Patient Safety Alert

Veterans Health Administration Warning System
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Item: **Look-Alike Hemodialysis Solutions**

Specific Incident: A VA medical center reported that the wrong concentration of dialysis solution was used on a hemodialysis patient. The patient should have received **acid** concentrate solution with Ca2.5/K2.0 milliequivalents per liter (mEq/L) and inadvertently received **acid** concentrate solution with Ca0.0/K2.0 milliequivalents per liter (mEq/L). There were no adverse consequences to the patient; however, there is potential for harm if hemodialysis patients receive dialysis solutions with wrong concentrations of electrolytes. A contributing factor in this incident is that the containers and the labels of the two products look very much alike (see photo below).

NOTE: If your facility does not provide hemodialysis care, skip actions 1 and 2, and go directly to action 3.

Actions:

1. By close of Business (COB) September 30, 2011, the **Facility Director (or designee)** will ensure that the Hemodialysis Nurse Manager and Pharmacy Chief are made aware of this Patient Safety Alert and have shared it with their respective staff, **regardless of the brand of concentrate solution used at your facility.**

2. By COB October 14, 2011, the **Hemodialysis Nurse Manager and Pharmacy Chief (or designee)** will identify hemodialysis concentrate solutions, such as Ca0.0/K2.0 solution, that are not routinely used in the hemodialysis unit or other units such as ICUs. Non-routine use solutions are to be removed from the floor stock storage area, and store in a separate, distinct, secure area. These non-routine solutions should be labeled with an appropriate caution tag and only released to the unit/floor for use when an order is written for a specific patient. In other words, treat these less frequently used hemodialysis solutions as you would treat concentrated potassium chloride (KCl) on the units and floors of your facility.

3. By COB October 21, 2011, the **Patient Safety Manager** must document on the VHA Hazard Alerts and Recalls website that facility management has reviewed and implemented these actions or they are not applicable to your facility.

Additional Information: All facilities are strongly encouraged to have CPRS Quick orders in place for dialysis orders. For assistance with setting up Quick orders, technical support can be obtained by contacting the VA Service Desk at (888) 596-4357.

The manufacturer (MINNITECH) has also recently changed the **bicarbonate** solution to a blue label and the dialysis staff at the reporting VA medical center stated that this has decreased confusion between the **bicarbonate** and the **acid** solutions.

If your facility is using a different brand than that shown in the example picture, of this Patient Safety Alert, please ask your supplier to provide labeling that distinguishes less frequently used concentrate solutions from more frequently used concentrations, if appropriate, to minimize the potential for look-alike adverse events or close calls.

Source: A VA medical center

Contact: Bryanne Patail or Keith Trettin, National Center for Patient Safety (NCPS) at (734) 930-5890.