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ANALYSIS OF WASTED UNIT DOSES IN A CHILDREN'S HOSPITAL TO IMPROVE RESOURCE UTILIZATION (C1). Tracy Betterley, Melanie Chan, Terri Lim. Lucile Packard Children's Hospital at Stanford, Palo Alto, CA. (tbetterley@lpch.org) IRB approval not needed

The unit dosing of medications is an especially important part of patient safety in pediatrics. The potential for medication errors in adults is 2-fold compared to 400-fold in pediatrics. Unit dose preparations for pediatric patients require extensive repackaging and compounding. The purpose of this study is to determine methods for improving medication use while decreasing pharmacy related costs at our institution. Unit doses prepared, but not used were collected for a seven day period. Approximately 87% of the discarded medications were scheduled medications; while 13% were for as needed use. From this data, medication safety, along with pharmacy time and labor were identified as factors for process improvement. Computerized provider order entry (CPOE) systems allow providers to easily initiate and renew medication orders. While CPOE can lead to improved patient care, the ease in the renewal process may potentially lead to continuation of medications that are no longer indicated. Process improvements identified with associated financial implications will be presented and discussed.