# Implementation of a collaborative method to improve the dispensing process of experimental anti-cancer drugs: feedback at M+6

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## INTRODUCTION

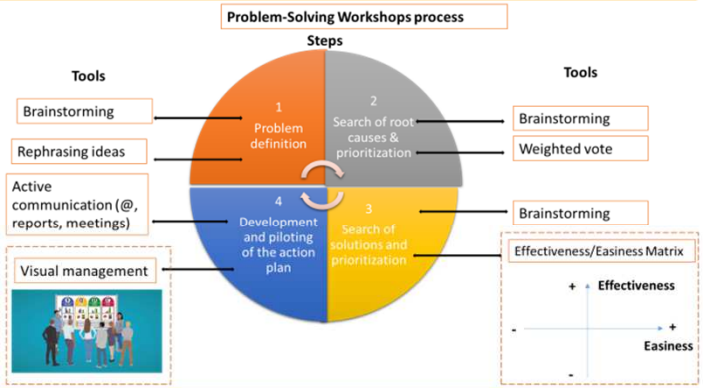
The quality of care improvement is often achieved through top-down hierarchical approaches with little space given to operators in the decision-making process, making it difficult to change the organisation. Delays in dispensing clinical trials (CT) and dysfunctions were highlighted by an audit and mapping of the CT process.

## OBJECTIVES

To improve the dispensing process using a collaborative method, involving all the protagonists to drive change.

## METHODS

- Study period: March to September 2020
- 4 problem-solving workshops: receiving of medical validations (1), the sending of injectable CT (2), scheduling of preparations (3) and CT reception (4)
- Each session lasted 35 min during routine
- Participants were pharmacists, pharmacy technicians (PT), managers and storekeepers
- The animator had to have a facilitator's posture and were at first accompanied by an experienced pharmacist
- Solutions implemented have been evaluated




## RESULTS

| Pb | Preparation sent w/o medical validation (1) | One injectable CT forgotten in the exit lock (2) | Important waiting time at each step of the process (3) | CT shipments lost after being arrived at site (4) |
|---|---|---|---|---|
| Causes | 3/5 causes prioritized<br>3/9 solutions implemented | 2/4 causes prioritized<br>4/5 solutions implemented | 3 /4 causes prioritized<br>5/7 solutions implemented | 3/6 causes prioritized<br>5/12 solutions implemented |
| Implemented solutions | 1. Creation of a scheduling system for manufacturing sheets<br>  <br>2. Creation of traceability stampers "medical validation", "CRA calling"<br>OK MEDECIN … H …<br>APPEL ARC … H …<br>3. Workplace reorganisation (5S method) : keep what's necessary | 1. Routing of IV bags by pharmacy technicians (PT) to the dispatch area at each break<br>2. To call the manager if the storekeeper is not available (in case of emergency)<br>3. To create a sending procedure for clinical trials (injectable, oral)<br>4. Shipments coordination by PT according the new procedure<br>• No more than 20 min after the end of preparations to call the storekeeper | 1. Training and recruitment of PT(to be done)<br>2. Workplace reorganisation to help making the process more fluid<br>3. Purchasing of a stamper with "priority" mention<br>4. Purchasing of trolley for picking and use of one container per preparation<br>5. To define medication order of administration when setting up new clinical trials | 1. Receiving area specific to clinical trials created and delimitated<br>2. Storage space reorganisation and worksheet created for a real-time follow-up of locations<br>3. Reception check-list created<br>4. Reception procedure created<br>5. Flash 10' meetings every morning about new clinical studies |
| Assessment | 1. No preparation sent w/o medical validation since implementation<br>2. Good use of traceability stampers (2 days) : 90/94 (95,7%) manufacturing sheets compliant with the system<br>3. Space saving, better working conditions in the coordinating room<br>➔ Safety improved | 1&2. No injectable bags forgotten during breaks (a 3-days audit)<br>3. Sending procedure created and validated with collaborators<br>4. Baseline production data measured as a new reference. An audit will be held to compare data.<br>➔ Main objective achieved | • "Priority" stamper purchased<br>• Trolley for picking purchased (not delivered yet)<br>• Medication order defined in advanced<br>• Anticipated medical validation received for the two main clinical services<br>➔ need to be assessed | 1. No shipment lost during receiving process since implementation<br>2. Qualitatively: Less time to find out locations of clinical trials (measure to be done)<br>3. Better traceability of the process (name, date, location, computer stock entry)<br>5. Positive feedback by pharmacy technicians and storekeepers |

## CONCLUSION

**This method made it possible to facilitate change** (i.e. change in the most reluctant speeches), promote team cohesion (assiduity of the participants), **launch a dynamic of continuous improvement** (the implemented solutions must be re-evaluated). A total of **7/10 pharmacy technicians have been trained** and **driving pharmacy technicians have been revealed** through the workshops. The staff members' experience, planning of the workshops and the change in managerial thinking were the main difficulties encountered.