DEVELOPMENT AND IMPLEMENTATION OF GUIDELINES FOR THE SAFETY MANAGEMENT OF INTRATHECAL CHEMOTHERAPY IN PATIENTS WITH HEMATOLOGICAL MALIGNANCIES

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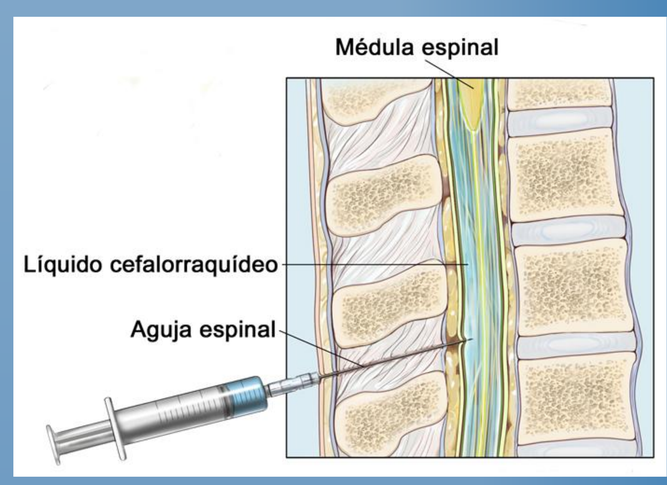
WHAT WAS DONE ?

It was developed and implemented the guidelines for the safety management of intrathecal chemotherapy in patients with hematological malignancies.



WHY WAS IT DONE ?

The guidelines were made after detection a near miss event related with the intrathecal (IT) administration of methotrexate. It was used a syringe to prepare the intrathecal drug, but it was filled with bortezomib instead of methotrexate. The method of preparation was analyzed and the medication error detected. Because of the potentially devasting consequences of accidental intrathecal administration of bortezomib a guidelines was done.

HOW WAS IT DONE ?

The guidelines were done by the pharmacists and were agreed with the hematologists. These established what drugs could be delivered by the intrathecal route (methotrexate, cytarabine and corticosteroids) and their usual doses. The guidelines issue recommendations about the prescribing, preparation, dispensing, storing and administration of intrathecal drugs. All IT preparations were visually inspect by the pharmacist before being delivered. Intrathecal drugs should be packaged separately and clearly labeled with "For Intrathecal Use" both on the syringe and outer container. The guidelines were shown to all staff involved in the management of intrathecal chemotherapy.

Therapy	Drugs/Doses	Nº of doses
Intrathecal	Methotrexate 12 mg	93
Triple intrathecal	Methotrexate 12 mg Cytarabine 30 mg Hydrocortisone 20 mg	39

WHAT HAS BEEN ACHIEVED ?

The guidelines were implemented in February 2013. One hundred and thirty two intrathecal syringes were prepared from February 2013 to September 2014: ninety three contained methotrexate as a single agent and thirty nine a combination of three drugs. No errors have been detected since guidelines were implemented.

WHAT NEXT ?

The guidelines will be sent to the Safety Patient Observatory, a local institution with the purpose of being transferred into other healthcare settings.

Observatorio para la Seguridad del Paciente

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