short timeframe suggests a systemic issue in the medication packing process for Recormon at this location. This problem needs to be addressed urgently to prevent further incidents, ensure patient safety, and maintain the hospital's high standards of care and reputation.

### Aim Statement

We aim to reduce Recormon dispensing errors to zero and maintaining it there, at Level 2 Outpatient Pharmacy, and sustain this from Apr 2024 to Jul 2025.

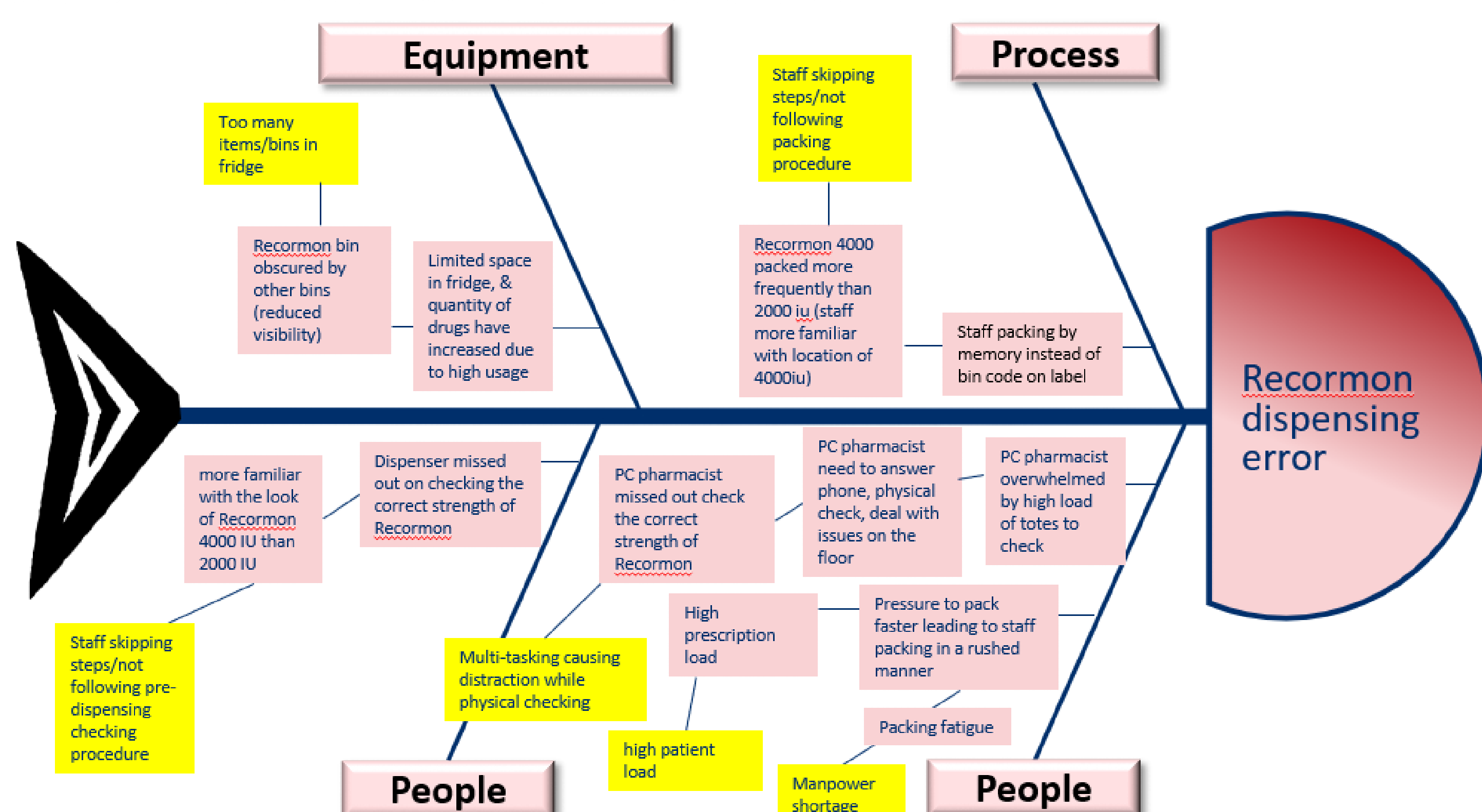
## Establish Measures

Type of Measure (Outcome / Process / Balancing)	Measure
Outcome Measure	Number of Recormon dispensing errors
Process Measure	Number of Recormon packing near misses
Balancing Measure	Number of packing errors for other medications



## Analyse Problem

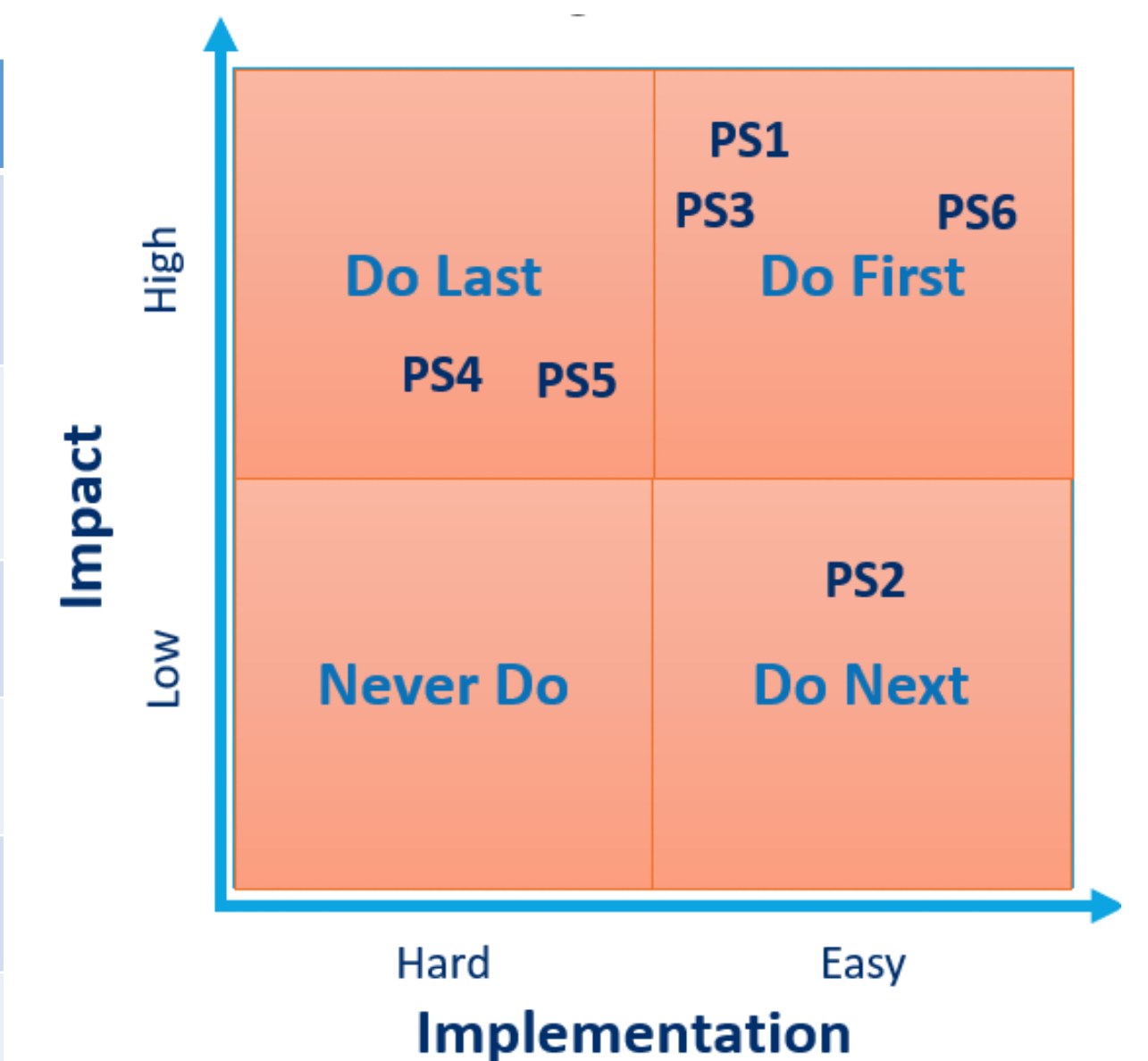
### What are the probable root causes?



## Select Changes

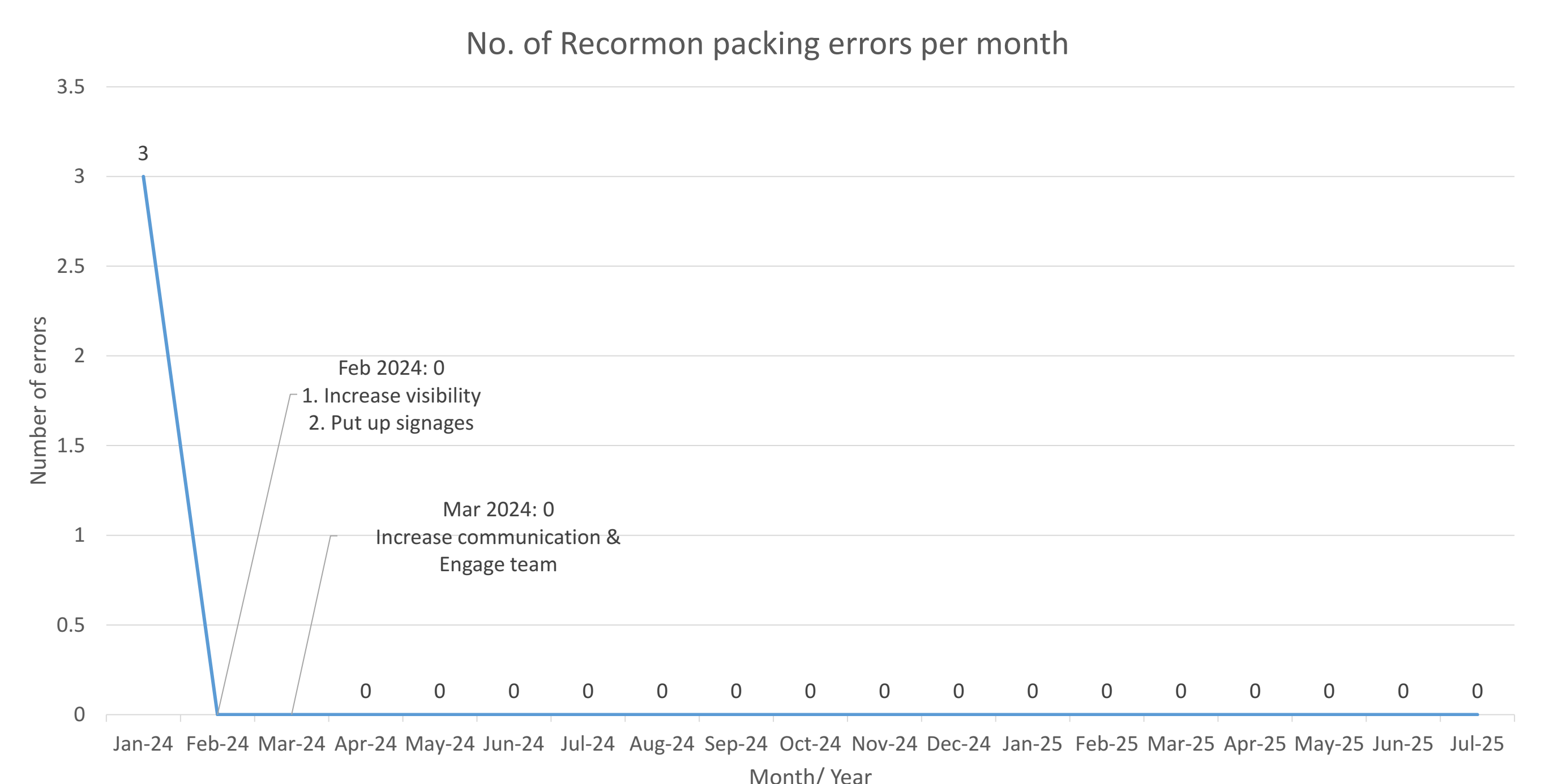
### What are all the probable solutions? Which ones are selected for testing?

Root Cause	Potential Solutions
Root Cause: People	1 Put signages in front of the Recormon bin to alert packers to check the strength
	2 Improve communication with the team to raise awareness and reduce error
Root Cause: Equipment	3 Increase visibility of drug bins
Root Cause: Distraction	4 Increase the number of PC pharmacists (to lighten checking load)
	5 Increase the number of packers (to lighten packing load)
Root Cause: Process	6 Staff pack by bin code on label instead of by memory



## Test & Implement Changes

Cycle	Plan: "What will happen if we try something different?"	Do: "Let's try it."	Study: "What happened?"	Act: "What's next?"
1	Inventory team put pop-up sign in front of the Recormon bin to alert packers to check the strength of the medication they are packing.	• Signages that say "STOP! Are you packing/topping up Recormon 4000IU?" in red colour have been put up in the front of the Recormon bin since 26 Feb 2024.	The signages were very effective in alerting pharmacy staff to check and pack the correct strength of Recormon.	We will adopt the Signages for the 2 Recormon strengths (2000 IU, 4000 IU), and also create signages for look-alike drugs that have 2 strengths in the fridge (e.g. Cosentyx SECUKINUMAB 150MG vs 300MG, Trulicity DULAGLUTIDE 0.75MG vs 1.5MG)
2	Improved communication with the team to raise awareness and reduce errors	• Remind team on the importance of the "5 rights" during pre-dispensing checks, emphasize mandatory triple check process. • Remind the team of packing procedures to ensure consistency and reduce the likelihood of future errors. • Sharing of incidents (of wrong Recormon dose supplied) in 11 March 2024 OP meeting.	The communications made to the team were effective to help the team more compliant to existing packing workflows.	• Continue to engage staff on proper packing procedures: Med safety team and the Outpatient Pharmacy In-Charge continue to regularly share incidents and near misses during department meetings to keep the team informed and prevent further incidents from happening.
3	Increase visibility of drug bins	Recormon 2000 IU bin has been moved to the front of the fridge, where it has high visibility and no longer behind other bins/stocks since 12 Feb 2024.	Staff feedback that the bin is more visible and easier to access when packing.	Inventory team has continued to review L2 drugs and re-arrange drug bins to ensure visibility of all drug bins.



## Spread Changes, Learning Points

### What are/were the strategies to spread change after implementation?

- Create signages for look-alike drugs that have 2 strengths in the fridge to prevent packing errors.
- Continue to engage staff on proper packing procedures: Medication safety team continues to share incidents and near misses regularly during department meetings to keep the team informed and prevent recurrences.
- Inventory team continues to review drug locations and re-arrange drug bins to increase visibility and prevent packing by memory.