Safety Alert
Great Catch Winners Q2 - 2021
"Sharing Lessons Learned"

Nursing Affairs


Ms. Azhar Kamal

Prevented a Medication Error

The Staff Nurse assigned as a Patient Educator in the Cardiology Inpatient Unit, prepared the educational material for a patient's discharge. When she checked the medication prescription, she noticed a prescription of Empagliflozin, a medication with a primary use to lower blood glucose levels through the kidneys and reduce the risk of heart failure progression. The nurse first checked the patient's latest blood results and found the kidney function test has an abnormal rate (e-GFR less than 50) and realized that according to the guidelines, it's a contraindication that can cause acute kidney injury.

She confirmed this information with Endocrinology and the Clinical Pharmacist, to discuss the Cardiology Team's decision and potentially adverse effects of prescribing this medication.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity.


Ms. Anna Kristen San Luis

Prevented a Patient Identification Error

A patient was admitted to the Endoscopy Unit for a procedure under conscious sedation. While the Nurse checked the patient's file, she asked the patient for their information to double check and asked for the full name and MRN. The Nurse found an interdisciplinary note from another procedure area with an almost identical MRN (the only difference is the last digit) that was incorrectly added to the file.

Take Home Message:

Be attentive to details, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review), and cross-check for 200% accountability.

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Nursing Affairs

Ms. Menar Dogan

Discovered Wrong MRN Assigned to a Newly Hired Employee
The Occupational Health Nurse followed a newly hired employee for the clearance protocols by checking the COVID-19 swab.

The Nurse didn't find the employee's encounter for the swab clearance, so she called them to verify, then she called the Drive-Thru Swab Center to get the information of all staff who got swabbed, until she discovered the wrong MRN was given to the newly hired employee.

The Occupational Health Nurse contacted the Employment Office to validate and correct the MRN assigned to the new employee and correct all documents with the Appointments and Registration Office. The new file was activated, the COVID-19 swab was discarded, and a new one was sent with the correct information.

Take Home Message:
Be attentive to details, stop auto-pilot brain mode by self-checking using STAR (Stop, Think, Act, Review), and cross-check for 200% accountability.

Ms. Aljawhara Aljehani

Prevented a Procedure for a Wrong Patient
Two (2) Pediatric patients hospitalized in the same Inpatient Unit were scheduled for a Cardiac MRI under general anesthesia. When the Radiology Nurse validated and verified the patient identification, she realized the Inpatient Unit has sent the wrong patient for the scheduled procedure.

Take Home Message:
Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity.

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Nursing Affairs

Ms. Jisha George

Prevented a Medication Error

A 6-year-old patient on a Ketogenic Diet was prescribed glycopyrrolate. When the Nurse received an oral suspension she realized it contained sugar and contacted the Pharmacy to verify that the order should be prepared differently to prevent the contraindication of sugar with a Ketogenic Diet.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by Stopping the Line" for clarity, and cross-check for 200% accountability.

Ms. Nojoud Allinjawi

Prevented a Medication Wrong Dose

A six-month old patient admitted to the CSICU, received the Total Parental Nutrition (TPN) with the wrong concentration of Dextrose. The Nurse cross-checked with the Charge Nurse to validate the accurate dose and concentration and informed the Pharmacy. The Pharmacy corrected the TPN concentration.

Take Home Message:

Be vigilant with your own internal validation, and cross-check for 200% accountability.

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Nursing Affairs

Ms. Maab Basha

Prevented an Unsafe Procedure

A Pediatric patient came to the Dental Clinic for tooth extraction under sedation. The patient is known for heart disease and other comorbidities and is considered high-risk.

The Dentist ordered sedation Midazolam 0.5 mg/kg. When the Nurse realized this dose was not recommended for high-risk patients she shared the relevant IPP with the Dentist, and the safe dose was ordered.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by Stopping the Line" for clarity, maintaining 200% accountability.

Ms. Renad Khoja

Prevented a Medication Error

While the Nurse prepared the patient's medications, she noticed two (2) different orders for Tacrolimus, one (1) is scheduled before bedtime, and the other is every twelve (12) hours. This duplication can lead to confusion and risk administering an extra dose. The Nurse clarified with the Physician and confirmed the correct order was every twelves (12) hours. The additional order was removed from the system.

Take Home Message:

Be vigilant with your own internal validation, and cross-check for 200% accountability.

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Pharmaceutical Care Services

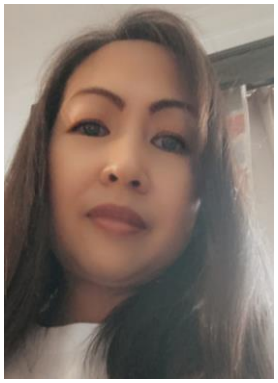
Mr. Mohamed Salem

Prevented a Toxic Dose

A 47-year-old female was admitted to the Emergency Department with severe pain, when the Physician prescribed Acetaminophen 1 g every four (4) hours. The Pharmacist called the Prescribing Physician to validate and verify the dose, explaining that the maximum dose should not exceed 4 g per day. When the Physician explained the patient's condition, the Pharmacist recommended adding another medication, such as Tramal with an adjusted dose, instead of increasing the Acetaminophen, to prevent a toxic dose.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity, and cross-check for 200% accountability.



Ms. Melinda Litao

Prevented a High Alert Medication Dose

A Physician ordered Potassium Chloride 60 mmol in 500 ml Dextrose 5% in Normal Saline. The Pharmacist realized while verifying the order that the Potassium's infusion rate exceeds the maximum in a regular unit without a cardiac monitor. The Pharmacist clarified with the Physician and discussed the high-alert guidelines, and the order was corrected to a safe volume and rate.

Take Home Message:

Be vigilant with your own internal validation, and cross-check for 200% accountability.

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Radiology Department

Ms. Monalisa Dela Cuesta

Prevented an Unnecessary Radiation Exposure

A 21-year-old female patient was scheduled for a Bone Scan, which is a Nuclear Test that requires radioactive material. When the Technologist checked the order in the system, the indication for the procedure was specific to test for the Osteopenia Score. The Technician called the Physician to confirm that the correct study is a Bone Densitometry and not a Bone Scan. This Technologist's vigilance in cross-checking avoided injecting the patient with radioactive material.

Take Home Message:

Be vigilant with your own internal validation, and verify any uncertainty by "Stopping the Line" for clarity, and cross-check for 200% accountability.

Mr. Eduardo Maniego

Prevented a Unnecessary Radiation Exposure

A 78 year old patient had a portable chest x-ray ordered. The Technologist reviewed the patient's file before performing the study and had to ask the Nurse a clarifying question of the patient's status and indication for the x-ray. The Technologist was still hesitant and unsatisfied with the order of the chest x-ray for the third consecutive day with the same indication, so he called the Ordering Physician to verify that it is ordered to be done after the patient underwent the ultrasound-guided Thoracentesis.

Take Home Message:

Be vigilant with your own internal validation, and always ask clarifying questions.

Mr. Sultan Almugbel

Reported an Unanticipated Finding

A 28-year-old male patient with Hodgkin's Lymphoma had an appointment for a routine CT scan. When the Technologist noticed an Internal Jugular Thrombosis, he immediately contacted the Radiologist to refer the patient to the Emergency Department.

Take Home Message:

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

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Laboratory and Pathology Medicine

Ms. Bayan Hassan

Prevented a Patient Identification Error

While the Phlebotomist was preparing the patient for the blood extraction and checking the patient's full identification, she found that the patient had two (2) different ID bands, that did not match. She immediately informed the Nursing Team to avoid any misidentification.

Take Home Message:

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

Mr. Naif Almalki

Prevented a Patient Identification Error

When the Technologist was requested to send a Cytology Report, he discovered that the report was sent in a different patient's electronic medical record, due to a mislabeled sample that happened in another department. The Technologist immediately tracked and corrected all documents and reports in the system before any harm reached the patient.

Take Home Message:

Be vigilant with your own internal validation, and attentive to details by self-checking using the STAR method (Stop, Think, Act, Review).