

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.

Help prevent product-selection errors involving tranexamic acid and other meds.

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

And consider adding "Contains tranexamic acid" labels over vial caps...to further differentiate it from other meds.

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 tenecteplase ("TNK") and alteplase ("tPA").

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).

-ISMP. Worth repeating...Tranexamic acid wrong route errors continue. August 24, 2023.

<https://www.ismp.org/acute-care/medication-safety-alert-august-24-2023> (Accessed March 13, 2024).

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-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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