Results The main pain reported by the staff was lumbar pain (70%). Several factors explain that result:

- Repeatedly carrying heavy weights (>7 Kg), especially when loading the Instrument Washer-Disinfector trolleys and sterilisers.
- Making little use of helping fork-lift trucks (60% of the staff use them <2 hrs/day).
- Not asking colleagues for help when carrying heavy weights.
- 80% of people work in front of a computer screen for 1/3 or ½ the day without adopting an ergonomic position.
- Highly repetitive actions during packaging.

Preventive measures:

- Staff training on ergonomics suited to any post.
- Organization of packaging posts and data capture according to the “comfort zone” concept.
- Reduction of distances to be covered when carrying or moving heavy weights.

Conclusions This study demonstrates that MSDs often appeared in sterilisation. The implementation of suitable preventive measures – according to posts – should increase efficiency and reduce the physical demands made on members of staff.

No conflict of interest.

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**ANALYSIS OF ANTINEOPLASTIC MEDICATION ERRORS IN A 500-BED TEACHING HOSPITAL**

**Purpose** To assess antineoplastic medication errors in terms of frequency, type of error and severity for patients.

**Materials and Methods** A 1-year prospective study was conducted (2011) in order to identify the medication errors that occurred during cancer chemotherapy for patients in a 500-bed teaching hospital. Wards included both day care and inpatient units. All prescriptions and production forms were verified by pharmacists. The different types of error were defined in a data collection system. For each medication error intercepted, the potential severity was evaluated according to the Ruiz-Jarabo 2000 version2 classification system.

**Results** During the study period, the pharmacy unit prepared 17241 distinct anticancer drugs. In total, 136 medications errors were detected throughout the medicines use process. Prescriptions errors represented 62% of errors, followed by pharmaceutical validation (7%), transcription (7%), preparation (2%) and administration errors (2%).

- The most common causal drug was carboplatin, which was involved in 25 cases, despite corresponding to only 2.8% of antineoplastic drugs prescribed at our institution. Overall, in 66 cases erroneous doses of the medicine were recorded (48.5%), 24 errors were linked to the choice of antineoplastic regimen (17.6%) while in 12 cases, erroneous duration of treatment was prescribed (8.8%).
- Of the 136 medication errors, 124 were intercepted prior to administration while 12 reached the patients (9%). Overall 66% of non-intercepted medication errors had no impact on the patient and only 3 cases required enhanced monitoring.

**Conclusions** In our study pharmaceutical validation mainly allowed us to identify prescription errors (82%), almost all errors were intercepted prior to administration to the patient. Wrong dose represented the most common type of error. Few pharmaceutical errors (transcription, validation, preparation) were detected.

No conflict of interest.