MedStar Montgomery Medical Center

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A Medication Error

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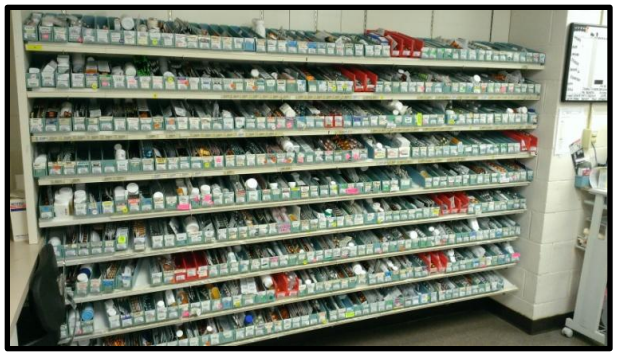
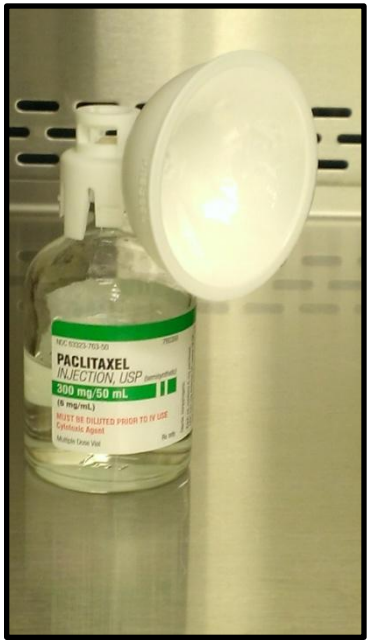
AVP Clinical Excellence

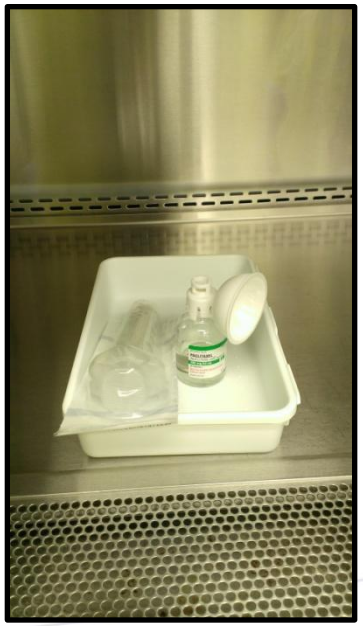
Jane, the oncology pharmacist creates list of chemo drugs to be mixed for the infusion center and distributed around pharmacy each morning.

Jane then called Sue, the chemo tech, and gave a verbal “order” to start mixing the drug.

Sue then primed the tubing for a fluid bag into which chemo would be mixed. She then took the incorrect chemo drug off the shelf and pulled up into a syringe. The syringe, chemo bottle and fluid bag/tubing were in the hood.



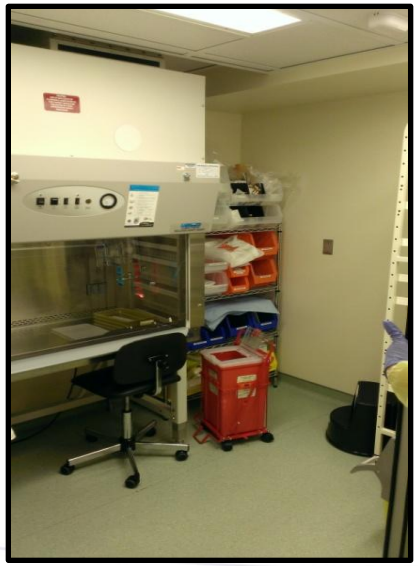


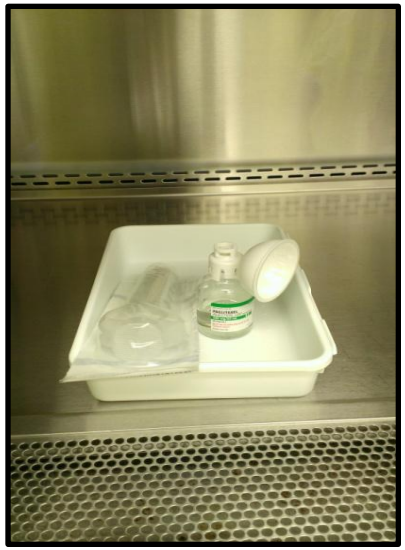


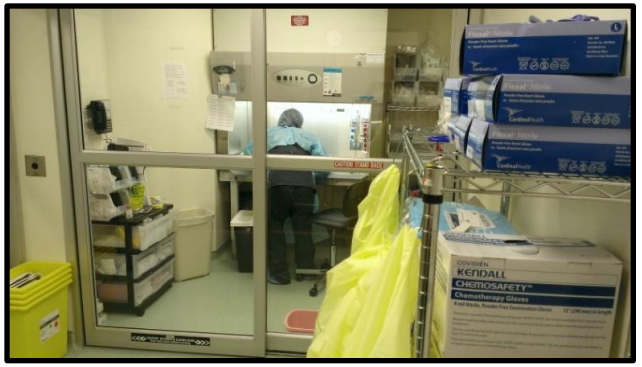
Sally, the checking pharmacist, came into the chemo hood room with the order and was surprised the drug had already been taken off the shelf without the order (which she had in her hand).

Without any verbal clarification with Sue (the technician), Sally then picked up the chemo vial and "checked it" against the order in her hand. She did not pick up that the vial said taxotere but that taxol was ordered. At the time there were no read backs.

Sue, the chemo tech, then proceeded to mix the chemo into the bag with the wrong label and it was delivered to the infusion center where it was infused.







Vivian, the lead pharmacy tech, reviewed the daily usage log to determine which drugs needed to be re-ordered and discovered a mismatch in the drug name and vial size.

Sue (the tech) was unavailable for question, however when Vivian went into the room where chemo is prepared, she discovered a docetaxel (Taxotere) box in the trash.

This was brought to the attention of Sally (the checking pharmacist), who confirmed it was likely that docetaxel (Taxotere) was used, even though the bag was labeled as Paclitaxel (Taxol).

Approx one hour into the infusion, the call was placed to the infusion center but unfortunately, most of the drug had been infused already.