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www.perinatal.org

Psychiatric Medications Used in Perinatal Populations

Although a broad spectrum of maternal psychiatric conditions may occur in women who are pregnant or postpartum, major depression is likely the most common psychiatric disorder occurring in women of reproductive age. The lifetime prevalence in women may be as high as 21% (1).

Use of psychiatric medications in pregnancy and the postpartum period has become more commonplace and, in some ways, more controversial in recent years. While most medications have not been well-studied for safety in pregnancy (2), a number of studies have been published regarding maternal use of a very frequently prescribed class of medications, the selective serotonin reuptake inhibitors (SSRIs). A few of these studies suggest that there may be very small increased risks for specific birth defects when some of the SSRI medications are used in the

ACOG's Committee emphasizes that decisions about depression treatment should involve the obstetrician and the mental health clinician, along with the patient, ideally prior to pregnancy.

first trimester, although the evidence is not conclusive (3,4). In particular, one SSRI, paroxetine, has been linked in several studies, but not all, to an approximate 2-fold increased risk for congenital heart defects (5,6). Many studies have more consistently demonstrated an increased risk for other adverse outcomes such as a preterm delivery and respiratory or other withdrawal-like complications when mothers take an SSRI medication late in pregnancy near the time of delivery (7,8).

Every pregnant woman has a baseline risk of about 3% of having a baby with a major birth defect. Using an SSRI in pregnancy may introduce a very small increased risk over that baseline for selected birth defects and serious respiratory complications. However, these small risks must be balanced against the very real concern that pregnant women might avoid necessary treatment or be under-treated based on fear of potential harm to the fetus.

Depression and Pregnancy

One recent study has demonstrated that major depression is not likely to subside during pregnancy and postpartum, and that under-treated or untreated women are at high risk of relapsing into depression during pregnancy or following (9). These psychiatric events in and of themselves may be harmful to the mother and baby perhaps leading to poor maternal weight gain or substance use. Therefore, appropriately treating maternal depression is important to the health of the mother and her baby, and in some cases the only effective treatment may involve medication.

The American College of Obstetricians and Gynecologists' (ACOG) Committee on Obstetric Practice advises that the use of SSRIs and selective norepinephrine reuptake inhibitors (SNRIs) for the treatment of depression during pregnancy should be individualized based on their respective risks and benefits, and that paroxetine be avoided, when possible, by pregnant women or women planning to become pregnant.



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ACOG's Committee emphasizes that decisions about depression treatment should involve the obstetrician and the mental health clinician, along with the patient, ideally prior to pregnancy. However, because approximately half of pregnancies in the U.S. are unplanned, preconception planning for women with depression will not always be feasible, and treatment decisions about SSRIs will undoubtedly occur during pregnancy.

Current information on medications and other exposures during pregnancy and breastfeeding can be obtained through the CTIS Pregnancy Risk Line, toll-free for California residents at 1-800-532-3749.

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EDITOR'S NOTE

The American College of Obstetrics and Gynecology published the ACOG Practice Bulletin, Number 92: Clinical Management Guidelines for Obstetricians - Gynecologists: Use of Psychiatric Medications During Pregnancy and Lactation on April 4, 2008. OB-GYN Vol 111, No 4, April, 2008, 1001-1020.

National Center for Health Statistics

Releases National Births Data for 2006

The following statistics are featured in a new report, "Births: Preliminary Data for 2006," prepared by CDC's National Center for Health Statistics. The full preliminary report can be obtained at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_07.pdf

- The preliminary estimate of total births in the U.S. for 2006 was 4,265,996, a 3% increase or 127,647 more births than in 2005.
- Between 2005 and 2006, the birth rate for teenagers 15-19 years rose 3%, from 40.5 live births per 1,000 females aged 15-19 years in 2005 to 41.9 births per 1,000 in 2006. This follows a 14-year downward trend in which the teen birth rate fell by 34% from its peak of 61.8 births per 1,000 in 1991.
- Birth rates increased for women in their twenties, thirties and early forties between 2005 and 2006, as well as for teenagers.
- The study revealed that the percentage of all U.S. births to unmarried mothers increased to 38.5%, up from 36.9% in 2005.
- The cesarean delivery rate rose again in 2006, to 31.1% of all births, a 3% increase from 2005 and a new record high. The percentage of all births delivered by cesarean has climbed 50% over the last decade.
- The preterm birth rate rose slightly between 2005 and 2006, from 12.7% to 12.8% of all births. The percentage of births delivered before 37 weeks of gestation has risen 21 percent since 1990.
- The low birthweight rate also rose slightly in 2006, from 8.2% in 2005 to 8.3% in 2006, a 19% jump since 1990.

Study Reveals Factors That Influence Premature Infant Survival

Based on observations of more than 4,000 infants, researchers in the National Institutes of Health (NIH) newborn research network have identified several factors that influence an extremely low birth weight infant's chances for survival and disability. The findings offer new information to physicians and families considering the most appropriate treatment options for this category of infants.

Every day, physicians and new parents must struggle with the type of care to provide to extremely low birth weight infants, the smallest, most frail category of preterm infants. These infants are born in the 22nd through the 25th week of pregnancy. Many die soon after birth, despite the best attempts to save them, including the most sophisticated newborn intensive care available. Some survive and reach adulthood, relatively unaffected. The rest will experience some degree of life long disability, ranging from minor hearing loss to blindness, to cerebral palsy, to profound intellectual disability.

Controversy exists about the best course of treatment for extremely premature infants. For example, physicians and family members may be reluctant to expose an infant to painful life support procedures if the infant is unlikely to survive. In such cases, they may opt for "comfort care," which provides for an infant's basic needs, but foregoes painful medical procedures. In deciding the kind of care to provide, specialists at intensive care facilities traditionally have relied heavily on an infant's gestational age—the week of pregnancy a premature infant is born. Gestational age is known to play a large role in the infant's survival. For this reason, in many facilities, intensive care is likely to be routinely given to infants born in the 25th week of pregnancy, whereas infants born in the 22nd week may be more likely to receive comfort care. The study authors noted, however, that it is often difficult to assess gestational age. Moreover, an estimate that is inaccurate by only a week could result in an infant receiving care that was not appropriate for his or her individual case.

To identify other factors that influenced survival and disability risk, the study authors observed 4,446 extremely low birth weight infants, born between 22 and 25 weeks gestation, born at level III neonatal intensive care facilities in their network. Using standardized measures of mental development, vision, and hearing, the researchers assessed the health status of surviving infants when the infants were from 18 to 22 months corrected age. At that time 49% had died, 21% lived and did not have disability and the remainder experienced some degree of disability. The researchers published their findings in the April 17, 2008 *New England Journal of Medicine*.

In addition to gestational age, factors influencing survival and risk of disability consisted of: whether the baby is male or female (sex); birth-weight; whether the baby was a single baby, or one of two or more infants born; and whether the baby's mother was given antenatal steroids during pregnancy to prompt the development of the baby's lungs. After conducting mathematical analyses of all the infants' cases, the researchers determined that infants were more likely to survive—and more likely to survive without disability—if they were of older gestational age, their mothers had been given corticosteroids, if they were female, were single born rather than part of a multiple birth, and been of a higher birthweight.

Physicians and parents may access an online tool that generates statistics, based on the factors the researchers listed in their article, at http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/.

By specifying the baby's sex, weight, and information related to each of the variables listed below, physicians and family members can generate composite statistics on infant outcomes, based on the experiences of extremely low birthweight infants in the NICHD Neonatal Research Network study.

The Web tool is not a substitute for a physician's careful assessment, but physicians and families may find the statistics it generates useful when considering the most appropriate care to provide an infant. However, the researchers' findings, and the tool they developed, provide important information that physicians and family members can consult to help them make the most informed treatment decisions possible.

NICHD Neonatal Research Network (NRN):Extremely Preterm Birth Outcome Data

Can I use the data to determine individual outcomes?

These data are not intended to be predictive of individual infant outcomes. Instead, the data provide a range of possible outcomes based on specific characteristics.

If you choose to use these data to determine possible outcomes, please remember that the information provided is not intended to be the sole basis for care decisions, nor is it intended to be a definitive prediction of outcomes if intensive care is provided. Users should keep in mind that every infant is an individual, and that factors beyond those used to formulate these standardized assessments may influence an infant's outcomes.

Enter the characteristics below.

Gestational Age (Best Obstetric Estimate in Completed Weeks):

Birth Weight (401 Grams to 1,000 Grams): grams

Sex: Female Male

Singleton Birth: Yes No

Antenatal Corticosteroids (Within Seven Days Before Delivery): Yes No

Based on the following characteristics:

Gestational Age (Best Obstetric Estimate in Completed Weeks): 24 weeks
 Birth Weight: 500 grams
 Sex: Female
 Singleton Birth: Yes
 Antenatal Corticosteroids: Yes

Estimated outcomes* for infants in the NRN sample are as follows:

Outcomes	Outcomes for All Infants	Outcomes for Mechanically Ventilated Infants
Survival	45%	50%
Survival Without Profound Neurodevelopmental Impairment	33%	37%
Survival Without Moderate to Severe Neurodevelopmental Impairment	22%	24%
Death	55%	50%
Death or Profound Neurodevelopmental Impairment	67%	63%
Death or Moderate to Severe Neurodevelopmental Impairment	78%	76%

Hypoxic-Ischemic Encephalopathy & Therapeutic Hypothermia

Hypoxic Ischemic Encephalopathy (HIE) is a complex trajectory of pathophysiological events occurring in the perinatal period and is considered to be the most common cause of neurological deficits in children.^{1,2} The impact of hypoxia and ischemia from altered placental blood flow and gas exchange results in an asphyxial insult due to decreased oxygen and nutrient delivery secondary to impaired fetal cerebral blood flow. Oxygen deprivation initiates a cascade of biochemical changes associated with anaerobic metabolism in the brain and includes depletion of phosphate, loss of cell membrane function, accumulation of lactic acid, calcium, free radicals, and neurotransmitters including glutamate and eventual loss of cell function or acute cell death.^{2,3} Multiple factors, which may not be preventable, impact the progression and extent of cellular necrosis and death and include the nature, duration, and severity of the intrauterine insult.

Alleviation of the intrauterine insult and/or resuscitation of the newborn may facilitate improved cerebral reperfusion and oxygenation. However, within 6 to 48 hours of this recovery phase, the fetus or newborn is at risk for a secondary or latent phase of brain injury associated with a series of interrelated factors causing cell injury and death due to mitochondrial damage from toxic exposures to calcium, free radicals, nitric oxide, iron, and inflammatory mediators.^{2,4} This secondary injury precipitates a process called apoptosis that is characterized by further cell damage and cell death in the brain occurring over days to potentially weeks after the hypoxic ischemic insult and is associated with adverse neurodevelopmental outcomes.^{3,5} As with the initial intrauterine insult, there are multiple factors that may impact the extent of this recovery or latent phase of injury including the severity of the initial insult, the degree of brain maturation, and the newborn's health status. Therapeutic goals for infants who experience hypoxic-ischemic

insults include identifying newborns at risk for this latent phase of injury, supporting perfusion and nutrient delivery to the brain, and incorporation of interventions to limit the potential of ongoing brain injury.²

Hypothermia is considered to be a neuroprotective intervention in limiting the potential for ongoing brain injury in newborns with HIE.^{1,9} Three large randomized-controlled trials documented that this therapeutic intervention improved survival and neurodevelopmental outcomes in newborns with HIE.⁶⁻⁸ In addition, a recent Cochrane Review⁹ that reflected eight randomized controlled trials incorporating therapeutic hypothermia for a total of 638 term infants with moderate/severe encephalopathy and documentation of intrapartum asphyxia, determined that use of therapeutic hypothermia resulted in reduced mortality without increased major neurodevelopmental disability in infants to 18 months of age.



Infant with CoolCap

The exact neuroprotective mechanisms associated with hypothermia have not been determined but lowering the temperature of key brain structures such as the basal ganglia to 32-34 degrees celsius is likely to decrease the risk of the biochemical and cellular responses that occur in the secondary or latent phase of brain injury.⁹ Two different modes of therapeutic hypothermia with selective head cooling or whole body cooling have been used in the clinical trials to determine the potential neuroprotectiveness of hypothermia.¹⁻⁹ The protocol developed by the National Institute of Child Health and Human Development (NICHD) for total body cooling with the Blanketrol[®] device is available on the Internet at https://neonatal.rti.org/studies_hypothermia.cfm but this system is not FDA-approved for use with infants with HIE.³ Head cooling can be accomplished through the use of the Olympic Cool Cap[®], an FDA-approved system for hypothermia management in infants with HIE.¹⁰ The newborn receiving therapeutic hypothermia is at risk for numerous adverse events including: decreased cardiac output, hypotension, arrhyth-

mias, hyperviscosity, platelet dysfunction, diuresis, pulmonary hypertension, impaired leukocyte function, metabolic acidosis, hyperglycemia, and hypokalemia.

There is no definitive evidence that either strategy for therapeutic hypothermia is superior and it is strongly recommended that this therapy should only be implemented with established protocols for this intervention.^{3, 10} The Neurointensive Care Nursery (NICN) at the University of California, San Francisco has established protocols for determining the eligibility of newborns to receive therapeutic hypothermia with the use of the Olympic Cool Cap[®] system. This NICN has also developed management guidelines for out-born infants eligible for this head cooling. The eligibility criteria for therapeutic hypothermia include:

1. ≥ 36 weeks gestation
2. Prolonged resuscitation at birth (one or more of the following)
 - Low Apgar Scores: < 5 at 10 minutes
 - Severe acidosis: pH < 7.0
 - Base excess < -12 mmol/L
3. Moderate to severe encephalopathy (one or more of the following)
 - Lethargy
 - Stupor or coma
 - Hypotonia
 - Abnormal reflexes, including oculomotor or papillary abnormalities
 - Absent or weak suck
 - Clinical seizures
 - Hyperalert state
 - Abnormal amplitude EEG (aEEG) background and/or seizures

In summary, newborns experiencing HIE are at risk from a primary injury to the brain associated with the intrauterine insult and also to a secondary or latent injury during the recovery or reperfusion interval. Therapeutic hypothermia may be one strategy that can decrease the risk of this secondary injury.

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HIE & Hypothermia (Continued from Page 4)

Submitted by Mary Lynch, Suzanne Cervantes, Susan

Peloquin: North Coast Perinatal Access System, Region 1

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Birth Certificates Matter

As everyone knows, California's birth population continues to grow. The State of California alone experiences more annual births than many countries of the world. All those births must be registered and that registration should be carried out as correctly as possible the very first time. All birth clerks must make sure that parents review and sign the birth certificate. The birth clerk should only sign as a last resort. Errors on a birth certificate are problematic for everyone and can take as long as a year to correct. Some corrections may require a court order. Parents must be instructed to realize the importance of the accuracy of this document before they place their signature on it.

For the vast majority of parents, naming a new baby has been decided long before birth. Some parents wish to wait until they actually see their child before giving the name. There also may be some cultural traditions around name giving for some families. It is critical that parents be informed that the child be named by the time the birth certificate is completed. If no name is chosen, birth clerks can be instructed to leave dash lines and submit the document without a name. Without a name, the child cannot receive benefits, be issued a social security card or apply for a passport. Adding the name requires an amendment. According to Karen J. Roth, Chief, Policy, Compliance and Standards Section, Office of Vital Records, for the California Department of Public Health, the amendment process can take up to one year. An amendment to a child's birth certificate will also make it a two-page document, which will follow the child the rest of his or her life.

Submitted by Kathy Bird, RN

Inland Counties Regional Perinatal Program, Region 7



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Preventing Pediatric Medication Errors

The Joint Commission released sentinel event alert #39 on April 11, 2008 regarding the prevention of pediatric medication errors. In the alert, the Joint Commission reported that errors associated with medications are believed to be the most common type of medical error and are a significant cause of preventable adverse events. Experts agree that medication errors have the potential to cause harm within the pediatric population at a higher rate than in the adult population. For example, medication dosing errors are more common in pediatrics than adults because of weight-based dosing calculations, fractional dosing (e.g., mg vs. Gm), and the need for decimal points.

Children are more prone to medication errors and resulting harm because of the following:

- Most medications used in the care of children are formulated and packaged primarily for adults. Therefore, medications often must be prepared in different volumes or concentrations within the health care setting before being administered to children. The need to alter the original medication dosage requires a series of pediatric-specific calculations and tasks, each significantly increasing the possibility of error.
- Most health care settings are primarily built around the needs of adults. Many settings lack trained staff oriented to pediatric care, pediatric care protocols and safeguards, and/or up-to-date and easily accessible pediatric reference materials, especially with regard to medications.
- Emergency departments may be particularly risk-prone environments for children.
- Children—especially young, small and sick children—are usually less able to physiologically tolerate a medication error due to still developing renal, immune and hepatic functions.
- Many children, especially very young children, cannot communicate

Recommended Risk Reduction Strategies

Below is a partial list of recommendations cited in the sentinel alert. For a complete

list of recommendations please visit the Joint Commission Sentinel Alert website at

http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm

Standardize and identify medications effectively, as well as the processes for drug administration.

- Establish and maintain a functional pediatric formulary system with policies for drug evaluation, selection and therapeutic use.
- Limit the number of concentrations and dose strengths of high alert medications to the minimum needed to provide safe care.
- Use oral syringes to administer oral medications. The pharmacy should use oral syringes when preparing oral liquid medications. Make oral syringes available on patient care units when “as needed” medications are prepared.

Ensure full pharmacy oversight—as well as the involvement of other appropriate staff—in the verifying, dispensing and administering of both neonatal and pediatric medications.

- Assign a practitioner trained in pediatrics to any committee that is responsible for the oversight of medication management.
- Provide ready access, including website access, to up-to-date pediatric-specific information for all hospital staff.
- Orient all pharmacy staff to specialized neonatal/pediatric pharmacy services in your organization.
- Provide a dosage calculation sheet for each pediatric critical care patient, including both emergency and commonly used medications.
- Develop preprinted medication order forms and clinical pathways or protocols to reflect a standardized approach to care. Include reminders and information about monitoring parameters.
- Create pediatric satellite pharmacies or assign pharmacists and technicians with pediatric expertise to areas or services such

as neonatal/pediatric critical care units and pediatric oncology units. At a minimum, pediatric medications should be stored and prepared in areas separate from those where adult medications are stored and prepared.

Use technology judiciously.

- Use methods to ensure the accuracy of technology that measures and delivers additives for intravenous solutions, such as for total parenteral nutrition.
- If dose and dose range checking software programs are available in hospital or pharmacy information systems, enable them to provide alerts for potentially incorrect doses.
- Medications in automated dispensing cabinets that do not undergo appropriate pharmacist review should be limited to those needed for emergency use and/or to those medications under the control of a licensed independent prescriber.
- Recognize that the use of infusion pumps, or smart pumps, is not a guarantee against medication errors.
- To prevent adverse outcomes or oversedation, use consistent physiological monitoring – particularly pulse oximetry – while children are under sedation during office-based procedures. Use age and size appropriate monitoring equipment and follow uniform procedures under the guidance of staff appropriately trained in sedation, monitoring and resuscitation.
- Providers are encouraged to develop bar-coding technology with pediatric capability.

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Preventing Pediatric Medication Errors (continued from page 6)

Official "Do Not Use" List ¹		
Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO ₄ and MgSO ₄	Confused for one another	

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Existing Joint Commission requirements

As part of National Patient Safety Goal 2B, Joint Commission accredited organizations are required to follow The Joint Commission's Official "Do Not Use" Abbreviations List.

In addition, Goal 3 (Improve the safety of using medications) and Goal 8 (Accurately and completely reconcile medications across the continuum of care) establish several medication standardization, identification and communication requirements that are especially important in pediatrics and neonatology. Three Sentinel Event Alerts also address specific issues relating to pediatric medication errors, Alerts 34 (Preventing Vincristine Administration Errors), 35 (Using Medication Reconciliation to Prevent Errors), and 36 (Tubing Misconnections – a persistent and potentially deadly occurrence).

Other Joint Commission Suggested Actions

The Joint Commission offered the following suggested actions to prevent pediatric medication errors and their related adverse events in pediatric care settings:

1. Since patient weight is used to calculate most dosing (either as weight-based dosing, body surface area calculation, or other age-appropriate dose determination), all pediatric patients should be weighed in kilograms at the time of admission (including outpatient and ambulatory clinics) or within four

hours of admission in an emergency situation. Kilograms should be the standard nomenclature for weight on prescriptions, medical records and staff communications.

2. No high risk drug should be dispensed or administered if the pediatric patient has not been weighed, unless it is an emergency.

3. On inpatient medication orders and outpatient prescriptions, require prescribers to include the calculated dose and the dosing

determination, such as the dose per weight (e.g., milligrams per kilogram) or body surface area, to facilitate an independent double-check of the calculation by a pharmacist, nurse or both.

Exceptions to this are medications that do not lend themselves to weight-based dosing, such as topicals, and ophthalmics.

4. Whenever possible, use commercially available pediatric-specific formulations and concentrations. When this is not possible, prepare and dispense all pediatric medications in patient-specific "unit dose" or "unit of use" containers, rather than in commercially available adult unit doses. For oral liquid preparation medications, use oral syringes to ensure correct dosage.

5. Clearly differentiate from adult formulations all products that have been repackaged for use in pediatric populations. Use clear, highly visible warning labels. To prevent overdoses, keep concentrated adult medications away from pediatric care units. Avoid storing adult and pediatric concentrations in the same automated dispensing machine/cabinet drawer.

6. Ensure comprehensive specialty training for all practitioners involved in the care of infants and children, as well as continuing education programs on pediatric medications for all health care providers. Training and education should include information on how adverse effects should be reported.

7. Communicate verbally and in writing information about the child's medication to the child,

caregivers and parents/guardians, including information about potential side effects. Ask the caregiver/parent/guardian to repeat back their understanding of the drug and how it is to be administered. Encourage the asking of questions about medications.

8. Have a pharmacist with pediatric expertise available or on-call at all times.

9. Establish and implement medication procedures that include pediatric prescribing and administration practices.

Should a serious error or adverse event occur, the Joint Commission recommends that the organization conduct a root cause analysis and develop and implement a corrective action plan which should be monitored to assure that it is effective. The Joint Commission also encourages apology and transparency about the error with both staff and the families involved.

The Joint Commission also encourages pharmaceutical manufacturers to develop pediatric-specific formulations as well as the standardization of labeling and packaging for all types of medications. Researchers are encouraged to conduct additional research on interventions to reduce pediatric medication errors, especially in emergency departments, ambulatory clinics and home environments.

In conclusion, since parents and caregivers play an extremely important role in the health care of children, The Joint Commission encourages parents and caregivers to seek out information and ask questions about their child's medications and to repeat back instructions to clinicians in order to ensure understanding about the drug, dosages, timing and routes of administration. This is done both to reassure staff that parents or caregivers have a true understanding of the medications the child is taking and, most importantly, to ensure that everyone involved can safely administer medications to this most vulnerable population.

Article excerpted from **The Joint Commission Sentinel Event Alert #39**. Full text can be obtained at

http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm

California Public Policy

ASSEMBLY INITIATIVES

AB 30: Evans - Inborn Errors of Metabolism

This bill would require health plans to cover the cost of treatment, including formula and food, for children with metabolic disorders. Coverage is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet.

AB1962 De La Torre—Maternity Services

Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health insurer that provides maternity coverage may not restrict inpatient hospital benefits, as specified, and is required to provide notice of the maternity services coverage. This bill would require specified health insurance policies to provide coverage for maternity services, as defined.

AB 2129: Beall - Maternal Health: Alcohol and Substance Abuse

This bill would require the State Department of Public Health to develop, coordinate, and oversee the implementation of a model program for the universal screening, assessment, referral, and treatment of pregnant women and women of childbearing age who are suffering from drug and alcohol abuse.

AB2262: Torrico—Child Protection: Safe Surrender

This bill appropriates funds from the General Fund to the State Department of Social Services to conduct a statewide awareness campaign publicizing the existence of the Child Protection Safe Surrender Program and to establish a toll-free telephone number for the purpose of providing education and assistance to the public regarding the program.

AB 2599: De Leon—Birth Defects Monitoring Program

This bill makes technical, non-substantive changes to existing law that relates to the activities of the Birth Defects Monitoring Program.

AB 2726: Leno – Healthy Food Purchase Pilot Program

Existing law, until January 1, 2011, requires that the State Department of Public Health to develop a “Healthy Food Purchase” pilot program to increase the sale and purchase of fresh fruits and vegetables in low-income communities. This bill would extend the program to January 1, 2012. It would also expand the variety of funding sources to allow more fresh fruits and vegetables to get to inner city grocery stores and to give food stamp participants rebates on purchases of fruits and vegetables.

AB 2898: Mullin – Coroners

This bill relates to situations where the suspected cause of death is sudden infant death syndrome. It authorizes the coroner to retain only those parts of the body as may be necessary or advisable to the inquiry into the case, or for the verification of his or her findings.

SENATE INITIATIVES

SB 164: Migden – Prenatal Screening

Changes the name of the Birth Defects Monitoring Program. Requires the Department of Public Health to charge investigators who are approved by the department to use pregnancy blood for research purposes, a fee for costs related to data linkage, storage, retrieval, processing, data entry, reinventory, and shipping of newborn blood samples or their components, and related data management. Protects identifying information. Requires billing of specified entities to cover the costs of confidentiality protection.

SB 840: Keuhl - Single-Payer Health Care Coverage

This bill would establish the California Healthcare System and make all California residents, including those who travel out of state, eligible for specified health care benefits. The California Healthcare System would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would create the Office of Health Planning and the Office of Health Care Quality to support the delivery of high quality care and promote provider and patient satisfaction.

SB 179: Ashburn – CalWORKS Reporting Requirements

Current law requires the county to implement a recipient monthly reporting system where the county would redetermine recipient eligibility and grant amounts on a quarterly system. This bill would repeal the requirements relating to quarterly redetermination and prospective determination grant amounts, and would impose similar requirements for a semiannual redetermination, to take effect January 1, 2009.

SB 825: Padilla – Public Health: Shaken Baby Syndrome

This bill establishes the Shaken Baby Syndrome Education Program. It requires the Department of Health Services to select eligible counties which are designed to provide new parents and other adult caregivers of newborns and young infants with information and education relating to the prevention of shaken baby syndrome. It requires a report on the effectiveness of the program in reducing the number of injuries and infant deaths resulting in shaken baby syndrome. This bill provides that the funding will be from the Children's Trust Fund.

SB 1661: Kuehl – Unemployment Compensation: Family Leave

This bill relates to the family temporary disability insurance program for workers who take time off work to care for a seriously ill family member, defined, or to bond with a new child. This bill provides that an individual shall be deemed to have left his or her most recent work with good cause if individual's employment terminated as a result of the individual's taking a qualifying leave under the family temporary disability insurance program.

