Safety Alert
Great Catch Winners Q4 - 2021
"Sharing Lessons Learned"

Pharmaceutical Care Services

Mr. Amr Mahmoud

Prevented a Medication Error

Patient with multiple Co-morbidities, was admitted to the ICU for Septic shock and Electrolyte Imbalance. The patient had a critically high Potassium level (k=6) and needed urgent correction. However, the Physician ordered the corrective medication for another ICU patient. The Pharmacist checked the patient's medical record and realized that Sodium Polystyrene and Insulin D50 water might cause Hypokalemia in a stable patient and missed a dose of urgent correction for the patient with Hyperkalemia.

The Pharmacist contacted the ordering Physician to clarify, and thus, both patients were saved from a high-alert medication and severe Electrolyte Imbalance.

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. Arwa Afana

Prevented a High-Alert Medication Dose

Magnesium Sulfate was ordered for a 39-year old patient with 2 grams in 500 Normal Saline, continuously infused at a rate of 200 ml/hr. The Pharmacist verifying the order calculated the dose and found that the total would be 19.2 grams in only 24 Hrs., which is an extremely high dose.

The Pharmacist then called the primary Physician and asked about the intended dose to correct the patient's Electrolytes. Both agreed it should be one bolus of 2 grams and not a continuous infusion.

Take Home Message:

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

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Pharmaceutical Care Services

Mr. Ahmed Bashmail

Prevented a High-Alert Medication Error

A young patient with a history of a Mechanical Valve on Anticoagulation Therapy was prescribed Enoxaparin and Warfarin for bridging. While checking the prescription, the Pharmacist noticed the frequency of Enoxaparin was daily rather than twice per day. He thought the dose was Renal adjusted so the Pharmacist checked the patient's Kidney functions and asked the patient to validate that the patient did not have any Renal issues. So the prescribing Physician was contacted to adjust the dose again to the appropriate therapy regimen.

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. Aljohara Alzaydi

Prevented a Medication Dose

A 70-year old female patient with 18 years history of Rheumatoid Arthritis is on Methotrexate once weekly. While on her regular follow-up, the Physician prescribed 5 mg of Folic Acid once daily. The Pharmacist verifying the order called the prescribing Physician to clarify the frequency of Folic Acid, as it should be once weekly the day after taking the Methotrexate. The order was corrected.

Take Home Message:

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Pharmaceutical Care Services

Mr. Hossam Abed

Prevented a High-Alert Medication Error

A patient had sudden and severe chest pain, and headed to the nearest primary Health Care Center. He received 325 mg of Aspirin and Lasix, but the pain did not subside. So, he came to KFSH&RC's DEM, where he was assessed by the DEM Physician, who stabilized the chest pain, then consulted the Cardiologist as a case of Acute Coronary Syndrome. Another 325 mg of Aspirin was mistakenly ordered; however, while checking the DEM Physician's assessment, the Pharmacist noticed that the patient had already received it at the PHC. Therefore, the Pharmacist contacted the Cardiologist to cancel the additional Antithrombotic dose.

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. Raghda Aly

Prevented a Medication Dose

A neonate weighing 0.84 kg had an order of Fentanyl IV push of 2 mg per kg, which is 32 ml, a very high and toxic dose and about 1,000 times more than the acceptable dose for this baby's weight.

The verifying Pharmacist calculated the correct dose to be only 1.6 mcg, equivalent to 0.032 ml. The difference between mg and mcg could have reached a catastrophic error, but fortunately, the Physician was informed and corrected the dose.

Take Home Message:

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Pharmaceutical Care Services

Mr. Mohamed Salem

Prevented a High-Alert Medication Error

A 22-year old patient diagnosed with Advanced Lung Cancer was admitted for Palliative Care. Potassium containing Normal Saline was ordered. However, when the Pharmacist checked the patient's latest blood Laboratory results, he found potassium (5.1), a high value. When he contacted the prescribing Physician, it was clarified that the intended order was only Normal Saline. The Pharmacist shed light on a system improvement idea that could alarm the Prescriber of Electrolyte values when ordering them.

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.

Laboratory and Pathology Medicine

Ms. Alaa Juran

Prevented a Mislabeled Specimen

The Lab Technologist received three (3) samples from the Emergency Department. Two (2) of the samples belonged to a 46-year old female patient, while the third sample belonged to an 80-year old patient. The Technologist noticed they were all collected by the same person at the same time as written on the label. After verifying the process of collecting and labeling those samples with the collector, it was discovered that the sample was mislabeled.

Take Home Message:

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

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Radiology Department

Mr. Eduardo Maniego

Prevented Unnecessary Radiation Exposure

A 64-year old patient with Co-morbidities was admitted for planned Heart Surgery and had a Radiology request for a Chest X-ray for Pre-operative Assessment. The Radiology Technologist checked the patient's history and found the patient had the same X-ray last week. When he asked to double-check the information, he found the patient was actually admitted.

The operation was rescheduled so the patient was discharged, then re-admitted, and all the routine requests were ordered. Thus, the Technologist and primary Nurse confirmed with the primary Physician that the Chest X-ray was not needed again.

Take Home Message:

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

Ms. Narjes Alahmadii

Prevented a Wrong Radiological Study

A 53-year old female with Hyperparathyroidism had an order for a Bone Scan to determine the localization of a Parathyroid Adenoma. The Nuclear Medicine Technologist first called the referring Physician to ask a clarifying question as this image can be obtained by Bone Densitometry instead.

Indeed the correct order was the Bone Densitometry; thus, by asking this question, the Technologist helped save the patient from unnecessary Radiation and increased efficiency by reducing the exam time from four hours to 15 minutes.

Take Home Message:

Be vigilant with your own internal validation, and always ask a clarifying question.

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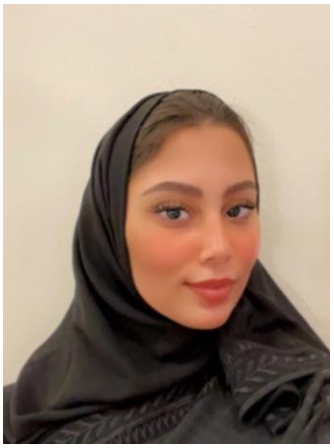
Nursing Affairs



Ms. Hanen Alotybe

Prevented a Medication Error

A 25-year old lady with a history of Genetic Kidney Disease and other hormonal disorders had a successful Cesarean Section and delivered her baby. While ready to be discharged from the Hospital, the Physician prescribed Enoxaparin to prevent Deep Venous Thrombosis at home.

The primary Nurse checked the prepared medication and realized that the Enoxaparin dose and frequency should be adjusted since the patient has an active Renal Disorder. The Nurse contacted the Pharmacist, and they confirmed after re-checking. So, the Pharmacist contacted the Physician to change the Enoxaparin dose from 30 mcg twice daily for sixty (60) days to the safe dose of 30 mcg once daily.

Take Home Message:

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

Ms. Maab Basha

Prevented an Unsafe Procedure

A 4-year old boy with a history of several Congenital Heart defects came to the Dental Clinic for clearance before his planned Cardiac Catheterization procedure. After assessing him, the Dentist decided to perform some procedures under Nitrous Oxide. However, it is high-risk to use Nitrous Oxide, especially with the patient's current situation with an Oxygen Saturation of 85%. The Dentist was informed of this information and canceled the procedure to reschedule it under General Anesthesia.

Take Home Message:

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

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Nursing Affairs

Ms. Mary George

Prevented a Wrong Medication

The OR Nurse received a patient from the 24-Hour Admission Unit for a Colostomy Creation and Stent Exchange. While checking the file of the patient and pre-op medications, she asked the primary Nurse if the recommended antibiotic for this procedure (Ertapenam) was ordered and prepared. Other antibiotics ordered had been ordered for the patient.

So the OR Nurse called the Surgeon to ask for the best recommended antibiotic for this particular case and communicated with the Pharmacist to prepare the dose before starting the procedure.

Take Home Message:

Be vigilant with your own internal validation, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review).

Ms. Jamila Alzahrani

Prevented an Allergic Reaction

A new staff member was in the process of Employment and visited the Employee Health Clinic. The Staff Nurse, who took his complete medical history and prepared to give the new employee Measles, Mumps, and Rubella (MMR) Vaccination, asked if he had any allergies. The employee mentioned that he had an egg allergy with hypersensitivity and a somewhat severe reaction. The Nurse checked the leaflet information on the vaccine, and the content included Egg Protein Allergy.

The Nurse immediately contacted the Family Medicine Physician to consult him. After assessing and verifying the allergy and contraindications, the vaccine order was canceled and saved the newly hired employee from any adverse reactions.

Take Home Message:

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

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Nursing Affairs

Ms. Shahad Brnawi

Prevented an Allergic Reaction

As the last strong barrier in the system, this Staff Nurse's vigilance protected a patient going to the Operating Room from receiving a Pre-op Antibiotic.

The patient had a Penicillin allergy. The prescribing Physician and the verifying Pharmacist were notified, and the Pre-op Antibiotic was changed.

Take Home Message:

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