Tuesday Talks with John

Easily avoidable medication errors involving high alert drugs

I recently sent you an edition of *Tuesday Talks with John* concerning Magnesium Sulfate and other commonly used concentrated electrolytes. I discussed the importance of treating high alert drugs with special precautions. If you read my newsletters and round with me during pharmacy inspections, you know how seriously I take this matter.

I was sad to read about a fatal medication error that occurred at Vanderbilt University Medical Center in Nashville, TN. Last year, a stable patient requested a sedative during a radiology exam. The physician ordered 2mg of Versed and the nurse accidentally administered 10mg of Vecuronium. The patient suffered cardiac arrest and died. *You can read more about the incident here*. Ultimately, Vanderbilt mis-reported the details of the death internally and failed to report the incident to appropriate agencies

such as CMS. The hospital now faces serious consequences, including revocation of their CMS status.

To be clear, it was the hospitals response to the incident and lack of reporting of the medication error that is placing them in jeopardy. But you have to ask yourself...how did this medication error occur and how could it have been prevented?

The nurse that administered the wrong medication bypassed several safety protocols while accessing the drug. Also, the drug was accessed from an automated dispensing cabinet, only the first two letters were typed in "VE...", and the dose/ drug was not checked before administering to the patient.

When events like this occur and make national headlines it's vital that we take the opportunity to review our own medication safety protocols. How does your facility prevent medication errors? I'm often asked whether or not high alert drug lists are truly important, and the answer is, *yes*. It's not enough just to hang the list on the wall of the medication prep area. Staff should be familiar with that list, should know *why* the drug is on that list, and should understand both the risk mitigation strategies associated with the drug and the potential harm that could occur if the drug is used or administered improperly.

If you would like more information on how your high alert or look alike/ sound alike medication lists can help prevent medication errors, contact Brittney or Madison at Britt@jdjconsulting.net or Madison@jdjconsulting.net

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Tuesday Talks with John will now be delivered to your inbox weekly.

[609-313-7572] [JOHN@JDJCONSULTING.NET] [www.JDJConsulting.net]