CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert

July 2014

Patients Experienced SERIOUS SAFETY EVENTS

Take Action to Reduce Risk of Similar Harm

Events: Sustained/Extended Release Medication Fill and Administration Errors

Target Audience:

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

Resultant Harm to the Patient:

Event 1: A patient was transferred to the ICU for hypoventilation after receiving multiple doses of a sustained release narcotic, which was inaccurately filled and administered to the patient.

Event 2: A patient received a naloxone infusion for five hours after extended release Morphine was crushed and administered via a J-tube.

Fundamental Issues:

Event 1: The patient's order was for an IR (immediate release) form of oral Morphine Sulfate. The pharmacy inadvertently filled the prescription with an ER (extended release) tablet. The delivery bag label indicated immediate release. However, the medication tablet inside the bag was ER instead of IR.

Event 2: The patient was ordered to be NPO for an upcoming test. The patient had a J-tube. The patient's medications included an oral extended release Morphine Sulfate. The nurse did not recognize that the prescribed medication was extended release, crushed the tablet and administered via a J-tube.

Key Contributing Factors:

- Process: Inadequate checks and review of medications, Omitted action - not checking "right medication"
- Workflow: Failure to validate/verify, distraction
- Policy and Protocol: Failure to follow Medication Administration and Enteral medication administration policy

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

psosupport@childpso.org

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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Actions to Mitigate Risk of Similar Harm at Your Hospital

- Assess dispensing and verification procedures for high-risk medications such as sustained/extended release narcotics (e.g., frequency ordered, locations where administered, services who order)
- Consider identifying extended release medications through unique labeling
- Consider implementing a "red zone" to decrease distractions during medication preparation
- Use an automated dispensing cabinet for high-risk medications (e.g. look alike/ sound alike)
- Distribute ISMP's list of oral dosage forms that should not be crushed to clinical staff *(https://www.ismp.org/recommendations/do-not-crush)*

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.*
- *Forty-one children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.*

Resources

- *Institute for Safe Medication Practices, 2014. Oral Dosage Forms That Should Not Be Crushed. Found at: https://www.ismp.org/recommendations/do-not-crush*
- *Institute for Safe Medication Practices, 2010. Preventing errors when administering drugs via an enteral feeding tube. Found at: https://www.ismp.org/resources/preventing-errors-when-administering-drugs-enteral-feeding-tube*
- *The American Society for Parenteral & Enteral Nutrition, 2009. A.S.P.E.N. Enteral Nutrition Practice Recommendations. JPEN J Parenter Enteral Nutr 2009; 33; 122 originally published online Jan 26, 2009; DOI: 10.1177/0148607108330314. Found at: https://pubmed.ncbi.nlm.nih.gov/19171692/*
- *Boullata, J., 2009. Drug Administration through an Enteral Feeding Tube AJN, American Journal of Nursing, October 2009. Found at:* Nursing Center - CE Article

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