# ERRORS DETECTED IN THE TELEPHARMACY PROCEDURE

A.SÁNCHEZ RUIZ[1], C. MUÑOZ CID[1], N. GARCIA GOMEZ[1], J. JEREZ ROJAS[1].
[1]HOSPITAL UNIVERSITARIO DE JAÉN, FARMACIA, JAÉN, SPAIN.
andres.sanchez.ruiz2@gmail.com

## Background and importance

After the rise of telemedicine with the COVID-19 pandemic, a telepharmacy consultation has been implemented in our hospital in the pharmacy outpatient area, sending medicines to community pharmacies within a population area of 600,000 inhabitants.

## Aim and objectives

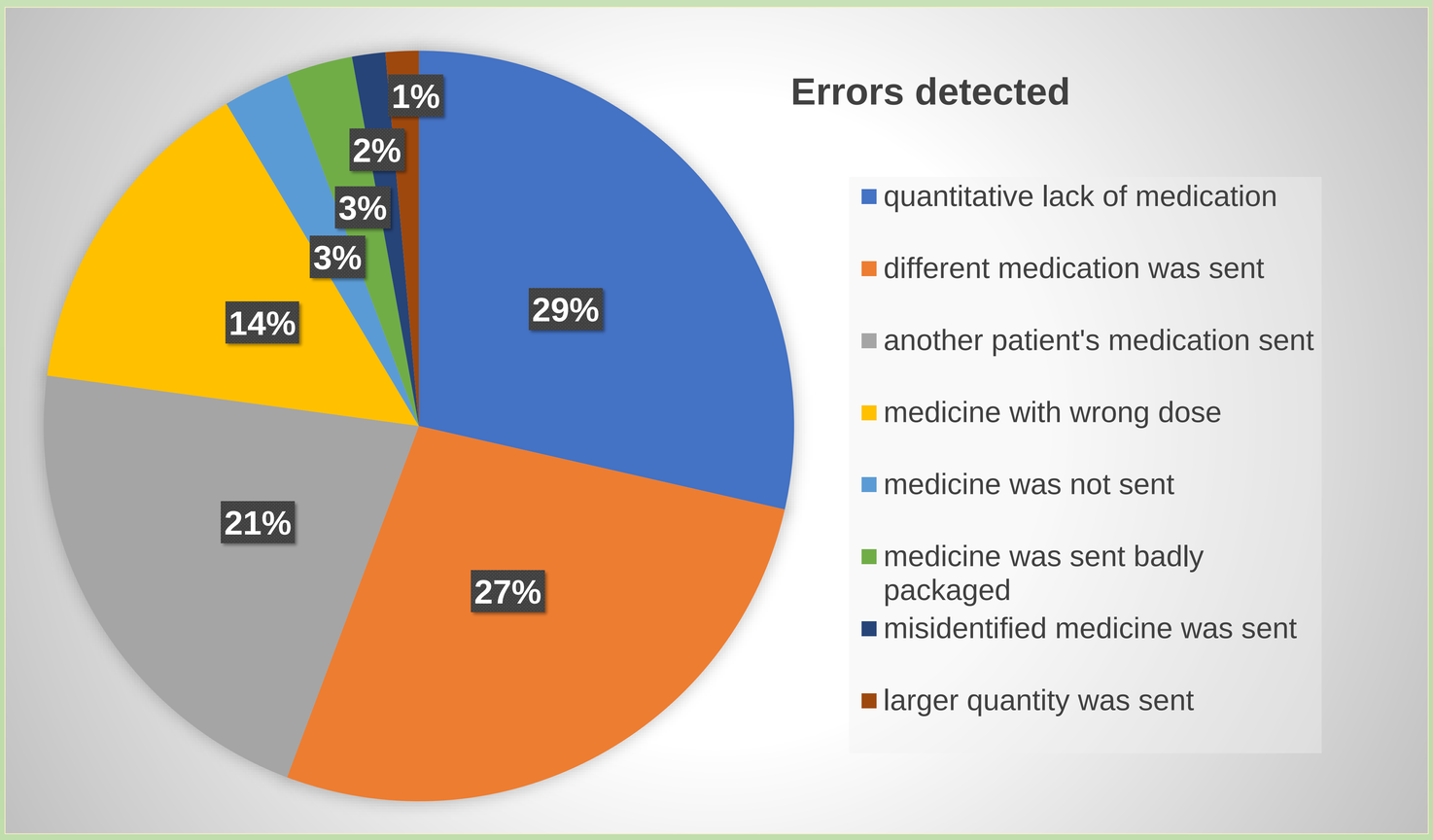
The purpose of this study is to analyze the medication errors (ME) that have occurred during a specific period of time, throughout the process of medication delivery. The aim is  finding causes and possible improvements.

## Material and methods

We carried out a retrospective descriptive study. The errors that occurred between January 2021 and August 2022 (20 months) in the telepharmacy process were analyzed, taking into account everything from the preparation in the hospital pharmacy to the collection of the medication by the patient in the community pharmacy. The MEs were collected in a local database. We described date, personal data of the patient, codes assigned to the single shipping route and destination community pharmacy, type of error and step in which the ME was detected.

## Results

In the period studied, a total of 69 MEs were recorded. We break them down into the following types: 20 cases with a quantitative lack of medication (28.99%), 19 cases in which a different medication was sent (27.54%), 15 with another patient's medication (21 .74%), 10 with medicine with wrong dose (14.49%), 2 cases in which the medicine was not sent (2.90%) and another 2 in which the medicine was sent badly packaged (2.90%), 1 case in which the one in which the misidentified medicine was sent (1.45%) and 1 case in which a larger quantity was sent(1.45%). 48 MEs were detected by the patient (69.56%), 15 were detected in the community pharmacy (21.74%), 4 were detected in the hospital pharmacy (5.80%) and 2 cases were detected during the transportation of the medication (2.90%). None of the errors detected had consequences for the patient to our knowledge.




## Conclusion and relevance

Among the MEs detected, the most common were those related to a quantity defect or lack of a medication and those in which a different medication was sent. In general, they are errors that could be avoided by automating processes that are currently carried out manually.