

# THE ROLE OF THE CLINICAL PHARMACIST AVOIDING MEDICATION ERRORS IN A CLINICAL RESEARCH ONCO-HEMATOLOGIC UNIT

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# BACKGROUND AND IMPORTANCE:

The complexity in the design and execution of clinical trials has created the need to coordinate a multidisciplinary team in which the pharmacist has a fundamental role to avoid <u>medication errors (ME)</u>.



### **AIM AND OBJECTIVES:**

To analyze the medication errors detected in the clinical trials area of the Clinical Research Onco-hematologic Pharmacy Unit, in order to identify the points of greatest risk and establish improvement measures

ME are especially important in clinical trials since any minimal deviation in the protocol can lead to the patient leaving the study.

# **MATERIALS AND METHODS:**

A prospective analysis of ME detected **during 6 months (January 2021-June 2021)** was conducted by pharmacists in the Clinical Research Onco-hematologic Pharmacy Unit in the course of their activity.

At the same time, the errors detected during the validation of the medical prescription and during the quality control of the intravenous preparations were analyzed.

#### A total of 250 errors

were recorded.

RESULTS

Most of the errors detected were originated in the **prescription process**.

(n = 135)



errors were detected regarding the preparation process

46%

(n= 115)

63.47% were due to errors in the conservation specifications: 57.39% storage temperature specifications and 6.08% related to photoprotection.

21.90% confusions that required repeat the preparation 20% referred to infusions systems.

In 8 (5.93%) cases, the error reached the patient.

Neither of these caused serious consequences.

### **CONCLUSION AND RELEVANCE:**



Most of the ME that occur in the Clinical Clinical Research Onco-hematologic Pharmacy Unit are intercepted before they reach the patient. Most of them were generated in the prescription process, mainly due to an error in the patient's weight.

The information obtained in this analysis, reinforces the role of clinical pharmacist avoiding errors and improve measures to increase patients' safety.





