Intravenous literature: Bateman, R. and Donyai, P. (2010) Errors associated with the preparation of aseptic products in UK hospital pharmacies: lessons from the national aseptic error reporting scheme. Quality and Safety in Health Care. 19, p.1-6.

Abstract:

Background – Pharmacy aseptic units prepare and supply injectables to minimise risks. The UK National Aseptic Error Reporting Scheme has been collecting data on pharmacy compounding errors, including near-misses, since 2003.

Objectives – The cumulative reports from January 2004 to December 2007, inclusive, were analysed.

Methods – The different variables of product types, error types, staff making and detecting errors, stage errors detected, perceived contributory factors, and potential or actual outcomes were presented by cross-tabulation of data.

Results – A total of 4691 reports were submitted against an estimated 958 532 items made, returning 0.49% as the overall error rate. Most of the errors were detected before reaching patients, with only 24 detected during or after administration. The highest number of reports related to adult cytotoxic preparations (40%) and the most frequently recorded error was a labelling error (34.2%). Errors were mostly detected at first check in assembly area (46.6%). Individual staff error contributed most (78.1%) to overall errors, while errors with paediatric

parenteral nutrition appeared to be blamed on low staff levels more than other products were. The majority of errors (68.6%) had no potential patient outcomes attached, while it appeared that paediatric cytotoxic products and paediatric parenteral nutrition were associated with greater levels of perceived patient harm.

Conclusions – The majority of reports were related to near-misses, and this study highlights scope for examining current arrangements for checking and releasing products, certainly for paediatric cytotoxic and paediatric parenteral nutrition preparations within aseptic units, but in the context of resource and capacity constraints.