Cutting Risks, Not Tablets
Utilizing Choice Architecture to Minimize Split Tablets

THE UNIVERSITY OF CHICAGO UChicago Medicine | Center for Healthcare Delivery Science and Innovation

Authors: Jason Orr

AT THE FOREFRONT UChicago Medicine Department of Pharmacy

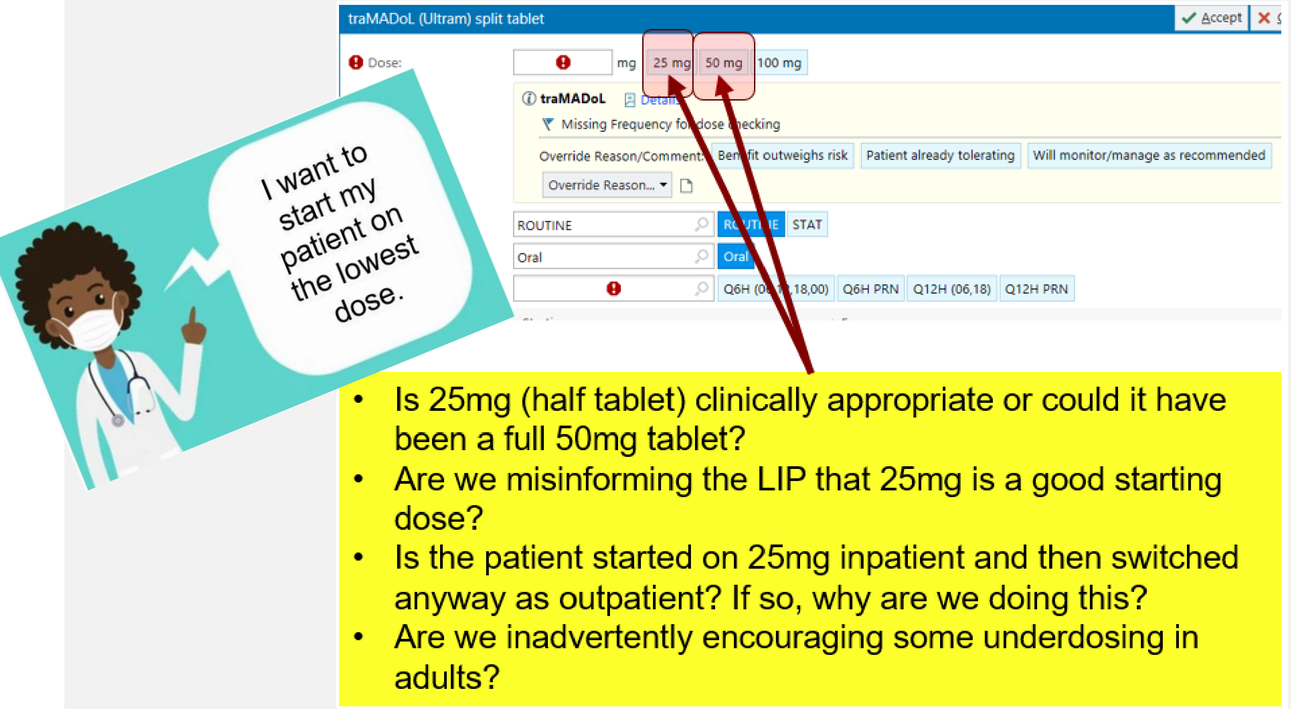
Problem

The CCD2 Pharmacy had noticed an increase in the incidence of cut tablets for adult inpatient patients that was leading to added technician and pharmacist labor. The Pharmacy Team questioned if this work was valuable and if the doses ordered were clinically appropriate. The Pharmacy team took a step back and reviewed why the incidence of split tablets had been increasing to a point that was becoming unmanageable and creating overtime.

Goals

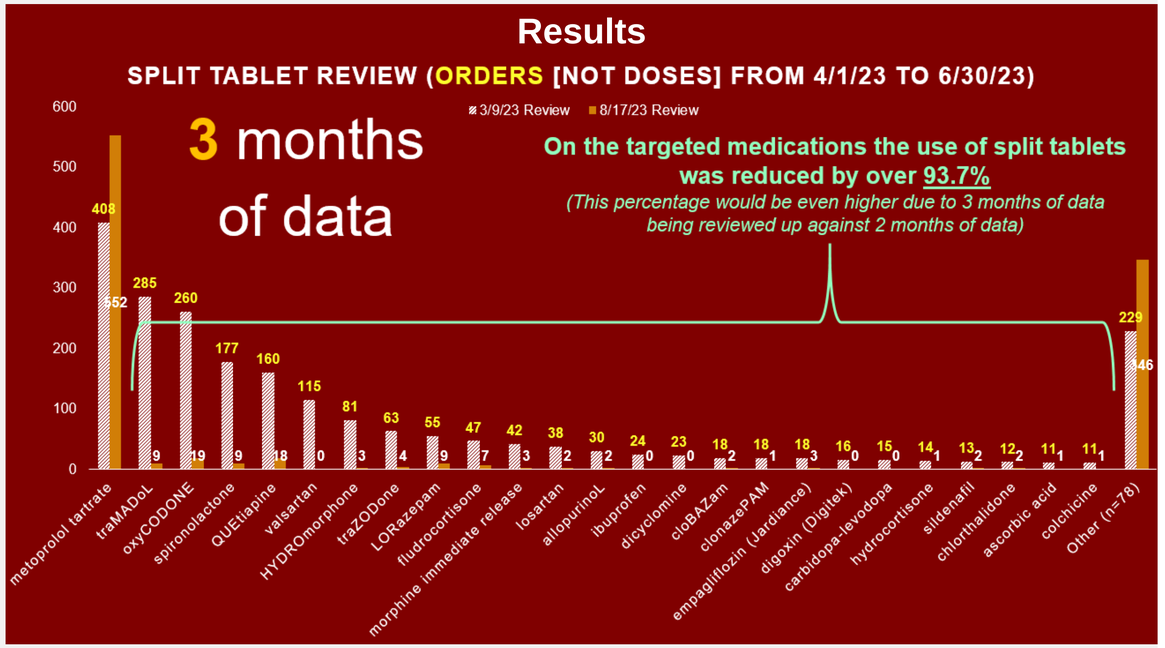
- Identify if all our split tablets were clinically necessary.
- Discover if there were opportunities to decrease unnecessary work.
- Streamline our operations to allow for less physical manipulation of medications and provide the dose to be pulled from the Automated Dispensing Cabinet (ADC).
- Identify if patients were inadvertently on split tablets simply because there was a dosing button for half a tablet.

Strategy



- Is 25mg (half tablet) clinically appropriate or could it have been a full 50mg tablet?
- Are we misinforming the LIP that 25mg is a good starting dose?
- Is the patient started on 25mg inpatient and then switched anyway as outpatient? If so, why are we doing this?
- Are we inadvertently encouraging some underdosing in adults?

Results



Targeted areas;

- Reviewing and with choice architecture limiting the dosing buttons for providers.
- Adding dosage forms to the drug formulary that are manufactured but we were cutting by hand.
- Removing some split tablets that have no clinical support.

Conclusions

- This frees up Pharmacy Technicians and Pharmacists to focus on other important operational work.
- This provides more full-dose tablets available in the ADC rather than coming from the Pharmacy hand-prepared.
- If this project were to expand in the future the Pharmacy Department could likely establish that this project resulted in; 1) Patient's being on a more appropriate clinical dose. 2) Reduction of discharge complications of split tablets. 3) Protected patients from split tablets that were acceptable in-house but not as outpatient.

Acknowledgements

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