contribute to the optimization of pharmacotherapy and to prioritising safety in an Intensive Care Unit (ICU).

**Purpose** To identify and quantify medicines errors observed and interventions made in the ICU in question, drawing a profile of the main actions of the pharmacist in critical care specialising in women’s health.

**Materials and Methods** The study was conducted in a Brazilian ICU of a university hospital specialising in women’s health, from February to May 2012. Interventions were performed after analysis of patient prescriptions (18 years old or over, hospitalised for more than 24 hours in the ICU) and discussions of clinical cases during multidisciplinary meetings. Interventions were classed on whether or not they were accepted by the medical staff. Drug-related errors observed were classed as preventable or not and ranked by an adaptation of the classification of the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP).

**Results** The study involved 82 patients, and 386 prescriptions were evaluated. The mean age was 41.1 ± 19.0 years old and the average hospital stay was 4.7 ± 3.3 days. We identified 45 medicines errors (mean 0.6 ± 3.5/patient), 86.7% of these were preventable and 15.3% were not. The most common error types were: unsafe medicine due to drug interaction (26.7%), higher dose than recommended (15.6%) and unsafe medicine during lactation (15.3%). Fifty-one interventions were made (mean 0.6 ± 4.2/patient), and 94.3% of these were accepted; 3.9% partially accepted; and 11.8% were not accepted. The most common interventions were to recommend an alternative dose (25%), identify drug interactions (23.3%), and risk during lactation (11.8%).

**Conclusions** Partial results obtained show the necessity for clinical pharmacy services in the ICU as an important contribution to reducing risks from drug treatment.

No conflict of interest.

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**PHARMACY INTRAVENOUS IRON PROTOCOL IN A CENTRAL HOSPITAL**

- **Background** Iron deficiency anaemia (IDA) is a common condition. The pharmacy intravenous iron protocol (100 mg/5 ml iron sucrose vials) includes assessment of patient analytical data, dose calculation, schedule and information about iron administration intended to prevent adverse reactions.

- **Purpose** To assess the use of intravenous iron in hospitalised patients being treated by the pharmacy protocol.

- **Materials and Methods** An eight-month retrospective, observational study (January to August 2012). Hospitalized patients treated with pharmacist-managed intravenous iron were selected. Demography, main diagnosis, comorbidities, basic data, dosage suggestions and haemoglobin and haematocrit values were collected from electronic clinical files and pharmacotherapeutic profiles.

- **Results** A total of 35 patients (19 male) were included. Mean age was 75.9 years (range 43–94). 9 (25.7%) patients were admitted for surgery and 26 (74.3%) for a variety of medical conditions. 20 patients (57.1%) were treated without complete investigation of the anaemia.

The most frequent intravenous iron dosage was 200 mg 3x week. 27 (77.1%) patients had increased haemoglobin and haematocrit values after an average of 10.3 days (range 3–20) of intravenous iron replacement treatment. The mean increase in haemoglobin concentration was 2.5 g/dl (range 0.2–6.6). Only 9 patients (25.7%) achieved the haemoglobin target during admission. The majority of patients were discharge before achieving the target haemoglobin.

No adverse reactions were reported to the pharmacist.

**Conclusions** As stated in the literature, a large proportion of patients in our study were not confirmed to be iron deficient. Pharmacist should advise physicians about the importance of a complete IDA study before starting this therapy. The information about iron administration and a test dose in the pharmacy protocol seem to be useful in preventing adverse reactions.

No conflict of interest.