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Pharmacy Technician's Letter
Hospital

Reinforce Strategies to Prevent Serious Hospital Med Errors

ISMP's list of best practices for hospitals is spurring **discussions on how to prevent some of the top causes of harmful med errors**.

Work as a team to implement error-reduction strategies for tranexamic acid...vaccines...and at transitions of care.

Prevent wrong-route errors with tranexamic acid. Look-alike tranexamic acid vial caps make it easily mistaken for local anesthetics (bupivacaine, lidocaine, etc)...which are sometimes given intrathecally.

Accidental intrathecal administration of tranexamic acid can cause seizures...permanent brain damage...and death in about 50% of patients.

Use premixed 1 g IV bags whenever possible...and store tranexamic acid vials OUT of anesthesia trays. If premixes are unavailable, manually compound tranexamic acid drips...to avoid mix-ups in procedural areas.

Arrange vials horizontally so labels can be seen. Consider adding "Contains tranexamic acid" labels to vial caps to provide another layer of protection...since barcode scanning doesn't always happen in these areas.

Reduce errors with vaccines. Double-check that brand AND generic names appear on vaccine orders...and reduce confusion with abbreviations.

For example, Tdap or DTaP is used for tetanus, diphtheria, and pertussis. But Tdap is for older kids and adults...DTaP is for children younger than 7 years. Use auxiliary labels to help differentiate.

Store 2-component vaccines together to avoid diluent mix-ups...and arrange similar vaccines in separate bins based on type and formulation.

Stock prefilled vaccine syringes when possible. If vaccines must be prepped, prepare immediately prior to administration and deliver stat...to limit bacterial contamination.

Provide nurses with the vaccine NDC, lot number, and expiration date...these need to be documented in the EHR before administration.

Limit med mishaps during transitions of care. These often occur when patients transfer in and out of the ICU.

Stay alert for ICU meds mistakenly left on a patient's profile, such as pressors (norepinephrine, etc)...and alert the pharmacist. They'll want to intervene to prevent unnecessary doses.

Don't be surprised if home meds are restarted when patients leave the ICU...since many are held due to acute issues. Keep an eye out for dose changes...and remove discontinued doses from patient care units.

Use our Transitions of Care Checklist at admission, transfer between units, and discharge to help prevent med mishaps.

Key References:

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