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Pharmacy Technician's Letter
Hospital

Stop Tranexamic Acid Errors in Their Tracks

There'll be renewed emphasis on **preventing tranexamic acid wrong-route errors**.

It's a new focus in ISMP's 2024-2025 *Targeted Medication Safety Best Practices for Hospitals*...due to the risk for mix-ups between vials of tranexamic acid and local anesthetics (bupivacaine, etc).

This has led to accidental intrathecal administration of tranexamic acid...which leads to seizures and is fatal in around 50% of cases. Patients who survive usually have permanent, serious neurological damage.

Take steps to stop tranexamic acid errors in their tracks.

Help prevent product-selection errors involving tranexamic acid and other meds. Scan barcodes, notify your admin or med safety officer about similar looking vials, etc.

And store vials so labels can be seen...not just caps. Tranexamic acid vials may have the same color caps as local anesthetics...or paralyzing agents (rocuronium, etc).

Separate anesthesia and non-anesthesia meds...and keep tranexamic acid vials OUT of anesthesia trays to avoid vial mix-ups.

Instead, dispense tranexamic acid preps...or 1 g premixes...for L&D, operating rooms, and peri-op if possible.

These areas tend to lag behind with implementation of barcode scanning...increasing the risk of product-selection errors.

Follow pharmacy policies to help prevent wrong-route errors with tranexamic acid preps for non-IV routes...such as by placing "For irrigation" labels on tranexamic acid irrigations.

And if you dispense tranexamic acid vials for nebulized or topical administration, use auxiliary labels to highlight the route.

Don't use the abbreviation "TXA" for tranexamic acid. It's easily confused with other error-prone abbreviations for the clot busters tenecteplase ("TNK") and alteplase ("tPA").

Clarify which med is needed if a colleague uses any of these abbreviations...to avoid misunderstandings.

Learn more ways to prevent errors with meds that are commonly used in operating rooms with our resource, *Inpatient Emergencies*.

Key References:

-ISMP. Targeted Medication Safety Best Practices for Hospitals. February 21, 2024. https://www.ismp.org/guidelines/best-practices-hospitals (Accessed March 13, 2024).
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-Moran NF, Bishop DG, Fawcus S, et al. Tranexamic acid at cesarean delivery: drug-error deaths. BJOG. 2023 Jan;130(1):114-117.
-Patel S. Accidental infusion of tranexamic acid via a thoracic epidural catheter. Can J Anaesth. 2023 May;70(5):915-916.

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