Purpose/Background
In the ambulatory infusion setting, administration and monitoring of chemotherapeutic regimens requires a team approach to safety. The interdisciplinary healthcare team collaborates to ensure safe order entry, review, drug preparation and administration of chemotherapy and biotherapy within the set operating hours of an ambulatory setting. Extended delays for patients can translate to both patient and healthcare provider dissatisfaction. The purpose of this quality improvement (QI) project was to identify and safely eliminate waste in the hazardous drug preparation pharmacy of a large academic medical cancer center’s infusion department.

Methodology
A team was assembled and tasked with the review of baseline wait time data, completion of a current state process flowchart, identification of potential waste, identification of strengths, and generation of a new workflow with proposed process changes utilizing the Plan, Do, Check, Act (PDCA) framework.

Results
Following the intervention, the mean time taken between notification to begin the drug preparation and completion of the drug, (turnaround time) decreased by 46%. The changes to the workflow did not have a measureable impact on the patient experience as it relates to the perception that infusion appointments begin on time, but the workflow changes did increase efficiency without negative impact on the safety standards of the hazardous drug compounding or administration process.

Implications for Practice
Introduction of lean processes, specifically workflow analysis and process mapping can lead to systematic changes in a hazardous drug compounding pharmacy. Further study would be recommended to examine the financial impact of the intervention here, and in similar settings.