Safety Alert
Great Catch Winners Q3 - 2021
"Sharing Lessons Learned"

Pharmaceutical Care Services

Mr. Amr Mahmoud

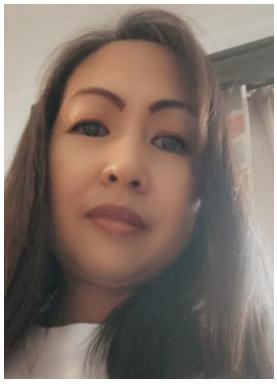
Prevented a Medication Error

The pharmacist received an order of Intravenous fluids with additives Potassium Chloride and Sodium Phosphate.

Before preparing the fluids, the pharmacist checked the patient's recent blood work and found the patient was hyperkalemic (Potassium is 5.5 mmol/L). The pharmacist called the primary nurse and the primary physician to cross-check and discontinue the order.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity, and cross-check for 200% accountability.



Ms. Melinda Litao

Prevented a High Alert Medication Dose

A cardiac patient was loaded with 250 mcg of digoxin and prescribed 1.2 mg daily as a maintenance dose. So, the pharmacist asked about the maximum dose that is safe for the patient to be prescribed, and checked the references in Lexicom to find that the full dose of 0.9 mg per day is only allowed to complete the loading amount for 24 hours. And the prescribed 1.2 mg will produce 12 ml. The pharmacist escalated the concern suspecting the unit used in the prescription was incorrect. After verifying, the clinical pharmacist adjusted the order to 0.125 mcg. The patient was saved from ten times higher dose of the cardiac medication.

Take Home Message:

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Pharmaceutical Care Services

Mr. Mohamed Ali

Prevented a High-Alert Medication Error

A patient with cardiac and vascular disease was on an oral anticoagulant (apixaban 5 mg Q 12 hr), admitted to the hospital needing further treatment for his condition.

The physician prescribed an anticoagulant injection (enoxaparin 80 mg sc Q12 hr). While verifying the order, the pharmacist called the physician to clarify and avoid combining both anticoagulants and both had agreed to suspend the apixaban.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity, and cross-check for 200% accountability.

Ms. Raghad Althubaiti

Prevented a High-Alert Medication Dose

A patient with comorbidities was ready to be discharged from the hospital. with a prescription of anticoagulant injections (Clexane) alongside his warfarin to adjust the INR level.

While reviewing the patient's file, the pharmacist preparing the discharge medications noticed that the patient is undergoing hemodialysis. therefore, the pharmacist confirmed with the physician since clexane is contraindicated in such cases.

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Nursing Affairs

Ms. Ola Sejeni

Prevented a Medication Error

A 7-year-old patient with an epileptic disorder requires a ketogenic diet to help control the seizures.

While preparing his medications, the primary Nurse noticed that glycopyrrolate was prepared with syrup containing sugar. The Nurse returned the medication to the pharmacy and asked to prepare another dose in a formulation safe with a ketogenic diet.

Take Home Message:

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

Mr. William II Santos

Prevented a Patient Identification Error

Dexamedetomidine, a sedative, was prescribed for an ICU patient at the Emergency Department and verified by a pharmacist.

The continuous infusion was ordered with the dose of 1000 mcg in 250 ml NS to start at 0.1 - 0.3 mcg per min. The Nurse checked the reference manual before running this dose and found it should be mcg/kg/hr instead. he crossed-checked this information with an experienced colleague from the ICU and confirmed the correct dose titration. The Nurse then discussed his concern with the ICU resident and the pharmacist to modify the order with the correct titration dose.

Take Home Message:

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Nursing Affairs

Ms. Jermaine Antivola

Prevented a Medication Error

A 66-year-old male patient with co-morbidities and a heart valve disease was planned for an echo study to evaluate and prepare him for heart surgery. The echo order in the system does not entirely give instructions for Dobutamine preparation for Echo studies, only a STAT dose of Dobutamine 250mg. The Nurse received the patient with a modified dose (800mg in 250ml D5W), the standard dose of Dobutamine. So, she contacted the pharmacy to explain and confirm the correct dose and protocol for the Stress Echo study while cross-checking with the cardiologist as they needed precisely (250mg in 250 ml NS). The pharmacist changed the dose to the correct protocol and identified an area of improvement in the system to recommend adding the protocol with the specific indication and concentration to prevent confusion and eliminate any errors or delays.

Take Home Message:

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

MS. Mariam Hamdi

Prevented a Medication Error

A patient was receiving a course of anti-inflammatory medication (Dexamethasone) and the treating team informed him after completing the course that he would not receive it with the discharge Medications.
The primary nurse gave the discharge instructions to the patient and the prescribed medications when she found Dexamethasone included. She called the prescribing physician to revise the plan, and the physician realized that the course of treatment was completed and discontinued the order.

Take Home Message:

Be attentive to details, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review), and cross-check for 200% accountability.

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Nursing Affairs

Ms. Rania Muhareq

Prevented an Allergic Reaction

A 49-year-old patient with Hodgkin's Lymphoma allergic to Egg, Banana, and Fish was on a Nasogastric Tube feeding. He has been prescribed a feeding formula (Nutrision Protein Plus).

Before giving the patient his formula, the primary nurse read the ingredients when she found out it contained Fish Oil. The nurse informed the physician to hold the feeding to prevent the patient from having an allergic reaction and provide a safer alternative.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by Stopping the Line" for clarity, maintaining 200% accountability.

Ms. Sara Yonbawi

Prevented a Wrong Patient Identification

When a patient was getting discharged home, and the nurse was assisting the patient with receiving the discharge medications, she found a medication refill card that belonged to a different patient.

She contacted the pharmacy to ensure patients would not confuse the refill medications process.

Take Home Message:

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Radiology Department

Ms. Rawan Bajunaid

Prevented a Wrong Radiological Study

A 54-year-old patient was scheduled for an ultrasound to assess her chronic peripheral vascular condition. However, the order in the system was an ultrasound for the groin. When the ultrasound technician checked the order and validated the reason for the exam with the patient's clinical history, she realized the correct exam should be an ultrasound doppler for the lower extremities. The technician contacted the primary physician of the patient to verify and perform the proper examination.

Take Home Message:

Be attentive to details, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review).

Mr. Eduardo Maniego

Prevented a Unnecessary Radiation Exposure

A chest x-ray was ordered for a 52-year-old female patient preparing for her upcoming surgery. The radiology technologist checked the patient's history and found she had an x-ray done in less than a week. The technologist immediately contacted the ordering physician but could not reach the resident, so he called the specialist to verify the duplication of the order. Thus, the patient was spared from unnecessary radiation exposure.

Take Home Message:

Be vigilant with your own internal validation, and Stop The Line for Clarity.

Mr. Fahad Alamri

Prevented a Wrong Radiological Study

The orthopedic referred a patient to the radiology to get an x-ray of his possibly fractured ankle. The technologist assessed the patient to get the history when he realized the patient complained of right ankle pain while the order in the system is the left ankle. The technologist called the referring physician to get the correct order and avoid getting the wrong images.

Take Home Message:

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Laboratory and Pathology Medicine

Mr. Naif Almalki

Prevented a Patient Identification Error

The laboratory technologist received a specimen indicating pleural fluid. Before running the sample, the technologist reviewed the clinical information and the procedure done to the patient.

He realized the patient had done a paracentesis, and the specimen should indicate ascetic fluid.

Then, the technologist contacted the ordering physician to confirm the correct procedure and tracked the sample to the performing radiologist to get the correct order and label.

Take Home Message:

Be attentive to details, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review).

Respiratory Care Services

Mr. Samer Al Thaqafi

Prevented a Medication Error

Acetylcysteine is a mucolytic (medicine that dissolves mucus), usually given by inhalation or nebulization for certain lung conditions when increased mucus makes breathing difficult. This medication needs specific instructions that are missing from the discharge instructions. Mr. Samer, a Respiratory Care Therapist, has noticed this missing information and recommends adding storage and administration information (adding Normal Saine). and the possible adverse effect of bronchospasm, which can be prevented by administering a bronchodilator before using acetylcysteine.

Take Home Message:

Be vigilant with your own internal validation, and attentive to details by self-checking using the STAR method (Stop, Think, Act, Review).