A medication error is an unintended failure in the drug treatment process that leads to, or has the potential to lead to, harm to the patient. Mistakes in the prescribing, dispensing, storing, preparation and administration of a medicine are the most common preventable cause of undesired adverse events in medication practice and present a major public health burden.

Introduction

The aim of the present study was to present the case of medication errors detected in the circuit of anticancer chemotherapy, type and risk minimization action.

Objectives

The aim of the present study was to present the case of medication errors detected in the circuit of anticancer chemotherapy, type and risk minimization action.

Materiel and methods

Type of study: prospective observational study.
Lieu: National Institute of Oncology, Rabat, Morocco.
Duration: 10 months.
Gathering information: We collected all medication errors from the prescription to the administration of anticancer drugs using a notification form provided by the national pharmacovigilance center (CAPM).
EM Analysis: team of CAPM.

Results

A-ME Detected

Graph 1: Types of Medication errors

ME class B: relate to potential errors.
ME Class C: refers to errors that occurred without consequence patients.
ME class D: for errors that occurred without damage to the patient but caused increased surveillance.

B-Analysis of ME

Degree of realization

Severity

Type B: 26
Type C: 2
Type D: 1

D-Measurement of medication risks

C-Role of pharmacist

Conclusion: This observation justifies the setting up of a procedure of an analysis of each error using a validated methodology. A preventive strategy combining security prescription, training, storage of drugs could reduce ME and to improve the management of patient drug load, the health professional must declare the ME.