Preventing Accidental Infusion Of Breast Milk in Neonates

Matthew Grissinger, RPh, FASCP

As the error rate continues to increase in neonatal and pediatric care, the Institute for Safe Medication Practices (ISMP) is providing updates and reiterating the need for safer systems of care. The ISMP has described a case of inadvertent IV administration of breast milk in a neonate, leading to organ damage and pulmonary edema. The case highlights the importance of preventing such errors through the implementation of safer systems and protocols.

The ISMP emphasizes the need for safer systems of care in neonatal and pediatric units, particularly in regards to the administration of non-parenteral drugs and fluids. Inadequate systems can lead to serious harm and potentially fatal outcomes, as evidenced by the case described in the article.

The ISMP recommends the following measures to prevent such errors:

- Trace the tubing to the point of origin before any connections or reconnections are made.
- Recheck connections and tracing all patient tubes and catheters to their sources upon transfer to a new setting.
- Label tubes and administration sets.

A review of the literature reveals cases of inadvertent IV administration of breast milk reported as early as 1972. As this case demonstrates, this error is still happening despite recognition of the problem more than three decades ago. Ryan et al. reported a similar case and noted that neonatal health professionals communicated eight previously unknown events to the authors after they posted a question about accidental milk infusion to an online e-mail discussion group.

All hospital staff—particularly workers in neonatal units—must take the risk of misconnections seriously and should take steps to eliminate all chances of IV infusion or direct injection of nonsterile, particulate fluids meant for enteral administration. A Joint Commission alert on tubing misconnections provided several excellent recommendations for preventing such tragedies:

- Trace the tubing to the point of origin before any connections or reconnections are made.
- Recheck connections and tracing all patient tubes and catheters to their sources upon transfer to a new setting.
- Label tubes and administration sets.

Although IV administration of breast milk does not happen often, the risk of patient harm is high when it occurs. A remedy is within reach of all health care practitioners: using an anti-IV NG tube and administration set and an oral syringe. At ISMP, we also recommend labeling the pumps as “Medication” or “Breast Milk” as well as labeling the breast milk syringes. This safety feature should become an item on the agenda in all facilities now. The mother of the child mentioned earlier wanted ISMP to advocate for immediate action before another child is injured from this potentially fatal but preventable error.

REFERENCES

3. Joint Commission. Tubing misconnections—a persistent and potentially deadly occurrence. Available at: www.jointcommission.org/SentinelEvents/continued on page 178
continued from page 127


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