Involving Nonclinical Departments in Patient Safety Discussions Can Reduce the Risk of Serious Errors

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PROBLEM: A patient safety nurse visited the operating room (OR) to speak with the staff about one safety matter, but she wound up uncovering another. While she was in an OR utility room, she happened to observe a pale pink disinfectant/deodorant solution packaged in a semirigid container with graduated volume markers on one side, similar to the sodium chloride irrigation solution containers purchased by the hospital. The disinfectant also had a plastic loop affixed on the bottom similar to the loop used for hanging irrigation solutions on an IV pole. Close inspection of the bottle (Figure 1) and subsequent investigation revealed that housekeeping personnel routinely obtained bottles of sterile irrigation solutions, added a disinfectant concentrate to the contents, and placed a manufacturer-provided label over the sodium chloride irrigation label.

The nurse’s chance observation may have prevented a tragedy. On more than one occasion, the Institute for Safe Medication Practices (ISMP) has learned of situations in which repackaged non-drug substances were confused with medical or other products.

For example, the ISMP learned that antibiotic solutions were inadvertently reconstituted with 10% formalin solution (3% formaldehyde and 15% methanol) in two different pharmacies. In both cases, non-pharmacists working in the pharmacy routinely used already empty plastic gallon jugs of distilled water to prepare 10% formalin for nearby surgical centers. Formalin labels were affixed to one side of the container; occasionally, however, the distilled water labels were also left on the containers in error. These were accidentally placed with empty jugs of distilled water, where they were later used to reconstitute antibiotic suspensions for a total of 35 children, some of whom required hospitalization.

Similarly, people handling these irrigation containers might forget to relabel the irrigation bottles properly, or they might place the label on the opposite side of the container, leaving the original irrigation label exposed.

Another example can be found in a book entitled Set Phasers on Stun, and Other True Tales of Design, Technology and Human Error by Steven Casey. One of the safety lesson anecdotes in this book concerns a bar that routinely used empty liquor bottles for storing caustic cleaners—until one was eventually mistaken for a peppermint twist and a patron lost the lining of his esophagus!

SAFE PRACTICE RECOMMENDATION: The Veterans Health Administration National Center for Patient Safety promotes the idea that patient safety considerations are not just the responsibility of clinicians. Here are some of the center’s suggestions:

1. Time should be allotted at all meetings of department heads (not just at professional department meetings) to review appropriate patient safety issues discovered within the organization or through external reports. For example, time could be set aside at an upcoming meeting to present the disinfectant case (described earlier) to all department heads, especially those in support areas such as dietary, housekeeping, central supply, and laundry.

2. It should be explained why it is dangerous to repackage non-drug items into empty containers that formerly held drugs or irrigation solutions or to add non-drug items to solutions in these containers.

3. A hospital policy should be developed to forbid this practice, especially in the absence of appropriate pharmacy oversight. One might even go so far as to poke a hole in the empty plastic containers to prevent another person from refilling them with another fluid. However, there is still the risk that someone could empty a full container.

4. The pharmacy staff should routinely assess the risk of accidental administration of non-drug substances during visits to various hospital areas. ISMP personnel who have visited hospitals to analyze their medication systems to assess their safety have noticed soaps, topical sub...

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stances, tissue fixatives, detergents, and even poisonous substances in bottles that look like drug containers. Who can say for sure that staff members would never confuse one of these substances with an internal or external therapeutic product? Unfortunately, this has happened all too often.

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAIL SAFE or via e-mail at ismpinfo@ismp.org.