

1/ INTRODUCTION

TI definition (according to the HAS) :

- Cessation of an activity resulting in a **break** in the course of this activity
- **Disruption** in the operator's concentration



Medication error



Objective :

Identify causes of TIs in chemotherapy reconstitution and finding solutions to limit them

2/ METHOD

Critical steps :

- 1) Pharmaceutical validation
- 2) Product preparation
- 3) Fabrication
- 4) Manufacturing check
- 5) Check, before release, by the technician
- 6) Release by the pharmacist

ZAC

Hors-ZAC

IDENTIFICATION
of critical step

OBSERVATION

Results ANALYSIS

Observation of functions
4 half-day per post
With this grid

FEEDBACK
and
SUGGESTIONS
to decrease
TIs

Heure	Comme nt	Origine de l'IT	Motif	Réaction	Tâche initiale reprise	Durée	Justificati on
	1. Télépho ne ; 2. Physi que ; Autre	1. Médecin ; 2. Autre pro de santé ; 3. Pharmacien ; 4. Soi-même ; 5. Coursier ; 6. Autre	1. Apport d'info 2. Recherche d'informations 3. Demande d'aide 4. Autre	1. Suspend l'action en cours et traite la nouvelle demande 2. Suspend l'action en cours et délègue la nouvelle tâche 3. Poursuit l'action en cours en écoutant	1. Reprise au début après l'IT 2. Reprise au moment de l'IT 3. Pas de reprise de la tâche (oubli...)	1. < 1min 2. 1-5min 3. > 5min	OUI NON

4/DISCUSSION & CONCLUSION

Make the team aware of TIs consequences

FEEDBACK

Implementation of actions

- The pharmacist stays **outside the manufacturing area** to avoid generating new IT
- **Improve communication between pharmacist and technicians** : limit use of the intercom system to emergencies, give priority to information by e-mail or paper (orders, inventory, ...)
- When presence of 2 room managers in the manufacturing area : priority of TIs of the one who's not on a critical step
- **DRUG CAM** : limiter les IT par contrôle de fabrication

Expected consequences

↓ number of TIs
↑ workstation ergonomics

Limits :
Selection bias
Observation bias
Interpretation bias

2nd observational study to be realized for an **evaluation of efficacy** of these actions.
Extension to other sectors of the pharmacy, with risk of medication errors?

3/RESULTS

PHARMACIST

67% physical/ 33% telephonic

Non justified : 43% causeless
→ continue the work by listening

Justified : 57% → suspends the work to process the new request
Origins :
→ 24% : nurses = information input
→ 15% : technicians = information request.

MANUFACTURING TECHNICIANS

80% physics

Justified : 64 % : by other technicians
Non justified : 32% : distraction
→ discussions ++ (afternoon ++ when there is less activity)
77% : continue the work by listening (< 5min)

ROOM MANAGER

100% physics

Justified : 85%
→ **60%** : volume checks
→ **10%** : input informations by pharmacists
Origine : **80%** technicians
Reaction : suspends the task to process the new request

Actions on sources

- ✓ Surrounding noise
- ✓ Reasoned use of communication tools
- ✓ DRUG CAM

Improve teamwork

- ✓ Understand each others work
- ✓ Prioritize tasks
- ✗ Place the pharmacist's office in the manufacturing area

ACTIONS SUGGESTED

Management of the secondary task

- ✓ Learn to delegate
- ✓ Learn to recover an interrupted stain, in progress or at the beginning (check-list ?)