



Evaluation of adjustment failures and improvement processes in a teaching hospital in a certain area of northern Taiwan

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【 OBJECT 】

There are 835 items of medicines in this hospital. The pharmacists often make mistakes in prescriptions due to various reasons. The department arranges patient medication safety meetings every month to discuss adjustment errors and improve the process. Through the meeting to promote, adjust the label of the drug name on the drug bag, or change the location of the drug, so as to increase the warning to reduce the error rate of dispensing.

【 METHOD 】

This study focuses on the improvement of the departmental adjustment miss in a northern regional teaching hospital from January 106 to December 109, including: adjusting the labeling of the drug name on the drug bag, or the change of the drug location, analysis and Review.

【 RESULT 】

The average number of adjustment error per month was 10.42 (0.05‰), and the number of changes was 1.58 (16.23%). The process is changed to the following table. There were 4 cases where the same error occurred again.

【 CONCLUSION 】

This study confirmed that the courage to report, review adjustment errors, and improve the process in time can reduce the error rate of adjustments, and also greatly reduce the occurrence of the same errors, which will help improve the quality of patients' medication and the safety of patients' medication. Adjusting the wrong way to improve is here for reference to related industries, and hope to establish a safe medication environment together.

The improvement measures are as follows:

Change in the name of the medicine bag 76.09%	Change of the capitalization of the drug name 13.04%
	Add the Chinese name or effect of the drug 39.13%
	Add of the color 19.57%
	Add dose 4.35%
Change the position of the drug 13.04%	
Other 10.87%	