Baum Harmon Mercy Hospital – License #28

Quarterly Waiver Report to the Iowa Board of Pharmacy

In March 2013 the Board of Pharmacy met and granted a waiver for 9.15(2) for a duration of two years. The waiver was granted provided the following: medication package barcode system continuously used and managed only by pharmacists licensed with the board, medication errors occurring at the bedside are reported to the Board and that 10% of the medications loaded independently by technicians are verified by a pharmacist.

Medications refilled or loaded by a technician during the period of time from January 1 to March 31, 2015 resulted in 328 products being filled or loaded into the automated dispensing cabinet (ADC) without pharmacist review prior to placement in the ADC.

Of the 328 products placed into the ADC by a technician without the medications being reviewed by a pharmacist prior to loading, 198 of the 328 (60.4%) medication slots filled independently were eventually pharmacist reviewed within 24 hours of being placed in the ADC.

Anomalies discovered are noted below.

Errors in the ADC:

No errors related to the ADC were noted during January 1 to March 31, 2015.

Medication Errors otherwise reported (as requested by the board):

2/3/2015: Nurse prepared IV antibiotics of azithromycin 500 mg (should have been mixed in 250mL) and ceftriaxone 1 Gm (should have been mixed in 50mL) simultaneously because they were STAT orders. Medications were mixed in the wrong fluid volume. When checking the mixed medications against the MAR on the portable computer in the patient's room, it was discovered prior to administration by this nurse that the volume to be infused was different that it should have been. The medications were discarded down the drain and new medications were mixed and administered properly. The nurse believes this occurred because of the order the medications were removed from Pyxis. The 50 mL bag of fluid was dispensed at the time the azithromycin dispensed and the 250 mL bag of fluid dispensed at the time the ceftriaxone dispensed. Also, nurse was also called away during the preparation time on three separate occasions.

Respectfully submitted on behalf of the Baum Harmon pharmacy,

Susan Roerig, Pharm. D.
Clinical Pharmacy Services & Pharmacy Systems
Mercy Medical Center – Sioux City
Email: roerigs@mercyhealth.com
Phone: 712-279-2799