



Safe Use of Oxytocin Project Update

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Background

- Oxytocin is used for various indications during labor and delivery.
- Improper use and administration has led to fetal hypoxia, maternal morbidity and in some cases, maternal, fetal and neonatal deaths.
- Both ISMP Canada and ISMP USA have analyzed errors related to oxytocin and identified opportunities to improve the safe use of this high-alert medication in 2019 and 2020 respectively.
- IMSN Oxytocin Special Interest Group established to further address the safe use of oxytocin globally.

Mandate

1. To share issues and errors on use and administration of oxytocin among members
 - a. Include various types of issues that lead to errors and fetal hypoxia
 - b. Include errors due to mix up with other medications
 - c. Include errors related to delivery devices
 - d. Evaluate errors in the context of indications for use
2. To develop comprehensive and global applicable recommendations including a guidance document on safe use of oxytocin
3. To engage international partners including ISoP, UMC and WHO to facilitate implementation of recommendations

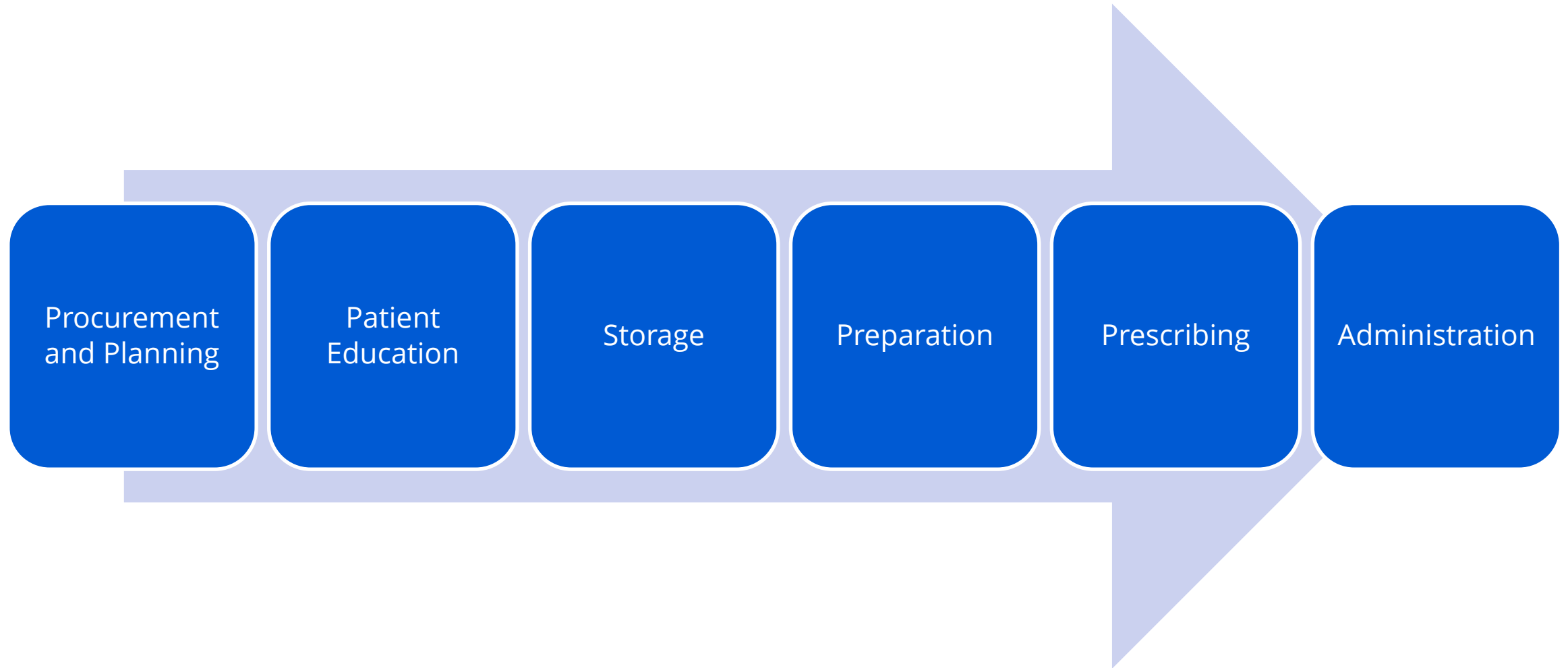
Membership

Country	Individuals
Canada	David U, Dorothy Tscheng, Alice Watt
Health Canada	Sally Pepper, Parag Buch
Colombia	Ismael Basto Benitez
France	Étienne Schmitt
Germany	Günter Emons, Birgit Vogt, Wolfgang Paulus
Ireland	Peter Duddy
ISoP Medication Error SIG	Brian Edwards
Netherlands	Thijs Ambagts
Saudi Arabia	Hind Almodaimegh, Ghadeer Banasser
Singapore	Cynthia Leow, Mohammad Nazri
Qatar	Wessam Elkassem
United Kingdom National Health Service	Donald Peebles, Sascha Wells-Munro, Sharon Murrell
United States ISMP	Mike Cohen, Rita Jew, Michelle Mandrack, Christina Michalek, Tyler Nichols
World Health Organization	Ayako Fukushima, Fumihito Takanashi, Alpana Mair

Themes

- Inappropriate/unnecessary use in labor induction in low-risk patient population
- Lack of standardized dosing regimen
- Confusion with look-alike and sound-alike medications
- Inappropriate use of brand names or unapproved abbreviations
- Non-standardized/centralized preparation of oxytocin infusions
- Use of multiple oxytocin infusion concentrations
- Insufficient monitoring of beyond use dates of pre-prepared solutions
- Manually programmed infusion pumps
- Mix-ups with infusion tubing
- Use/availability of oxytocin in the direct patient care area without appropriate orders

Recommendations - TBD





Questions?
