Safety Alert

Great Catch Winners Q4 - 2020

"Sharing Lessons Learned"

Pharmaceutical Care Services

Mr. Moath Albishri

Prevented Drug-Drug Interaction

Rifampicin, Tivicay and Clarithromycin were ordered, *Rifampicin* has drug-drug interactions with both medications. Therefore, while cross-checking, the Pharmacist reached the treating Physician to modify the treatment using Lexicomp as a reference.

Take home message:

Be vigilant with your own internal validation, verify uncertainty by using available resources and cross-check for 200% accountability.

Ms. Hala Aljassem

Prevented Medication Overdose

The Physician prescribed a medication (*Filgastrim*) that was ten (*10*) times more than the required dose for a pediatric patient. While validating the order, the Pharmacists found the error and immediately called the prescribing Physician, who acknowledged the error and corrected the dose.

Take home message:

Be attentive to your own internal validation and "Stop the Line" when you need clarification.

Ms. Sahar Khawjah

Prevented a Sound-Alike Medication Error

The Physician ordered *Folinic Acid,* instead of *Folic acid*. The Pharmacist cross-checked with the Physician to order the correct medication.

Take home message:

Remember to validate, verify and cross-check for 200% accountability.

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Pharmaceutical Care Services


Mr. Muhammad Rafi

Prevented Cytotoxic Medication Overdose

A cytotoxic medication (*Cyclophosphamide*) dose was calculated for a pediatric patient that was ten (*10*) times more than the required dose for the patient. The Pharmacist discovered the error and communicated with the Team to confirm and recalculate the dose.

Take home message:

Be vigilant with your own internal validation, and cross-check for 200% accountability.


Mr. Amr Mahmoud

Prevented Medication Adverse Effect

A medication was prescribed to an infant with an indication statement " To induce tachycardia". After checking multiple references, the Pharmacist did not find the indication and dose prescribed. The Pharmacist contacted the Prescribing Physician and the Consultant to recommend not to proceed with the order, and further elaborated that the patient is at-risk for Aminophylline's Neurotoxicity, given his history of seizures. Eventually, they all agreed not to give the medication.

Take home message:

Remember to speak-up for safety using A.R.C.C. and cross-check for a 200% accountability.


Mr. Mohamed Salem

Prevented Drug-Drug Interaction

The Infectious Disease Team prescribed antibiotics for a patient who was on other medications for active seizures. According to Lexicomp, there is category D interaction that decreases the medication effectiveness. The Pharmacist called the Neurology and the Infectious Disease Teams to clarify the issue and discuss an appropriate plan. The recommendation was to change the antibiotic.

Take home message:

Be vigilant with your own internal validation and verify uncertainty by using available resources.

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Nursing Affairs

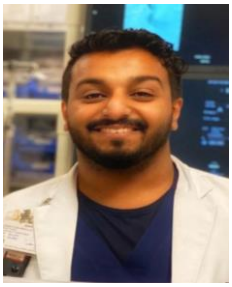
Ms. Shernalyn Balmaceda

Prevented Medication Overdose

High Alert Medication (*Enoxaparin 30 mg*) was prescribed and delivered to be administered to the patient; however, the Nurse noticed the medication received was a pre-filled syringe with an extra dose (*40 mg*). The Nurse immediately contacted the Pharmacy, and the correct dose was prepared and delivered.

Take home message:

Be attentive to details, stop auto-pilot brain mode by self-checking using the STAR method (Stop, Think, Act, Review), and ask clarifying questions.



Mr. Abdullah Alkhattabi

Prevented Un-necessary Radiation Exposure

Patient was referred for a CT contrast. Upon assessment, the Nurse confirmed that the patient was pregnant. However, the referring Physician was aware of her condition and ordered to proceed with the needed CT. The Nurse raised the issue to the Radiologist, and they discussed the case with the Physician to finally agree on canceling the procedure.

Take home message:

Be vigilant with your own internal validation, and verify any uncertainty by Stopping the Line" for clarity and speak-up for safety using A.R.C.C.

Ms. Maria Jocelyn Rayel

Prevented Medication Wrong Dose

Discharge medication (*Dexamethasone*) was ordered and dispensed with different instructions. The primary Nurse cross-checked the medication before handing it to the patient and noticed a wrong dose, so she clarified with the Discharge Pharmacist, then sent it back to correct it.

Take home message:

Be aware of your own internal validation, verify uncertainty by asking clarifying questions and cross-check for a 200% accountability.

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Nursing Affairs

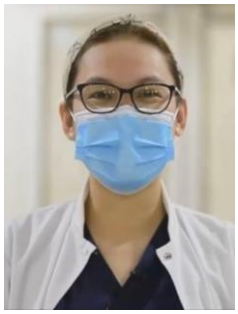
Mr. William II Santos

Prevented Medication Overdose

A medication was ordered and verified (*Ampicillin 2000 grams*). When the primary Nurse cross-checked the dose, he realized that its over the recommended dosage (*2 grams every 4 hours).* Hence, the Nurse checked the reference manual and notified the Pharmacy and then returned the medication.

Take home message:

Question uncertainty and "Stop the Line" when you need clarity and use resources to validate and verify.



Ms. Jay Anne Bonayon

Prevented Electrolyte Imbalance

The patient had IV fluids with electrolyte additives. The Pharmacy verified this order, but the primary Nurse did not find any indication for the order, so she checked the most recent serum electrolytes, which was within the normal range. The order was clarified with the senior Physician, and it was corrected and modified.

Take home message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity.

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Radiology Department

Mr. Johny Alejandro

Prevented Un-necessary Nuclear Medicine Exposure
Patient had a Bone Scan booked as an outpatient. The Technologist checked the indication, which was a clinical indication for a Bone Mineral Density (BMD). Therefore, the Technician called the referring Physician for clarification, then the order was modified.

Take home message:
Be vigilant with your own internal validation, and cross-check for 200% accountability.