CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert

June 2015

A Patient Experienced a SERIOUS SAFETY EVENT

Take Action to Reduce Risk of Similar Harm

Event: Pediatric Medication Concentration Standards with Retail Pharmacy

Target Audiences

Quality, Patient Safety, Legal, Risk Management, Cause Analysis Staff, Organizational Leaders, Pharmacy Leaders, Home Care, Case Management

Resultant Harm to the Patient

A patient required readmission to the PICU for head imaging and observation.

Fundamental Issue

There was a deviation and systems failure leading to 10x dispensing error at home that reached the patient. A prescription was written as: Enoxaparin 0.6 ml (6mg) subcutaneous Q12 hours (inpatient standard concentration was 10mg/ml). It was dispensed as standard adult concentration of Enoxaparin (100mg/ml) to give 0.6ml subcutaneous Q12 hours, which equates to 60mg**.** This was a high-risk medication requiring a standardized process without similarly complex or standardized ordering, teaching or dispensing systems. There was a lack of communication and collaboration between inpatient and retail pharmacy.

Actions to Mitigate Risk of Similar Harm at Your Hospital

- Create and use Enoxaparin prophylaxis and treatment order sets
- Implement prescriber education and communication
  - Implement an alerting system (Pharmacy, Case Management, Quality, IT) that includes:
    - Dose range checking
    - Review capability for all injectable medications
    - Evaluation of missing concentrations
- Use a standardized concentration for Enoxaparin on all doses 100 mg or less
- Implement the use of whole numbers and rounding guidelines when ordering
- Standardize the type of prefilled syringes if possible
  - Consider standardization for Enoxaparin doses under 40 mg with certain designated syringe (except for 30 mg dosages)
- Engage Case Management and Home Health stakeholders in the review of orders prior to dispensing of custom compounded high-risk medications
  - Standardize syringes used with non-prefilled doses
- Adopt other best practices for standardization and initiate state-wide collaborative initiatives for adoption
  - Michigan Pediatric Safety Collaborative on Compounded Oral Liquids (http://www.mipedscompounds.org/)

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.*
- *More than 50 children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.*

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 non-identification in accordance with 3.212 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO.

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