

# THE ERROR ROOM: A FUN TRAINING TOOL FOR THE PHARMACEUTICAL CHEMOTHERAPY UNIT



M Jaffuel, J Mangavelle, S Vernardet, I Lefort  
Centre hospitalier d'Ardèche Nord, Pharmacy, Annonay, France

5PSQ-052 L01 – Cytostatics



## Background

A significant part of hospital activity is now dedicated at the handling of oncology and the chemotherapy production by the pharmacy is an essential stage. This activity is still currently human dependent and one error can therefore have serious consequences. Through a “**room of errors**”, a participating training in real work conditions can improve the ongoing staff training and the security of this cytotoxic production path.

## Purpose



To evaluate the **critical capacity** of the pharmacy technicians to track the **major deviances** for the preparation of injectable anticancer drugs.

## Materials and Methods



A list of errors was established by the pharmacist and the resident and then implemented in the controlled atmosphere zone. A level of criticality has been assigned to each error. Usual technicians and pharmacist could participate in this “**room of errors**”. The time left to find errors was 15 minutes by participants. An information sheet was to be filled anonymously. In the following days, an error analysis and debriefing were conducted to discuss the most critical errors.

## Results



The 6 usual technicians and one pharmacist participated in this "room of errors". **Fourteen errors** were distributed in the area. On average, 7.7 errors out of 14 total errors were discovered by the 7 participants. Four out of 7 participants reported fifty percent or fewer errors.

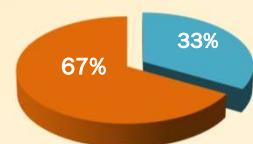


Nine errors out of 14 were classified as high criticality level for patient or environment. For these **9 high criticality errors**, 1 error was not found by any of the participants, 4 errors by less than 5 participants and 3 errors by all participants. Only 1/3 of this category of high-risk error was detected by all manipulators.



Errors	% of notification	Errors	% of notification
Alcohol outdated*	29 %	Adhesive label misplaced on the syringe	86 %
Disinfectant in the work space is not exactly the good one	0 %	Wrong fabrication form (switched patients)*	57 %
Transfer airlock wrongly loaded	43 %	Diluent's batch number written on the fabrication form is not for the right diluent*	100 %
Non-opened empty container in the transfer airlock*	14 %	Batch number of diluent missing on the fabrication form*	0 %
Cytotoxic agent stored in monoclonal antibodies area	86 %	"Heat-sensitive" specification non-written on the dispensation form*	57 %
Heat-sensitive monoclonal antibody at ambient temperature*	71 %	Non-sealed preparation packaging	29 %
Wrong dosage on the adhesive label*	100 %	Switched patients on delivery boxes*	100 %

\* 9 high criticality errors



■ Errors detected by all manipulators  
■ Errors detected by some manipulators

## Conclusion



It was the second time we had this experience. This room of errors is a **fun way to train staff** to minimize and prevent potential errors related to the production of chemotherapy. It's also an opportunity to provide reminders of good manufacturing practices. In view of the results, it would be interesting to continue training by this approach or other learning process like e-learning. This would maintain and bring new knowledge to pharmacy technicians to ensure the safety of the patient in his care process.



http://www.eahp.eu/2-4-PSQ-052