SOUTHWEST ONTARIO REGIONAL BASE HOSPITAL PROGRAM

PARAMEDIC SAFETY PAUSE

COLLABORATIVE CULTURE OF SAFETY

In keeping with a 'Just Culture' approach, the Paramedic Safety Pause enables the sharing of cases that have occurred in our region and strategies that can be utilized to prevent similar variances or errors from occurring. After uncovering system and human factors, these briefs will serve as a summary of recommendations put forth in order to prevent future adverse events or near misses.

EPI IV CASE: A 24 year old male is accidentally exposed to nuts while eating at a restaurant. He has forgotten to bring his Epipen. A call to 911 is initiated after he experiences difficulty breathing, nausea and urticaria.

Upon arrival, he has audible wheezes, is hypotensive and covered in hives. You quickly move the patient to the stretcher where his work of breathing significantly increases and his SpO_2 drops to 88%. You are well aware that this patient's condition is declining rapidly. You recognize that he requires epinephrine 0.5mg in order to treat his anaphylaxis.

As this is transpiring, your partner initiates cardiac monitoring and establishes an IV. You draw up and administer the 0.5mg of epinephrine and transport the patient to the ED. The patient's condition improves slightly. He begins to complain of chest tightness and palpitations as you deliver your report to triage. It is at this time that you realize your error; you administered the 0.5mg of epinephrine IV, rather than IM.

Your heart begins to race as you digest what has just occurred. You disclose the occurrence with the triage nurse, the ED physician and proceed to document and notify SWORBHP.

Shortly thereafter, SWORBHP meets with you and reviews the call, the medical directive and helps you through a simulated case. You return to work and are ever vigilant when administering medications on subsequent calls.

ALWAYS DOUBLE CHECK

The above case highlights a key point to mitigating medication administration errors. Always be sure to perform an independent double check prior to EVERY medication administration. This double check ensures that the right medication, dose and route are confirmed and applicable. Only then, should medication be administered to a patient. The key is that this independent check be performed on EVERY patient, especially the dynamic, fast-paced calls that require quick thinking and quick treatment.

There are numerous potential adverse outcomes to administering an IM dose of epinephrine via IV including tachycardia, myocardial ischemia, arrhythmia, severe hypertension and even cardiac arrest. In cases of anaphylaxis, consider administering the 0.5mg epinephrine IM PRIOR to initiating the IV to avoid the possibility of making the error and always perform a double check with your partner.