Safety Alert
Great Catch Winners Q2-2020

"Sharing Lessons Learned"

Pharmaceutical Care Services

Mr. Amr Mahmoud

Prevented Medication Error

Prevented a mismanagement of hyperkalemia and metabolic acidosis. Physician ordered Ringer's lactate, which contains potassium that can worsen the hyperkalemia; cross-checked with the physician to change the fluid to D5W with Sodium Bicarbonate.

Take home message:

Remember to cross-check for a 200% accountability.

Ms. Nada Saferuddin

Prevented Medication Error

Prevented an unauthorized medication prescription for a high alert medication.

Take home message:

Speak-up for Safety Using ARCC when you witness any unsafe behavior.

Hatun Labban

Prevented Medication Error

Prevented a Drug-Drug interaction. While verifying a patient's prescription for Rifampicin, discovered that the patient is already on Apixaban; cross-checked with the ordering physician to change from Rifampicin to Ciprofloxacin.

Take home message:

Remember to cross-check for a 200% accountability.

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Pharmaceutical Care Services

Hany Elatroush

Prevented Medication Error

Prevented a wrong medication prescription by confirming the indication. A physician has ordered a medication without adding the indication; the pharmacist was about to proceed with the order, when he decided to call the physician to confirm the indication.

Take home message:

Be vigilant with your own internal validation, verify uncertainty by asking clarifying questions.

Lama Fetyani

Prevented Medication Error

Prevented a wrong dose upon dispensing the prescription, the pharmacist clarified the correct dose with the ordering physician and confirmed that the dose was increased temporarily at that time and should return to the regular dose.

Take home message:

Be vigilant to details and ask clarifying questions.

Mohammad Alotaibi

Prevented Medication Error

Discovered two (2) drugs that look-alike on the same shelf (Latanoprost Xalatan) and (Latanoprost +Timolo Xalacom). Look-Alike and Sound-Alike medications should be separated to prevent errors.

Take home message:

Be vigilant to details, stop autopilot brain mode by Self-Check using STAR (Stop, Think, Act, Review).

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Jeddah Branch فرع جدة

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Nursing Affairs

Lujain Alhomaid

Prevented Electrolyte Imbalance

Potassium chloride and sodium phosphate were ordered and verified. However, they were both diluted in Sodium Chloride, the primary nurse validated as the patient has a critically high Sodium Chloride level. Order verified with the ordering physician and pharmacist to change the fluids to Dextrose.

Take home message:

Be vigilant to details, stop autopilot brain mode by Self-Check using STAR (Stop, Think, Act, Review). Verify uncertainty by asking clarifying questions.

Teodula Tuazon

Prevented Incorrect Patient Identification

While preparing to administer blinatumomab infusion, the nurse noted a handwritten label with a correct patient name but a wrong MRN due to a downtime situation.

Take home message:

Be vigilant to details, stop autopilot brain mode by Self-Check using STAR (Stop, Think, Act, Review).

Romy Absalon

Prevented Medication Error

The nurse received Morphine PCA bag from the Inpatient pharmacy with the wrong due date. The correct practice in Pharmacy, according to the policy and accreditation standards, is that any label should reflect the exact date and time of administration, even if recycled.

Take home message:

Speak-up for Safety Using ARCC when you witness any unsafe behavior.

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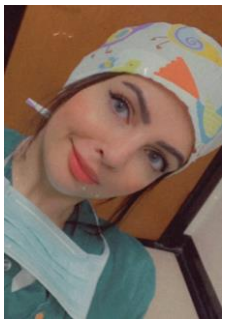
Respiratory Care Services Department



Alia Aldarwish

Prevented Medication Error

Prevented a wrong medication administration. Before administering Acetylcysteine inhalation, noted a white-milky solution instead of the clear-watery solution of acetylcysteine, staff asked the pharmacists a clarifying question and acted by sending the medication back to the Pharmacy to get the correct medication.

Take home message:

Be vigilant to details, stop autopilot brain mode by Self-Check using STAR (Stop, Think, Act, Review), and ask clarifying questions.

Maria Arceo

Prevented Wrong Gas Delivery

During the routine morning equipment check, staff discovered a strange gas mixture in the Respiratory Care Services (RCS) storage area.
The senior confirmed that this tank contains Oxygen & Nitrogen 31% actual concentration, not to be used for inhalation. It was escalated to the RCS supervisor and contacted the Medical Gas Team to correct the issue.

Take home message:

Be vigilant to details by Validating and Verifying uncertainty. Speak-up for safety using ARCC.

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Radiology Department

Johny Alejandro

Prevented a Wrong Procedure

Miss-match between an ordered Bone Scan for a patient and it's indication to rule out Osteoporosis/Osteopenia. Discovered by clarifying with the ordering physician for the correct procedure and correct indication.

The exam intended was Bone Mineral Density. By that, unnecessary radiation exposure to the patient was prevented.

Take home message:

Be vigilant for details, validate yourself and verify by asking a clarifying question.