Safety Alert
Great Catch Winners Q1 - 2021
"Sharing Lessons Learned"

Pharmaceutical Care Services

Mr. Mohamed Salem

1- Prevented a Toxic Medication Dose.

A physician was renewing the medications for a pediatric patient. While entering a new order for oral Acetaminophen, the physician mistakenly wrote 15 ml/kg instead of 15 mg/kg. With the pediatric patient weighing only 4 kg, it would have been an order of 60 ml. Acetaminophen's oral concentration was 160 mg /5ml, which means the 60 ml ordered would be equivalent to 1920 mg; this is a toxic dose for that patient.

Luckily as the pharmacist verified the order, he noticed the medication error and modified it promptly since it is a pyxis item, and nurses will prepare the dose.

2- Prevented a Toxic Medication Dose

A physician was prescribing Ferric Carboxymaltose 1000 mg Intravenously. While the pharmacist verified the order and reviewed the patient's history, he discovered that the patient received 500 mg of Ferric Carboxymaltose the same week. The pharmacist contacted the physician to inform them about the maximum dose of 1000 mg per week and clarify the physician should prescribe the cumulative dose over several weeks. The prescribing physician consulted hematology regarding the said recommendations and agreed to change the dose to the recommended amount.

Take home message:

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

Ms. Murooj Almuwallad

Prevented Medication Error

A post-op patient was prescribed both Cefazolin 1g Q8hr and Ceftazidime 1g Q12hr. While verifying the orders, the pharmacy resident noticed both antibiotics are from the same class. She immediately called the prescribing physician to clarify the indication of both medications and explained the duplication of orders. So the physician corrected the medication error by canceling one of the antibiotics.

Take home message:

Remember to validate, verify and cross-check for 200% accountability.

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Nursing Affairs

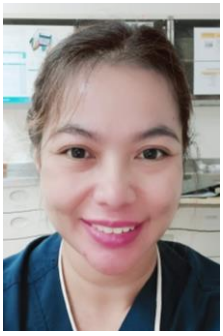

Ms. Maylene Catahan

Prevented Fluid Mismanagement

The neurologist ordered an additional 1200 ml of freshwater after each feeding. The primary nurse clarified the order with the neurologist to make sure the nephrology team recommended it since the patient is edematous and hyponatremic. However, the nurse was still hesitant as her instinct triggered her of the patient's condition with this large amount of fluid, leading to overload or severe hyponatremia. The nurse finally decided to ask the nephrology team to discuss the order. The clarification was to maintain the feeding of 160 ml with the water every 4 hours to get 1200 ml per day. The neurologist then canceled the incorrect order from the system, and the patient was saved from a total of 8340 ml per day.

Take home message:

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


Ms. Socorro Atiolla

Prevented Medication Error

The primary nurse received TPN and Lipids to administer to the patient in the NICU when the nurse noticed the MRN on the bag was incorrect.
The nurse called the pharmacy to cross-check the correct medication to the right patient.

Take home message:

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

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Nursing Affairs


Ms. Maureen Koh

Prevented Medication Error

As the patient was ready to be discharged, the sitter went to the to the outpatient pharmacy to receive the prescribed narcotic pain medication Acetaminophen/Codeine (Tylenol #2). Before they leave, the nurse took an extra step to double-check the discharge medications but found out the sitter has received (Tylenol #3) instead, which is a different concentration than the prescribed order. The nurse contacted the physician to confirm the strength of the narcotic medication when the physician realized the intention was to prescribe a plain Tylenol, which is Acetaminophen, without the narcotic Codeine. The physician placed the correct order.
The nurse contacted the outpatient pharmacy to inform them of the two medication errors and returned the wrong medication to deliver the correct one to the patient.

Take home message:

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

Ms. Gina Lape

Prevented Medication Error

In NICU, the primary nurse was preparing a prescribed medication; Cholecalciferol 400 Units.
She noticed that the pharmacy had dispensed a 1000 Units tablet with the instructions to dissolve the 1000 Units in 10 ml water and administer 0.4 ml to the patient. The nurse immediately realized the error while re-calculating the dose and reported it.

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. Shahad Abudawood

Prevented Medication Overdose

A physician treating a patient in Emergency ordered Intravenous Acetaminophen. He wrote 5000 mg, a highly toxic dose, and the pharmacy verified it when he entered the order. Before administering the dose, the primary nurse has realized the toxic dose and decided to discuss it first with the prescribing physician and the pharmacist to change the order to a safe dose.

Take home message:

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

Ms. Subi Abraham

Prevented Wrong Patient Procedure

A phlebotomist entered a patient's room and was getting ready to extract blood samples when the primary nurse remembered that patient doesn't have any blood works ordered. The primary nurse followed the phlebotomist to double-check before the phlebotomist started and checked the labels to discover the wrong department and wrong patient.

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

Prevent Wrong Patient Identification

When the admitting nurse identified the patient in the endoscopy unit and checked the patient's medical file, the nurse found the medical records have sent the wrong file with an almost identical Medical Record Number. The charge nurse contacted the medical records immediately to replace the medical file with the correct MRN.

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. Areej Aljezani

Prevented Allergic Reaction

A patient was scheduled for an Angiogram procedure.
On assessment, the nurse asked the patient about allergies and discovered the patient had an undocumented allergic reaction from a previous contrast exposure.

Take home message:

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


Ms. Charity Bienes

Prevented Controlled Medication Error

A primary nurse asked a colleague to witness preparing a controlled medication from the pyxis machine (Lyrica 150 mg). When the pyxis opened the cubie for Lyrica, the screen showed 75 mg with instructions to remove two capsules. However, as they both were double-checking, they noticed the capsule was the correct dose, 150 mg, leading to confusion and preparing the wrong dose. The narcotic pharmacy were notified of the machine's error.

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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Radiology Department

Mr. Eduardo Maniego

Prevented Un-necessary Exposure
The radiology technician was called for a STAT portable x-ray for a patient in the ICU.
The tech immediately answered the call and went to the ICU to perform the study when first, he had to verify the patient already had an x-ray that day. The primary nurse called the physician and clarified the order should be done after the planned removal of an existing chest tube.

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

Respiratory Care Services


Mr. Ahmed Althobaiti

Prevented Medication Wrong Storage
As the Respiratory Therapist provided care to his patient, he found a medication (Dornase Alpha) stored wrongly in the cabinet. This medication should be stored in the fridge with a temperature between 2-8 degrees.
The Respiratory Therapist confirmed this information with the pharmacy, and as they advised, the medication was discarded, and a new dose was prepared.

Take home message:
Be attentive to details, stop auto-pilot brain mode by self-checking using the STAR method (Stop, Think, Act, Review), and ask clarifying questions.