

# Bend Bulletin

## Darned decimal

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A baby in Oregon could have died recently because of a decimal point in the wrong place.

The baby got .6 milligrams of morphine sulfate, a pain killer, rather than the .06 milligrams the doctor ordered. The baby went into respiratory arrest.

Medical staff gave the baby CPR and the drug Narcan to fight the effects of the morphine. The baby recovered.

This kind of medical error is so common as to have a name: “the darned decimal.” Oregon’s Patient Safety Commission has begun to release detailed examinations of specific medical errors to help prevent them. Its first detailed look was at the overdose that the baby got.

The report strips out identifying details. The patient, the medical staff and the institution where the incident occurred are not identified.

In this incident, the baby was born and admitted to a neonatal intensive care unit. Its Apgar Score, which is a test administered after a baby is born, was low. It got a score of 4 at one minute and a score of 6 at five minutes. Anything lower than a score of 7 and a baby usually gets more careful monitoring.

The next day, the doctor ordered placement of a catheter and a dose of .06 milligrams of morphine sulfate before the procedure. The neonatal nurse practitioner was unable to place the line properly and the doctor told her to try again later.

She returned later and told the nurse to give the same dose as before, referring to the morphine sulfate. Based on what she remembered about the dosage the nurse asked: “Point six?”

The nurse practitioner agreed. The first nurse readied .6 milligrams. She did not look at the chart. She asked a third nurse, who verified .6 milligrams.

The dosage was given. They realized their mistake. The baby went into respiratory arrest. They saved the baby. It apparently did not have any lasting effects.

Jim Dameron, the director of the Oregon Patient Safety Commission, said there may have been more going on than a memory lapse. It was almost like multiple rights making a wrong.

First, in a neonatal unit, babies die without swift action. There is an urgency about what they do. There was no pause to check the baby's chart.

Second, there is also a high level of expertise in neonatal units. That expertise, though, does not immunize practitioners from mental lapses.

Third, colleagues in good neonatal units also trust one another. The trust can make it difficult to question a colleague's actions or judgment without insulting them.

Dameron hopes that by publicizing examples medical professionals will be more careful. The reports may also help the public understand why mistakes occur.

The reports are a good step toward preventing medical errors. But we believe hospitals, pharmacies, surgical centers and nursing homes shouldn't be able to decide for themselves if they want to participate in the patient safety commission's work. The Legislature should make participation mandatory. Medical institutions should be required to report their mistakes to the commission, so we can all learn from them.

It shouldn't add to concern about malpractice suits either. The mistake information does not identify individuals or organizations and is not subject to subpoena.

The Oregon Patient Safety Commission's Web site is <http://www.oregon.gov/DHS/ph/pscommission/>.

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