PSNet
PATIENT SAFETY NETWORK

Please don't sleep through this wake-up call.

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This is an alert from the Institute for Safe Medication Practices informing readers of a fatal medication error that occurred because of a misinterpreted decimal point. The error involved administration of morphine to a 9-month-old infant who received 5 mg instead of 0.5 mg of the drug. The order did not include a zero before the decimal point, and the nurse filling the order overlooked the omission. The child suffered a cardiac arrest and died. The case illustrates the importance of clearly communicating information about medications.