INTERCEPTED SERIOUS MEDICATION ERROR: INTRATHECAL USE OF VINCRISTINE

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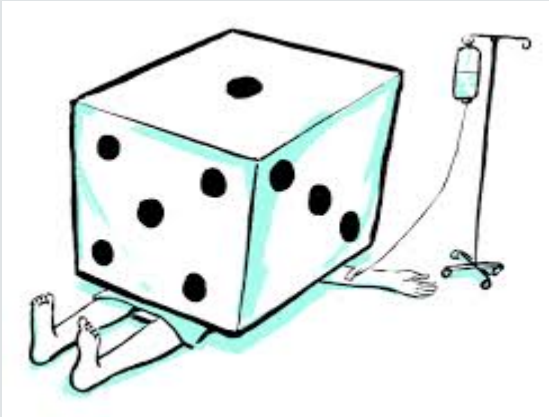
Medication error : Never Events

- **Never Events** is a serious incident or error that should not occur if proper safety procedures are followed.
- They include things like wrong site surgery or foreign objects left in a person's body after an operation.



Objective

The aim of this work is to present a case of fatal medication error occurred in the hematology department of Ibn Sina Rabat hospital.

THE CASE

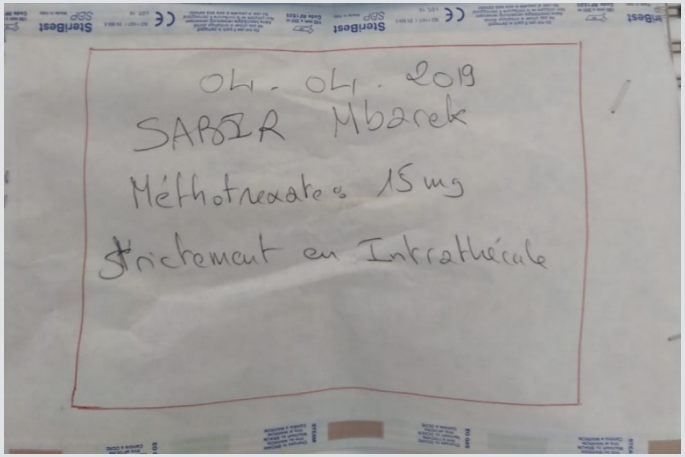
- This was a 38-year-old man
- Followed for a Diffuse Large B-Cell Lymphomas (DLBCL)
- By a RCHOP-IT protocol N 4 confirmed at 02h00 PM
- The patient had Five preparations :

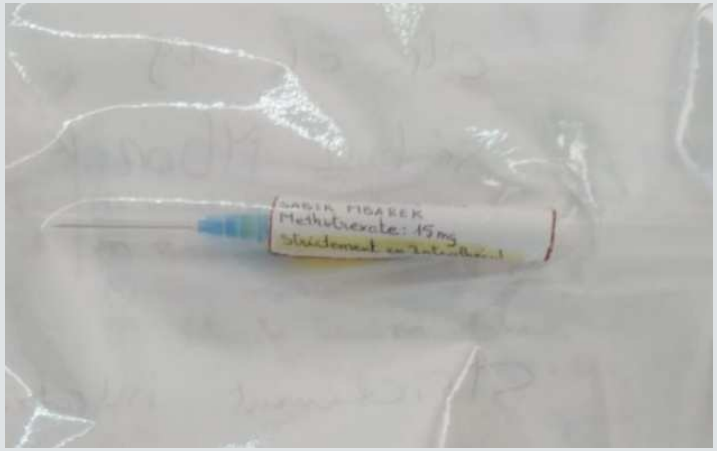
1. Pocket of Rituximab
2. Pocket of Cyclophosphamide
3. Pocket of Doxorubicine
4. Syringe of an intravenous Vincristine
5. Syringe of an intrathecal Methotrexate

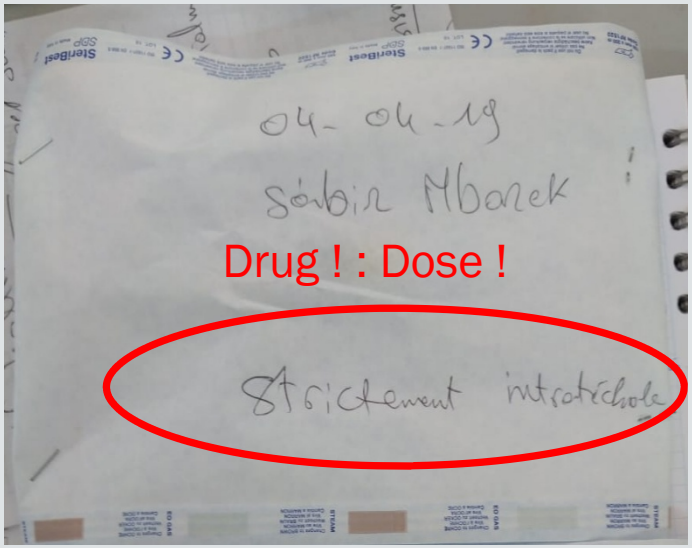
THE CASE

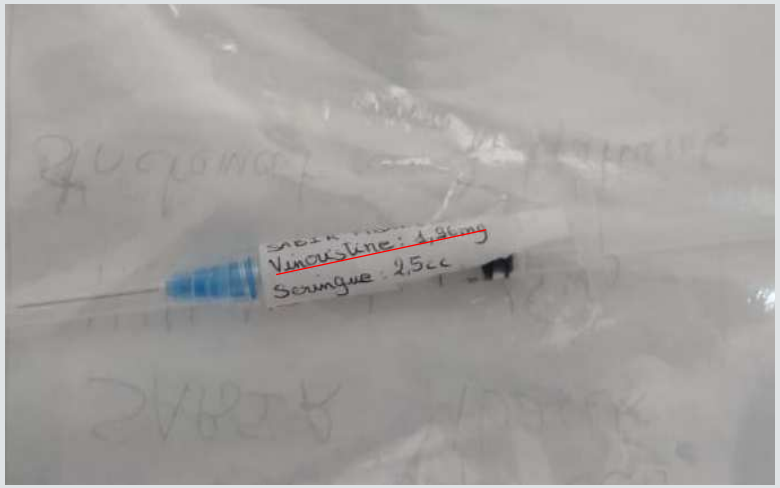
- It was a labeling error secondary packaging mistakenly wrote "strictly intrathecal".
- Thanks to the communication between doctor and pharmacist the hematologist understood that it was vincristine for an intravenous injection and not methylprednisolone for an intrathecal injection.
- The preparation is injected into the patient by intravenous

Medication error





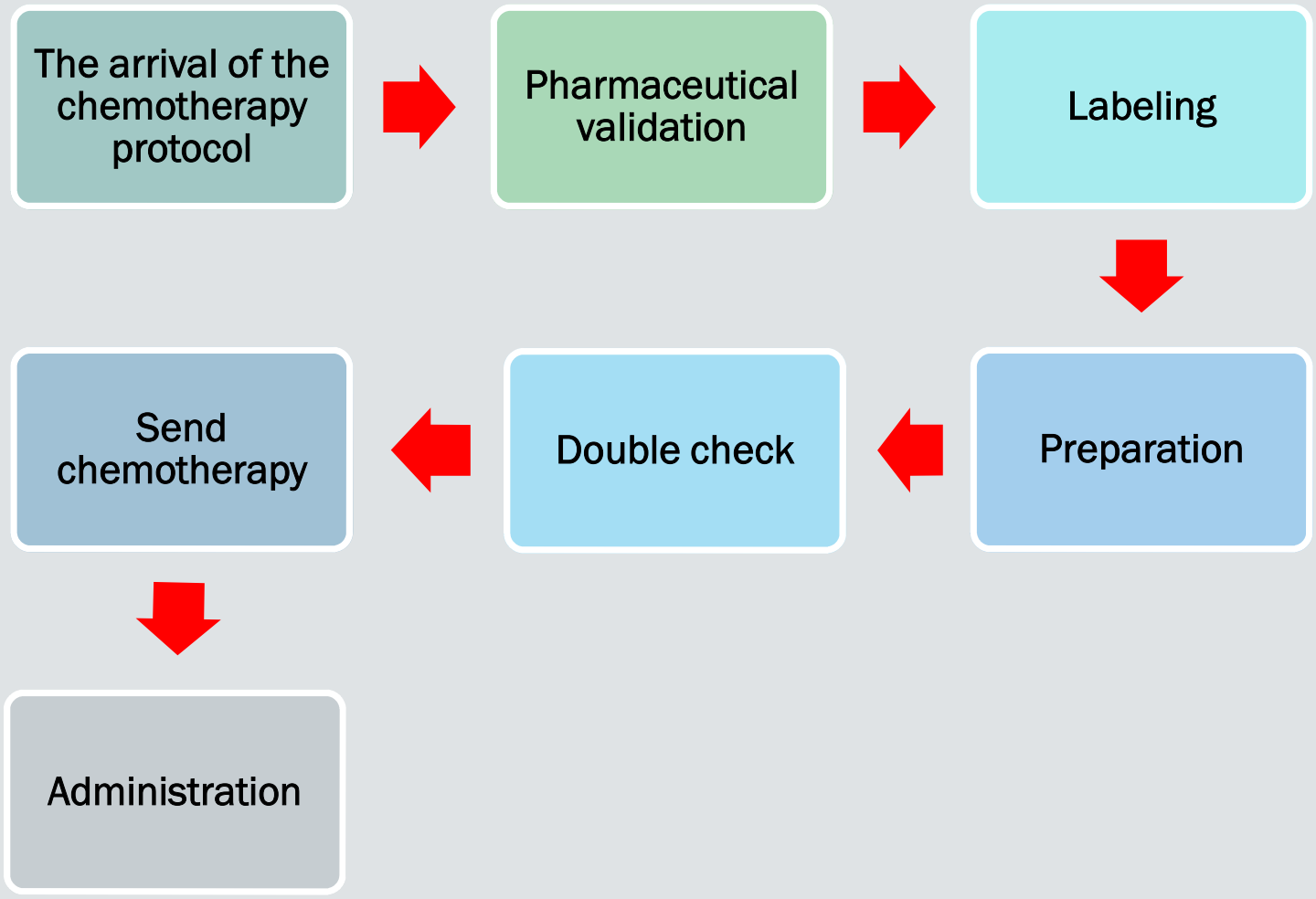




Risks of vincristine intrathecal injection

- Vincristine is a neurotoxic, antineoplastic drug of the vinca alkaloid group.
- Accidental administration of vincristine via the intrathecal route almost always results in central nervous system dysfunction and death.
- according to the WHO this error is classified as never-events

Procedure for the preparation of cytotoxic drugs



The causes of the occurrence of the medication error

- Writing labels manually
- Protocol confirmed at the end of the day and urgently
- Cumulative fatigue of the team of the cytotoxic preparation unit especially at the end of the week
- The lack of double control on the part of the cytotoxic unit only for this case

Corrective Actions

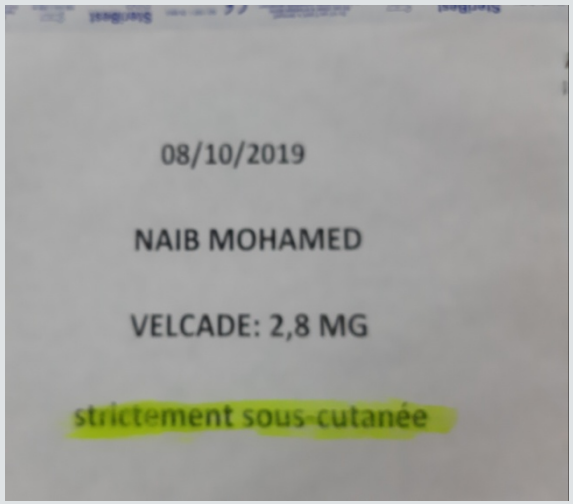
I. Action on labeling

- Color code
- Sensitization of the staff of the cytotoxic preparations unit
- Information of the clinical hematology service

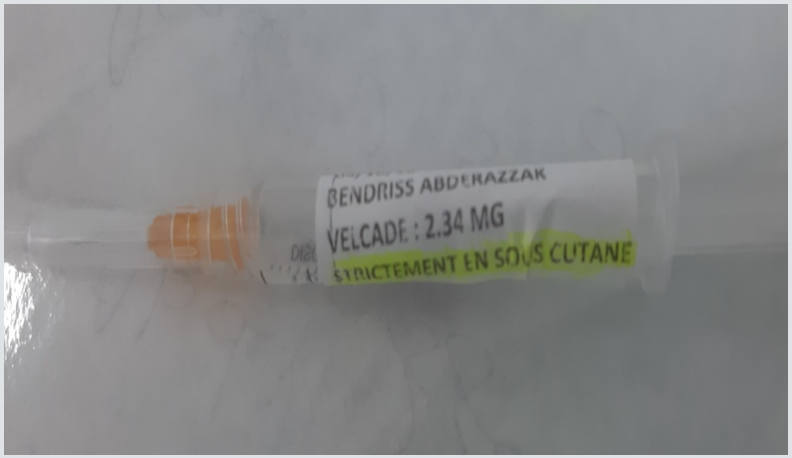
Corrective Actions

Subcutaneous syringe

Labeling of the secondary packaging of a subcutaneous syringe



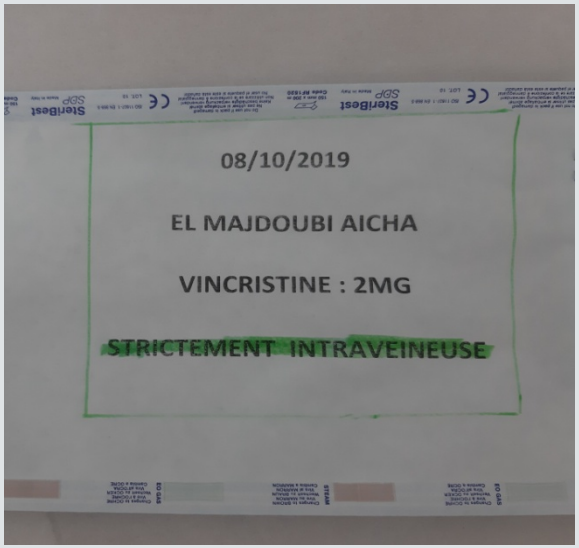
Labeling of the primary packaging of a subcutaneous syringe



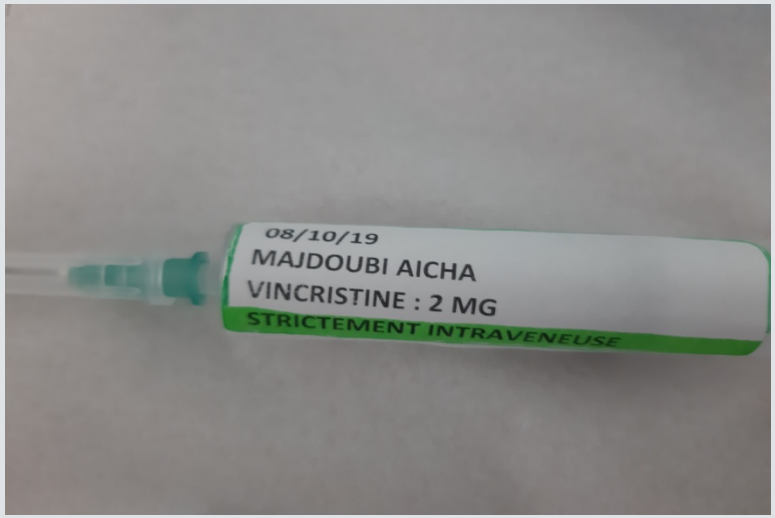
Corrective Actions

Intravenous Syringe

Labeling of the secondary packaging of an intravenous syringe



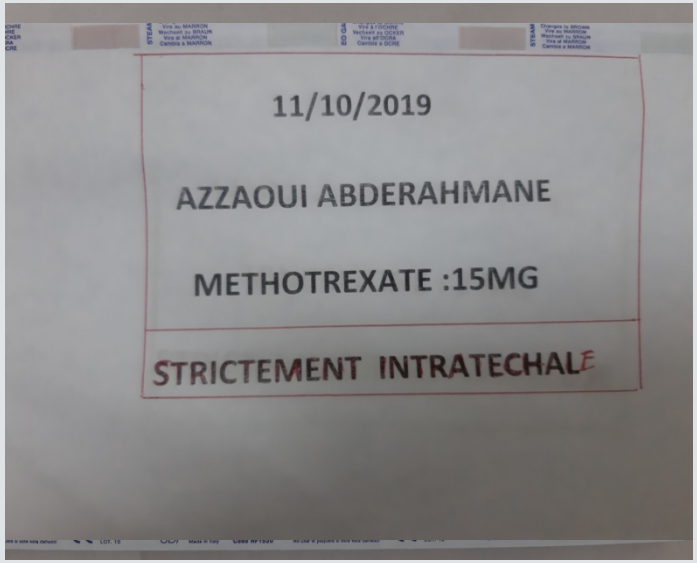
Labeling of the primary packaging of an intravenous syringe



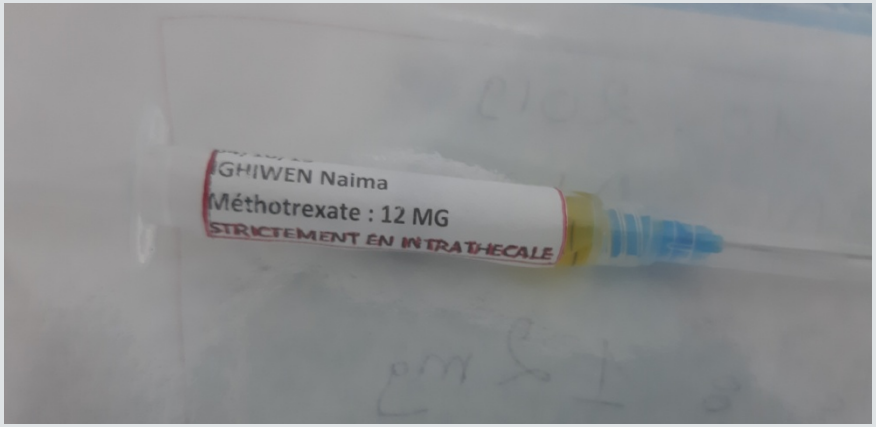
Corrective Actions

Intrathecal Syringe

Labeling of the secondary packaging of an intrathecal syringe



Labeling of the primary packaging of an intrathecal syringe



Corrective Actions

II. Change of the manual to informatics it's more visible

III. Change the size of intravenous syringe to 20ml

IV. Double check systhmaticly before the delivery of cytotoxic preparations

Conclusion

- The key roles of the hospital pharmacist are:

1- Improving patient safety by building a culture of communication and risk analysis among all health professionals.

2- Educating the health professionals about their role in monitoring adverse events and improving the safety of patients.

3- Implementing a positive impact that involves everyone to ensure adequate patient safety.


Thank You!