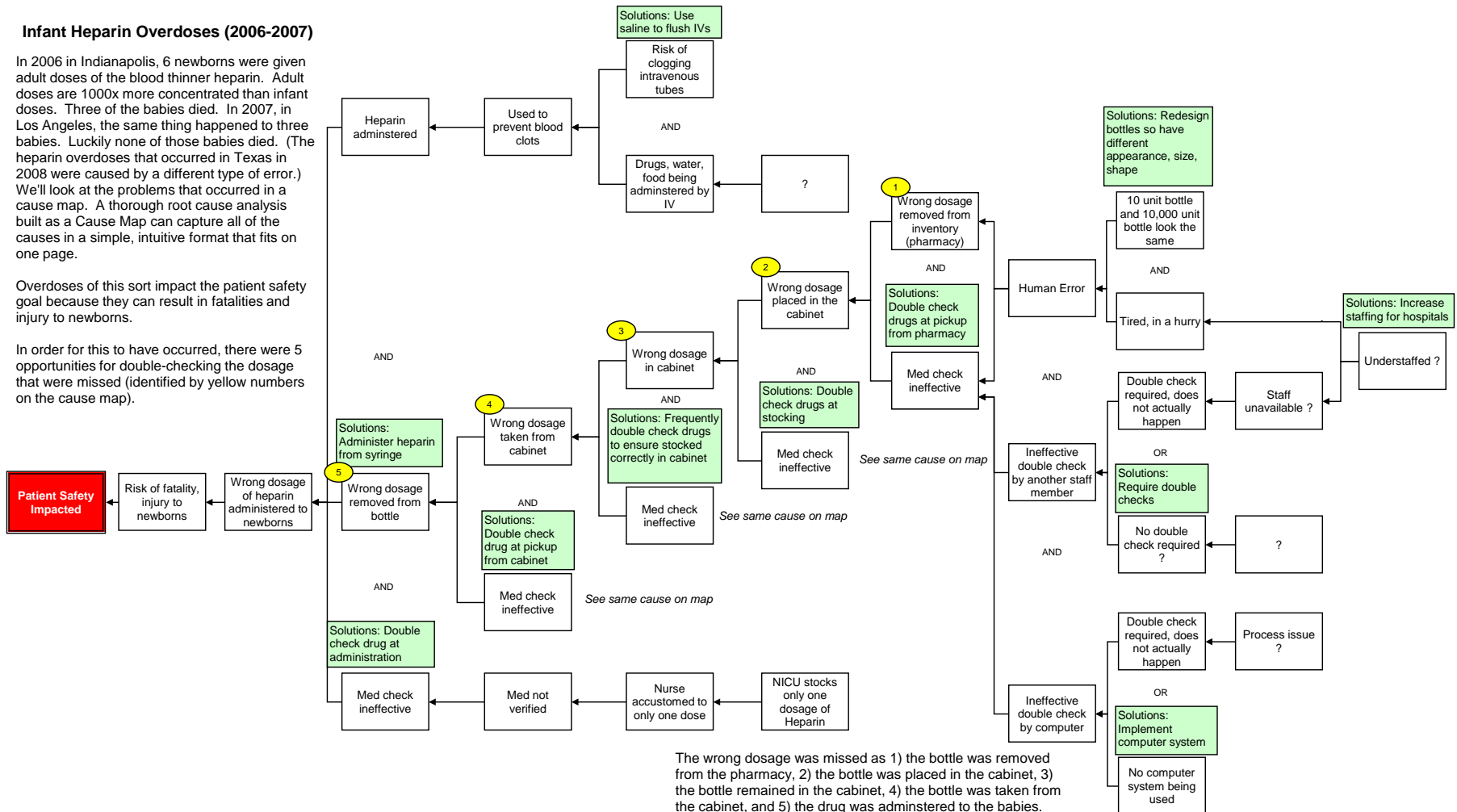


Infant Heparin Overdoses (2006-2007)

In 2006 in Indianapolis, 6 newborns were given adult doses of the blood thinner heparin. Adult doses are 1000x more concentrated than infant doses. Three of the babies died. In 2007, in Los Angeles, the same thing happened to three babies. Luckily none of those babies died. (The heparin overdoses that occurred in Texas in 2008 were caused by a different type of error.) We'll look at the problems that occurred in a cause map. A thorough root cause analysis built as a Cause Map can capture all of the causes in a simple, intuitive format that fits on one page.

Overdoses of this sort impact the patient safety goal because they can result in fatalities and injury to newborns.

In order for this to have occurred, there were 5 opportunities for double-checking the dosage that were missed (identified by yellow numbers on the cause map).



The wrong dosage was missed as 1) the bottle was removed from the pharmacy, 2) the bottle was placed in the cabinet, 3) the bottle remained in the cabinet, 4) the bottle was taken from the cabinet, and 5) the drug was administered to the babies. Some of the reasons that it was missed: there was no effective double check by another staff member, there was no check by a computer and of course due to human error, which was aided by the issue that the adult dosage bottle and the infant dosage bottle looked practically identical (this has since been remedied).

Other solutions to this tragic error are contained in the green boxes. Many are already being implemented at hospitals across the nation.

Cause Map Detail Level



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