SAFETY ALERT

Q3

Sharing Lessons Learned

Great Catch Winners

Pharmaceutical Care Services

Mr. Ahmed Bashmail

Prevented a Medication Error

During discharge preparation, the physician ordered a Heparin prophylaxis dose with a duration of 6 months. The pharmacist contacted the physician to validate the indication of the ordered Deep Vein Thrombosis prophylaxis and if the patient was or will be bedridden for that duration. The physician re-evaluated the plan and eventually canceled the order.

Take Home Message:

Be vigilant with your own internal validation, and remember Cross Check will ensure 200% Accountability.

Mr. Mohamed Abbas Salem

Prevented a Sound-A-Like Medication Error

While the pharmacist verified an order for Iloprost inhalation (Brand Name Ventavis), he cross-checked the patient's file for the indication and diagnosis. After contacting several physicians, he was finally informed the intended order was for Albuterol. (Brand Name Ventolin)

Take Home Message:

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

Mr. Naif Althomali

Prevented a Medication Error

Pharmacist III was filling a prescription for (Darunavir), an antiretroviral medication used to treat and prevent HIV. He cross-checked with the senior pharmacist if this medication should be taken along with (Genvoya).

Both pharmacists checked the patient's file and called the primary physician to confirm and order the complete and effective regimen.

Take Home Message:

Be vigilant with your own internal validation, and remember Cross Check will ensure 200% Accountability.

SAFETY ALERT

Q3

Sharing Lessons Learned

Great Catch Winners

Pharmaceutical Care Services

Ms. Melinda Litao

Prevented a High-Alert Medication Error

The pharmacist received a communication order to prepare a new bag of IV Potassium and Magnesium as a continuous fluids order and checked the patient's recent lab result. The potassium was (5.4), so she called the requesting nurse to hold this continuous IV order. While communicating with the nurse, the pharmacist realized the patient was also taking an oral dose of potassium. she immediately alerted the team to suspend both orders due to a high potassium level.

Take Home Message:

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

Ms. Israa Saber

Prevented a Medication Error

Diphenhydramine and Methylprednisolone were prescribed for a patient as prophylaxis before any CT scan procedure. Upon checking the patient's history, the pharmacist noticed that the patient had received both medications several months ago. The physician was called to verify the order, and the physician then cancelled the order due to the unavailability of CT scan appointments at that time.

Take Home Message:

Ensure effective communication by asking a Clarifying Question to Validate and Verify.

SAFETY ALERT

Q3

Sharing Lessons Learned

Great Catch Winners

Nursing Affairs

Ms. Meead Aldalbahy

Prevented a Premature Discharge

A 68-year-old patient came to DEM with high blood sugar levels and a tingling sensation in the tongue; he was given an insulin injection and was about to be discharged home. The nurse sensed the patient was still having signs of Diabetic Ketoacidosis. After repeating the blood sugar level, the nurse decided to raise her concern to internal medicine to stop the discharge, check the Venous Blood Gases, admit the patient for appropriate management.

Take Home Message:

Be encouraged to raise safety concerns and Stop the Line for Clarity.

Ms. Jenette Acibar

Prevented a Medication Error

While preparing the medication for a patient, the nurse noticed the color and consistency of the Acetylcysteine solution was different than what she routinely administered. The color was white rather than clear, and the texture was sticky. The nurse then went to the pharmacy for verification. The wrong medication was replaced with the correct one.

Take Home Message:

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

Ms. Wed Bukhary

Prevented a High-Alert Medication Error

While preparing the patient for discharge, the nurse cross-checked the dispensed anticoagulation (Warfarin) and found it was the wrong dose. The correct order was (5 mg) daily. However, the (5 mg) bottle was incorrectly labeled to take two tablets (10 mg) daily. The nurse contacted the pharmacy to replace the correct medication instructions.

Take Home Message:

Be vigilant with your own internal validation, and remember Cross Check will ensure 200% Accountability.

SAFETY ALERT

Q3

Sharing Lessons Learned

Great Catch Winners

Medical and Clinical Affairs

Mr. Mohannad Algarni

Prevented a Potential Complication

The physician called the respiratory therapist to start the patient on (Bi-PAP) Bi-level Positive Airway Pressure therapy. Upon assessing the patient, and the latest Venous blood gas, the therapist could not find a clear indication for the treatment. So, he communicated with the physician to further asses the Arterial Blood Gas and re-evaluate the situation. With proper communication he ensured an appropriate treatment plan and avoided the risk of overcompensating the patient.

Take Home Message:

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

Mr. Sultan Almugbel

Prevented a Potential Complication

A radiology technologist did a Chest Computerized tomography (CT) scan with contrast for a patient in the morning. In the afternoon, he received an order for Brain (CT) with contrast. The technologist noticed that the same patient had already received contrast in the morning, and it is contraindicated to receive more than one dose in less than 24 hours. The ordering physician was informed about the situation. The test was eventually canceled.

Take Home Message:

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

Mr. Anthony Crocock

Prevented a High Risk Situation

During daily Ambulance checks, the paramedic noticed that the stretcher and the locking plate used to secure the stretcher were loose. Further investigations revealed an improper securing method of the locking plate within the floor. This kind of wrong securing method after repair could lead to severe consequences for patients and staff in the moving vehicle.

Take Home Message:

Speak up by using ARCC- Ask, Request, Concern, Chain of command