

CASE STUDY WITH RISK MANAGEMENT STRATEGIES

Presented by HPSO and CNA

Medical malpractice claims may be asserted against any healthcare provider, including pharmacists. Although there may be a perception that physicians are held responsible for the majority of lawsuits, the reality is that pharmacists are more frequently finding themselves defending the care they provide to patients. This case study involves a pharmacist who worked in a hospital inpatient pharmacy.

Case Study: Alleged dispensing of wrong drug resulting in the premature delivery of a 23 week old fetus with subsequent brain damage

Indemnity Payment: Full policy limits **Legal Expenses:** in excess of \$50,000

Note: There were multiple co-defendants in this claim who are not discussed in this scenario. Monetary amounts represent only the payments made on behalf of the pharmacist. Any amounts paid on behalf of the co-defendants are not available. While there may have been errors/negligent acts on the part of other defendants, the case, comments, and recommendations are limited to the actions of the defendant; the pharmacist.

The patient (plaintiff) was a 23-year old female who was 23 weeks pregnant and had been experiencing slight vaginal bleeding with a suspected inadequate cervix. She was admitted to the inpatient obstetrical unit for observation and bed rest. Her physician ordered a progesterone suppository to stop the bleeding.

The pharmacist (defendant) was feeling ill, had asked to be relieved and was told she could leave. However, it was a very busy day and she decided to wait until the relieving pharmacist came on duty. The relieving pharmacist did not arrive for two more hours and the order for the progesterone suppository was received and handled by the defendant pharmacist before her relief arrived. The defendant pharmacist was unfamiliar with this drug, and it was later confirmed that the Progesterone suppository had not been carried by the hospital pharmacy for many years. She entered what she believed to be the correct

mnemonic (“sig” or speed codes and mnemonics are codes that represent the name and dosage of a drug for rapid entry into the pharmacy computer) for Progesterone into the computerized system and the drug Prostin appeared. The defendant pharmacist did not question the different name and dispensed Prostin suppositories believing it was the same drug.

Tragically, Prostin is a cervical ripening agent which is sometimes used for abortion procedures and which provides the complete opposite clinical effect of the drug that was ordered. The labor and delivery nurse did not identify the error and administered the Prostin suppository. The patient went into active labor and prematurely delivered a 23-week gestation male infant. The baby was severely impaired, required intubation and ventilator support and was transferred to a specialized hospital where he remains and receives total care.

The error was discovered the following day and was disclosed to the parents and to the defendant pharmacist. The defendant pharmacist agreed she should have investigated the ordered drug since she was unfamiliar with it. She further agreed that when entering the drug into the computer she failed to question whether the two drugs were the same and neither researched the drug names nor called the physician to clarify the order. Both the hospital and the involved nurse were named as co-defendants in the subsequent litigation.

Resolution

The incident was reported to the state department of health. The defendant pharmacist was devastated about the injury caused to the patient. She was unable to explain why she had failed to follow facility and pharmacy safety policies and acknowledged her negligence. Due to the infant’s need for lifelong full time care, the full limits of her policy were tendered.

Risk Management Comments

- ◆ While the defendant pharmacist was attempting to avoid errors by staying until her replacement arrived, her illness and the very busy pace of the pharmacy may have been factors in her lack of judgment and the resulting medication dispensing error. Regardless, the defendant pharmacist failed to utilize appropriate pharmacy procedures and safeguards to prevent inadvertent errors.

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Risk Management Recommendations

- Dispensing of any medication involves potential risk, and every possible safeguard should be undertaken to prevent errors.
- Do not dispense any drug with which you are unfamiliar without performing appropriate research.
- Ensure that comprehensive, current drug research is provided within the programming of each pharmacy computer and is automatically updated or is otherwise provided for each pharmacy staff member.
- Once the drug is researched and understood, clarify the patient's clinical history, diagnosis and drug history to ensure the ordered drug is appropriate for the clinical effect desired.
- Follow pharmacy protocols when entering the drug order into the pharmacy computer and use only approved sig codes or mnemonics.
- Consider an override of a computerized warning to be an incident and regularly review all overrides to identify system errors, incomplete formulary, inadequate or improper sig codes, practitioner ordering issues or pharmacist and pharmacy technician competency issues.
- Never assume similar sounding names are equivalents. Sound-alike errors are some of the most frequently made pharmacy errors. All steps should be taken to separate and/or clearly identify and use visible warning labels for sound-alike drugs.
- Contact the prescribing practitioner for any contraindications, potential interactions or ANY other question related to the ordered drug.
- Consult with the supervising pharmacist or pharmacy director, as needed.
- All prescriptions must be checked, preferably by a second pharmacist for additional safety, prior to dispensing. In a single pharmacist setting, the pharmacist must check each prescription against the original order; verify that the proper drug, dosage and quantity are dispensed and that the label, patient instructions and any warnings are correct.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks - A good Risk Management Plan will help you perform these steps quickly and easily!

Visit www.hpso.com/risktemplate to access the Risk Management plan created by HPSO and CNA. We encourage you to use this as a guide to develop your own risk management plan to meet the specific needs of your healthcare practice.



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