مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre

June, 2023

LESSONS LEARNED

Special Edition

King Faisal Specialist Hospital & Research Center celebrated the Great Catch Award winners for 2023 - Quarter 1 on June 8, 2023. The award acknowledges healthcare professionals who actively report near-miss events, emphasizing the significance of identifying potential hazards before they lead to adverse incidents.

The winners were chosen based on the impact of their near-miss reports, demonstrating their commitment to patient safety. Their proactive reporting contributed to preventive measures and enhancements in healthcare practices.

The hospital advocates for healthcare professionals to report near-miss events, as it is essential for cultivating a safety culture and addressing potential hazards.

These Q1 2023 winners inspire their colleagues, and the Patient Safety Section commends their dedication to patient safety. As we recognize their accomplishments, we encourage healthcare professionals to persist in reporting near-miss events to ensure patient safety.

For additional information on reporting incidents and near misses, reach us at psc@kfshrc.edu.sa

Never Dismiss a Near Miss.

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Great Catch Winners

First Quarter 2023

Great Catch Stories

Preparation & Administration

A ten-month-old baby girl with an inguinal abscess for incision and drainage under procedural sedation was ordered for Ketamine **15mg,** but the medication prepared was **250mg** which is **17 times more than the prescribed dose**. The error was caught before it reached the patient.

Dr. Mohammed Alfaifi. DEM Phvsician

Wrong Label & Rate

The wrong label was noted when the two nurses were about to connect the dispensed Fluorouracil pump to the patient. It was labeled to be infused over **24hrs,** instead of **120hrs**. The error was escalated, and the frequency of administration was rectified.

Natalia Cyran & Sarah Aldossary
SN1 – Infusion Center

Wrong Dose

Eculizumab 1200mg was prescribed and dispensed. While checking patient identification, the patient's father **questioned the dose. Upon checking the clinical notes, it was found that the** correct dose is **900mg.** The order was corrected and dispensed.

Maali Alotaibi & Care Partner
SN1- DMU

Wrong Dose of Chemotherapy

Chemotherapy Vincristine was prescribed with a **50 % dose reduction** due to elevated liver enzymes. The medication was dispensed with a **full dose**. The pharmacy was already closed when it was discovered**.** The patient was rescheduled for the following day to receive the chemotherapy.

Pumla Namba
SN1-Infusion Center

Prescribed & Dispensed Medication

The patient was documented as **allergic to Amlodipine** but was prescribed & dispensed a 5mg Capsule, orally. The error was escalated, and the medication was discontinued.

Melora Esther Reddy
SN1 – D4

Miscounted Discharge Medication

Discharge medication **Tramadol** arrived with **10 capsules** on the label, but when it was checked inside the box, **30 capsules** were found. The 20 capsules were immediately returned to the pharmacy.

Dolly Gallano
SN1-A3

Wrong Patient Identification

The patient was called for the procedure by OR front desk; the patient was identified by two staff in the unit before transporting to OR; upon arrival to OR holding area during the identification process, the nurse found the **wrong patient** was sent.

Jennifer Audije
SN1-ORL-2

OR Booking Discrepancy / Wrong Site

The patient was incorrectly booked for **Left Craniotomy** instead of **Right Craniotomy,** as indicated in the consent. The attending team confirmed the discrepancy. The surgical team was alerted and the booking in the system was rectified.

Anisha Thomas
SN1-OR L2

Medication Dispensing Error

Fluconazole 200mg OD for 4 days was prescribed, but the medication was dispensed with the wrong instruction label **"Take 4 tablets OD".** The error was escalated, and it was rectified.

Kholoud Sharahili
SN1-B2

High Alert Medication & Dispensing Error

A Potassium bolus of **20mmol** was prescribed through the peripheral line, but a double dose **(40mmol)** of Potassium was received. Medication was returned to the pharmacy, and the error was rectified.

Siziwe Jennifer Mkosna
SN1- Infusion Center

Patient Identification

Received a patient from the unit with **2 types of label stickers;** one is for the **donor patient** and the other for the **recipient patient**. Samples should be sent to the recipient only. The error was stopped before taking the sample from the patient.

Nor Hayati Nawang
SN1-KACO&LD OR

Wrong Prescription & Preparation

Lasix infusion of **50mg/hr.** was ordered, prepared, and dispensed which was **3 fold the required dose** based on the patient's weight. The error was immediately escalated & rectified to **15mg/hr**.

Rawan Alkharji
SN1-EMS B1

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Specimen-Wrong Order

Peritoneal fluid & AFB drain fluid were received in the microbiology lab for surgical culture and Gram Stain. The reporter called the collector to confirm the sample source & it was confirmed that the sample is a tissue biopsy from paravertebral and epidural phlegmon. The order was entered wrongly. The error was escalated & rectified accordingly.

Deema Alhafdi
Senior Medical Technologist

MRI Precautionary Measures

The patient came to an MRI appointment; upon checking and during the pre-assessment, it was discovered that the patient has a pacemaker. The safety questionnaire before MRI was incorrectly answered. The MRI exam was canceled.

Cherie Mae Dela Cuesta
MRI Technologist

Wrong Prescription: LASA

The patient was prescribed Hydrochlorothiazide 10 mg AM. Upon reviewing the patient's profile, he was taking **Hydrocortisone 10 mg AM**. The prescriber was contacted and stated that Hydrochlorothiazide was ordered by mistake instead of Hydrocortisone.

Yazeed Alharbi
Pharmacist II - OPD

Wrong Indication: LASA

A patient was prescribed on ALPROLIX 5 mg BID indicated for Atrial Fibrillation. This is a Coagulation Factor IX and is not used for this indication. Prescriber was informed and corrected the prescription to APIXABAN 5 mg BID.

Mazin Madkhle
Pharmacist - OPD

Wrong Prescription: LASA

The patient was prescribed Repaglinide NOVOnorm 6mg oral TID. During the patient education, the patient clarified that he is not on NOVOnorm instead he is on Insulin-Aspart (NOVOrapid). The error was escalated and the order was corrected.

Hadeel Drweesh & Patient
Pharmacist I- KACO&LD OPD

Wrong Dose

Intrathecal chemotherapy cytarabine was ordered as 50 mg (an age-dependent dose). The patient is less than 2 years, and the correct dose should be 30 mg, almost double the dose. The error was escalated, and the order was corrected.

Hana Alhindi
Pharmacist I – CCC Pharmacy

Wrong Dose

New prescription of Clonazepam 5mg BID was entered instead of 0.2mg BD, Which is (25x) times higher than the correct dose. The prescription was rectified and dispensed correctly.

Saad Alhuwaymil
Pharmacist Ii – North Tower

Wrong Indication

Pentamidine 28mg IV OD was ordered as PRN and the indication written was for allergy and drug reactions. Pentamidine is used in the treatment and prophylaxis of Pneumocystis Pneumonia (PCP). The error was escalated and the medication was discontinued.

Lene Caldito
Pharmacist I – Satelite

Wrong Dose

Envarsus XR (Tacrolimus extended release) 4mg OD was prescribed instead of Prograft (Tacrolimus immediate release) 3mg every morning, and 2mg at night. These medications are not interchangeable. The prescription was corrected and dispensed.

Reem Altamimi
Pharmacist I – North Tower

Wrong Dose

The patient was prescribed Potassium Bolus exceeding the maximum infusion rate by 2 folds (dose 3.5mmol/kg/hr. corrected to 1.8mmol/kg/hr.). The error was escalated and the prescription was corrected.

Tahani Alharthi
Clinical Pharmacist

Wrong Blood Specimen

A blood gas sample was taken from the patient. Before it was processed, it was discovered that an ABG was with the label of VBG. The involved staff was informed that the error was corrected.

Mara Abigail Reformado
Respiratory Care

Wrong Patient

A result showed critically high creatinine. The technologist called the unit to report the critical result and to confirm with a second sample; it was confirmed that the sample was taken from the wrong patient. She **escalated** the error, and it was corrected.

Jodela Del Pilar
Medical Technologist

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