

SAFETY WATCH TOPIC

## Take Action. EXPRESSED BREAST MILK

## MIX UPS ARE OCCURRING MORE THAN YOU MIGHT THINK...

The Center for Patient Safety (CPS) is issuing a PSO Watch to raise awareness about the effects of providing expressed breast milk to the wrong infant, otherwise called "mixing up" breast milk. ECRI Institute recently published a newsletter article and referenced a significant number of events which involved the use of "mixed up" breast milk. CPS has also received a number of similar reports.

As with the administration of any body fluid, including breast milk, there is an inherent risk of transmitting infectious disease. Also, in these cases, the potentional exists for increasing the stress of the family and infant.

## **CAUSAL FACTORS**

Some factors that have been identified as having caused these mix ups are:

- Mislabeling
- Faulty verification process
- Storage management issues
- Dispensing/Administering process

## **RESOURCES TO TAKE ACTION**

Suggestions to prevent a mix up of expressed breast milk at your organization include implementing systems to ensure accurate identification. A number of best practices and sample policies to ensure such systems are in place are available from the Pennsylvania Patient Safety Authority.

 Mismanagement of Expressed Breast Milk - PA PSRS Patient Saf Advisory 2007 Jun;4(2):46-50. - http://patientsafetyauthority.org/ADVISORIES/ AdvisoryLibrary/2007/jun4(2)/Pages/46.aspx

In addition, the CDC has recommended steps to take if an incident of mixed up breast milk does occur:

 What to Do if an Infant or Child Is Mistakenly Fed Another Woman's Expressed Breast Milk - http://www.cdc.gov/breastfeeding/ recommendations/other mothers milk.htm

For continued sharing and learning, continue reporting adverse events, near misses and unsafe conditions to CPS as your Patient Safety Organization.

