# Clinical oncology reflection example: significant event

**Title and description of activity or event**

Date: March 2015

Chemotherapy drug administration error. Patient received pemetrexed despite having an EDTA of 39 ml/min (should be above 45ml/min). Patient came to treatment clinic when I was on annual leave, having provisionally being booked for combination chemotherapy with pemetrexed dependant on EDTA. Registrar appropriately documented EDTA but prescribed pemetrexed, due to lack of knowledge of drug contraindications. Pharmacy checking did not identify error and drug was issued. Drug was subsequently administered by the chemotherapy CNS.

What category of activity does this match?

Significant event

**What have you learned as a result of the activity?**

For me, this has acted as a reminder that certain drugs are only prescribed for one tumour type and that current trainees often do not have experience of specific tumour sites early in their careers. It also reinforced that, although electronic systems increase patient safety, they are not infallible and background knowledge is still essential for safe prescribing.

**What has been the short and long term impact on your professional practice and patient care?**

* I now deliver a tutorial to registrars new to my practice on where specific drug information resides on the electronic prescribing system. This will hopefully improve patient care in the longer term.
* The emphasis of my pre-leave briefings has also changed, improving the quality and utility of the information imparted. Again I would hope this will mitigate against similar future errors.
* The registrar and I have discussed the issue as a learning point in systems failure. They have also reflected on the incident in their e-portfolio and been able to demonstrate learning on certain curriculum domains.
* I have discussed the incident with the lead pharmacist who will highlight this issue at the next pharmacy governance meeting.

**State any action points to be carried out following this activity**

* Lead pharmacist is considering an ongoing agenda item in governance meeting of “facts you need to remember in less common drugs”.
* A new pharmacist is due to start in the next month who will be based in the clinic which will hopefully reduce the risk of such an error being repeated. The trends of chemotherapy drug errors will be reviewed once this service has been established for a number of months to assess if trends have changed