

*Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.*

## ***Patient Safety Learning Advisory***

### ***Medication Adverse Event***

#### **Summary:**

A patient receiving palliative care was found to have an elevated serum potassium level of 6.5 mmol/L (normal value 3.5 – 5 mmol/L). The physician ordered a dose of Kayexalate to lower the serum potassium level. Instead the patient received a dose of Potassium Chloride which increases the serum potassium in the blood.

The medication adverse event was discovered a few hours later. At that time, the patient received the intended dose of Kayexalate.

The following day, the patient passed away. It is unknown whether the medication adverse event hastened the patient's demise as no further laboratory testing was performed following the administration of the Potassium Chloride.

**Keywords: Potassium Chloride, Kayexalate**

This review is based on a single event.

**Findings of the Review:**

Both medications sound alike (Kayexalate/K-Lyte) and are readily available on the medication cart as ward stock.

The order for Kayexalate (trade/brand name) was written as K-exalate 15 meq instead of sodium polystyrene sulfonate (generic/common name) 15 grams, which may have increased the likelihood that the medication was interpreted as K-Lyte.

**System Learning:**

Utilize and audit the Medication Order Writing/Transcribing Standards practice at the site.

Report the event to the Institute for Safe Medication Practices (ISMP) Canada to share learning with respect to sound alike names and the potential for adverse medication events.

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