CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert April 2015



Potential for an Event Related to Patients Receiving Liquid Medications Through An Enteral Route

Take Action to Reduce Risk of Harm

Issue: Medication Dosing

Target Audiences:

Nursing, Medical and Clinical Leaders, Pharmacy Leaders, Quality Improvement, Patient Safety, Legal, Risk Management, Clinical Educators, Supply Chain Leaders, Cause Analysis Staff and Organizational Leaders

Potential Harm to the Patient:

Children receiving small dose, high alert medications with the transition to the new ENFit syringes could experience 0.15 mL to 0.2 mL variability in dosing.

Actions to Mitigate Risk of Similar Harm at Your Hospital:

Review the ISMP Medication Safety Alert
<u>http://www.ismp.org/newsletters/acutecare/issues/20150409.pdf</u>, which
addresses dosing variability using ENFit Syringes.

Has a patient experienced an event at your organization that could happen in another hospital?

- Child Health PSO members submit event details into the Child Health PSO portal.
- Contact Child Health PSO Staff to share risks, issues to assess, and mitigation strategies with member hospitals.
- Fifty-one children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.

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What can I do with this Alert?

- Forward this Alert to the recommended target audience for evaluation.
- Include in your Daily Safety Brief.
- Create loop-closing process for evaluating risks and strategies implemented to decrease risk of repeat harm.
- Let Child Health PSO know what is working and what additional information you need.

Leverage your PSO membership: Learn from each other to reduce patient harm and Serious Safety Events

Contact Us

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This Alert is approved for general distribution to improve pediatric safety and reduce patient harm. This Alert meets the standards of nonidentification in accordance with 3.212 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO.