

IndyStar.com ★ Weather ★ Jobs ★ Cars ★ Real Estate ★ Apartments ★ Shopping ★ Classifieds ★ Dat

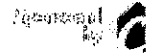
INDYSTAR.COM Indiana's No. 1 local media site

Customer Service

Local News Nation/World Opinion Business Sports Living Entertainment Travel Obituaries

Subscribe Now
and receive a 2007
Entertainment Book

Search:



Advertisement

Have a lot more chance encounters.

Today's top stories

- SWAT surrounds house near 33rd St. and Capitol Ave.
- FOP votes to not endorse sheriff
- West Nile claims 2 Hoosiers
- Baghdad sniper kills Elkhart Marine
- Park contact leads to molest charge
- Area school leaders focusing on safety

Top News stories

- 3 motorcyclists die when hit by car
- Not too raggedy: Riley images headed for Web
- For the record
- LOTTERIES
- Preschoolers gobbling up ads for fatty, sugary foods

IndyStar.com ▶ Metro & State

September 19, 2006

Methodist rolls out medical safeguards

Infants' doses were 1,000 times too strong; pharmacy, nurses must double-check

By **Tammy Webber**
tammy.webber@indystar.com

Methodist Hospital took immediate steps Monday to try to prevent fatal overdoses of an anti-clotting drug to infants, two days after six premature babies accidentally were injected with doses 1,000 times greater than they were supposed to receive.



⊕ zoom
New packaging: Sam Odle, Methodist Hospital president and CEO, shows how heparin vials may be changed so an infant's dose of the anti-clotting agent (right) would be quickly distinguished from an adult's dose (left). - Matt Detrich / The Star

What went wrong

- Methodist receives heparin in identical-sized vials that contain different concentrations of the drug: 10,000 units of heparin per milliliter for adults (above left) or 10 units per milliliter for infants (right).
- Pharmacy technicians place the vials in computerized drug cabinets in various areas of the hospital. Saturday, a technician took the wrong vials from inventory and stocked them in the

Two of the infants died late Saturday, and a third was listed Monday as unstable and in critical condition at Riley Hospital for Children. The other three were stable and showed no signs of harm from the overdoses, said Sam Odle, Methodist president and chief executive officer.

A pharmacy technician with 25 years of experience accidentally delivered vials of heparin in adult concentrations to the neonatal intensive care unit, officials said. The vials look nearly identical to those intended for the neonatal unit, where heparin is used to prevent blood clots in intravenous lines.

Two-day-old Emmery Miller and 5-day-old D'myia Alexander Nelson died late Saturday, likely from internal bleeding, officials said. Odle said no other infants were at risk.

"Our thoughts and prayers continue to be with these children and their families and all those who have been affected by this tragic incident," he said. "It's not surprising there's a lot of anger."

The hospital will continue its investigation and deliver a report — along with an improvement plan — by the end of the week to the Indiana State Department of Health and the national Joint Commission on Accreditation of Healthcare Organizations, Odle said.

Among the changes announced Monday: Adult-strength vials of heparin nearly identical

Adver



Acti Long

Mar Ret

Ret: Carp

Info Infor

Occ Eval

•Vic

Adver



Pay The Che

Dre: Drive

Coa Hug: Lux

•Vic

Adver

neonatal intensive care unit.

- Nurses type in information on the patient and drug they need and the computer unlocks the correct cabinet drawer.
- Neonatal nurses didn't check the concentration on the vials and gave the wrong dose to six infants.

to the infant dose vials no longer will be stocked by Clarian Health Systems hospitals; hospital pharmacies must double-check all drugs taken from stockrooms before delivering them to the floors; and at least two nurses must validate doses before they're given to an infant. In addition, a mass re-education of staff members on safely administering drugs was to be completed by Saturday. Riley and Indiana University Hospital are Clarian hospitals, as well.

Some Indiana hospitals have taken other steps in the past to avoid similar problems.

St. Vincent Hospitals stopped using heparin and now uses saline to keep IV lines open in the neonatal intensive care unit, said Dr. Niceta Bradburn, director of newborn services. St. Francis Hospitals and Health Centers has standardized heparin doses so staff members don't have choices, said Susan Brown, director of pharmacy services at St. Francis Hospitals and Health Centers. Pre-filled syringes come from the manufacturer at set doses for IV flushes as well as to prevent blood clotting.

And this summer, the hospital system began using a bar-coding system. All medications are scanned and must be matched to bracelets worn by patients.

Odle said Clarian also hopes to use bar coding and is "moving in that direction as rapidly as we can."

The employees involved in the overdoses — one pharmacy technician and five nurses — were on leave and receiving support and counseling but were expected to return to work, Odle s

"Whenever something like this happens, it's not an individual responsibility; it's an institutional re "Our system allowed this to happen. What we have to do is learn from this (and) make sure we i this cannot happen again."

Joint Commission spokeswoman Charlene Hill said punishing employees for mistakes — unless would discourage them from reporting errors so that they can be fixed.

"The first reaction (from the public) is that we should fire nurses and discipline doctors. But that v problems, because it's the system that's broken," Hill said.

Indiana in January began requiring hospitals to report 27 types of medical errors to the state Dep the results will be made public in the first quarter of 2007.

In 1999, an Institute of Medicine report estimated that almost 100,000 patients a year die in U.S. preventable errors, though many experts say the number is much higher. The Joint Commission injuries in Indiana hospitals from January 1995 through December 2004, though that number is c commission officials said.

That's why blameless error-reporting is important, Hill said.

"Blame and shame is part of culture in society, so it forces errors underground, and they do not c

**Star reporter Diana Penner contributed to this story.
Call Star reporter Tammy Webber at (317) 444-6212.**

Copyright 2006 IndyStar.com. All rights reserved



Subscribe to The Star and get a free gift

Email this Print this Post a messa

Partners: Jobs: CareerBuilder.com • Cars: Cars.com • Apartments: Apartments.com • Customer Service • Terms of Service • Send feedback about IndyStar.com • Subscribe Now

Use of this site signifies your agreement to the Terms of Service and Privacy Policy, updated June 7,

Copyright 2006 IndyStar.com. All rights reserved