When Mistakes Matter
Strategies for Enhancing Medication Safety and Managing Risk

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Copic Patient Safety & Risk Manager

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Learning Objectives

Identify and analyze	Identify and analyze common causes of medication errors.
Explore	Explore potential suggestions and solutions to reduce medication errors.
Awareness	Become aware of trends in claims and occurrences.

What Is A Medication Error?

The FDA defines a medication errors as “any preventable event that may cause or lead to inappropriate use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer.”

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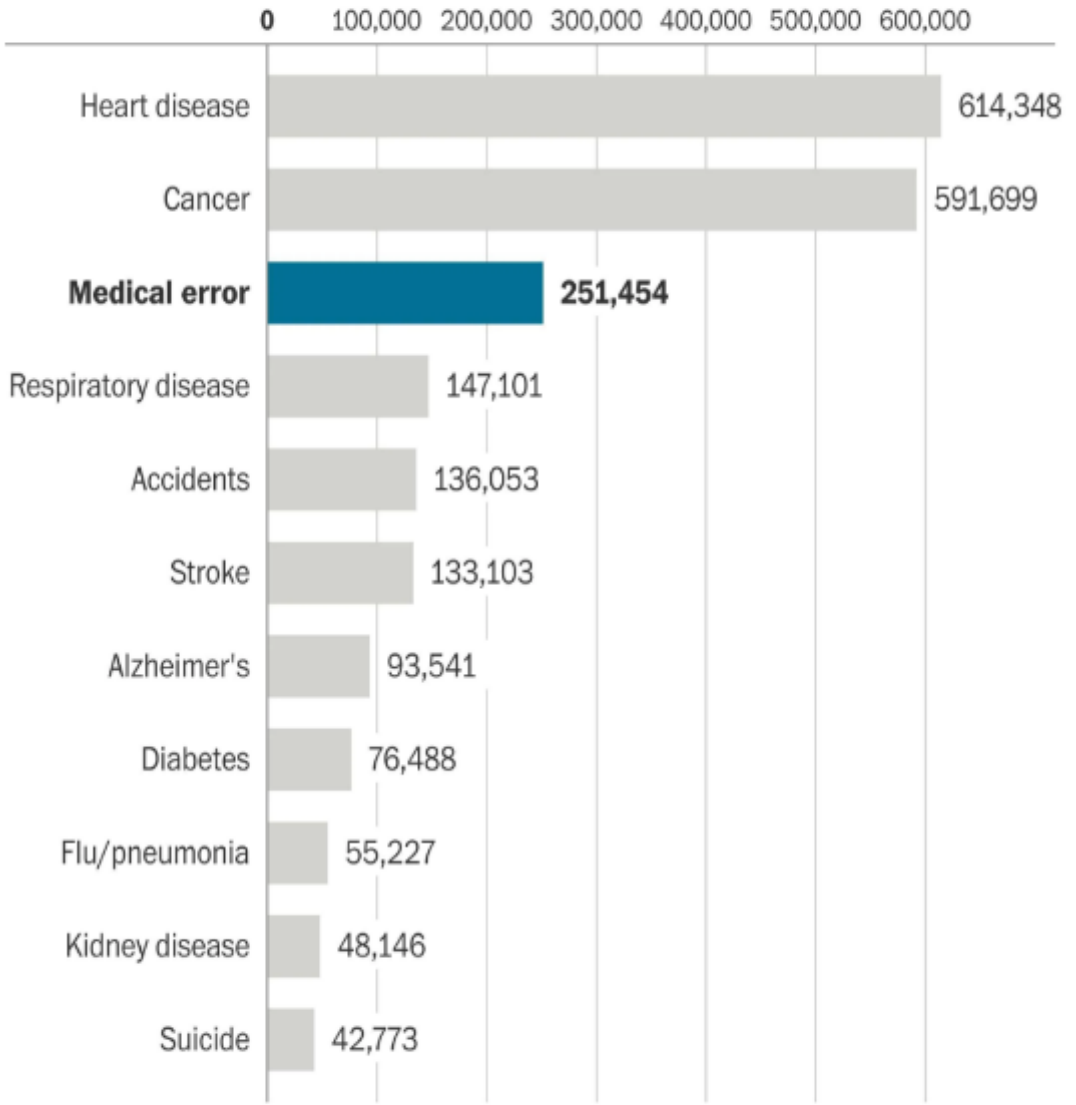
What's the Why?

Death in the United States

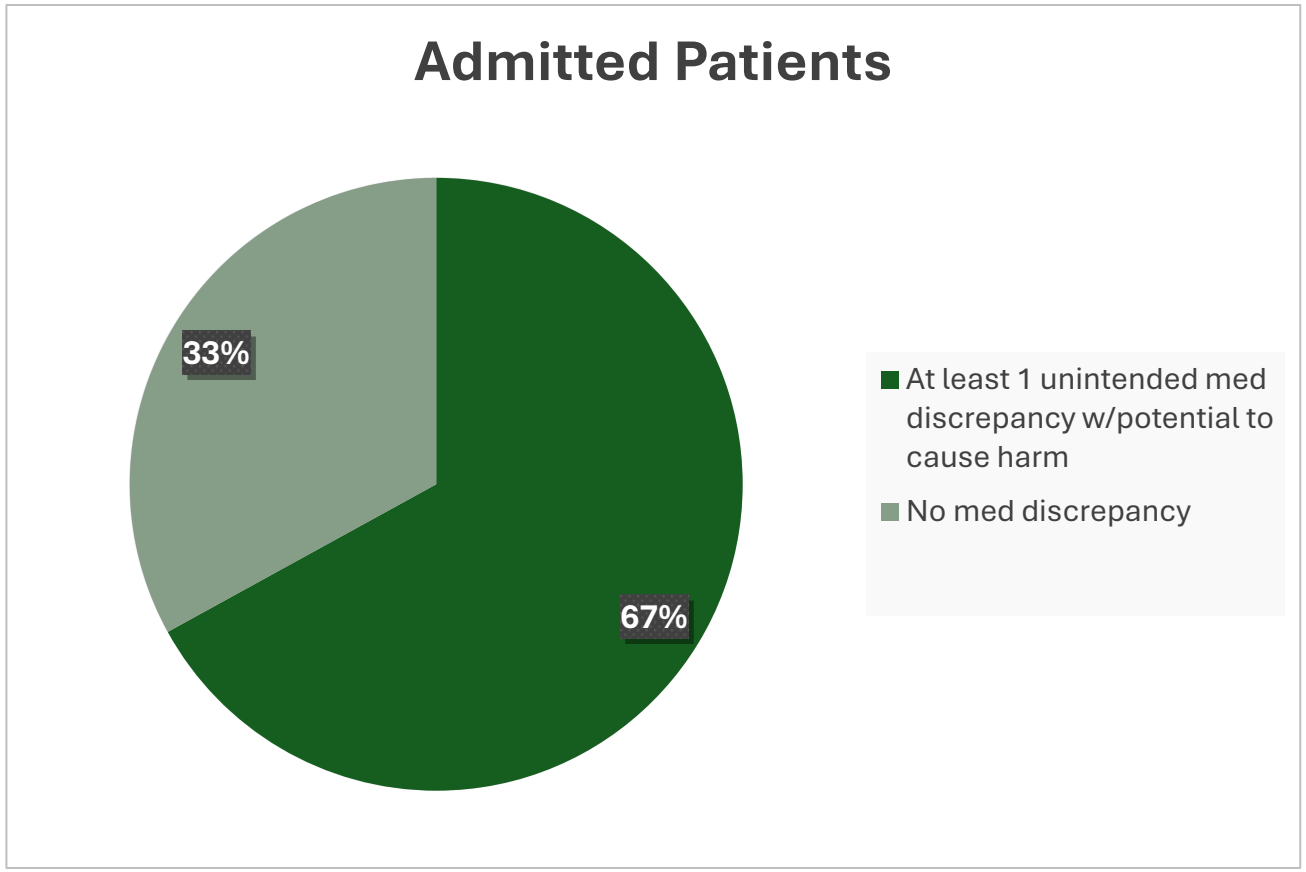
Johns Hopkins University researchers estimate that medical error is now the third leading cause of death. Here's a ranking by yearly deaths.



Source: National Center for Health Statistics, BMJ

THE WASHINGTON POST

How Prevalent Are Medication Errors?



530,000 injuries occur annually in outpatient clinics alone

What Do You Think Are The Most Common Causes?

The Most Common Types of Medication Errors

1. Manufacturing
2. Medicine Selection
3. Monitoring
4. Writing the Prescription
5. Dispensing
6. Administration

Aronson, J.K. (2009). Medication errors: what they are, how they happen, and how to avoid them. QJM: An International Jornal of Medicine, 102(8), 512-521

Risk Mitigation

Medication Safety & Risk Strategies

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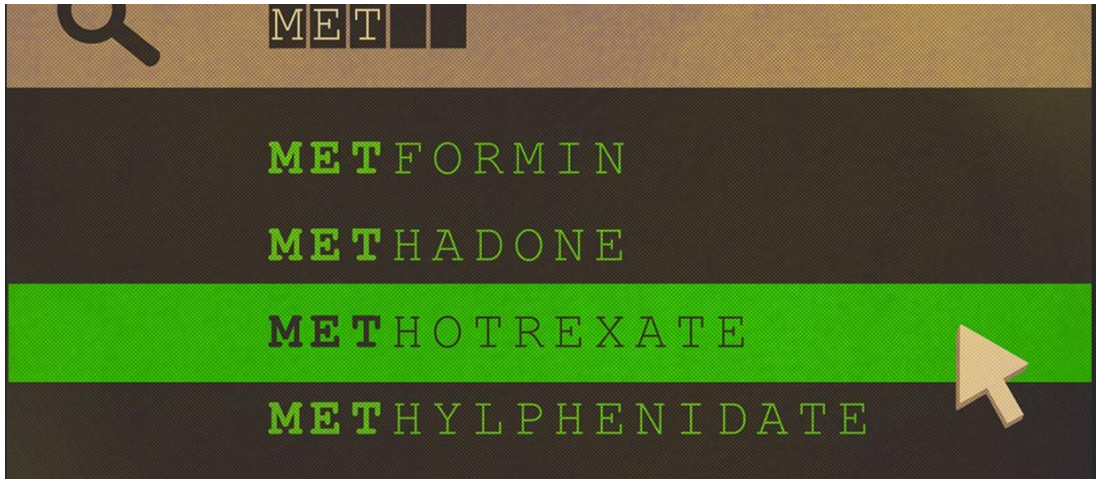
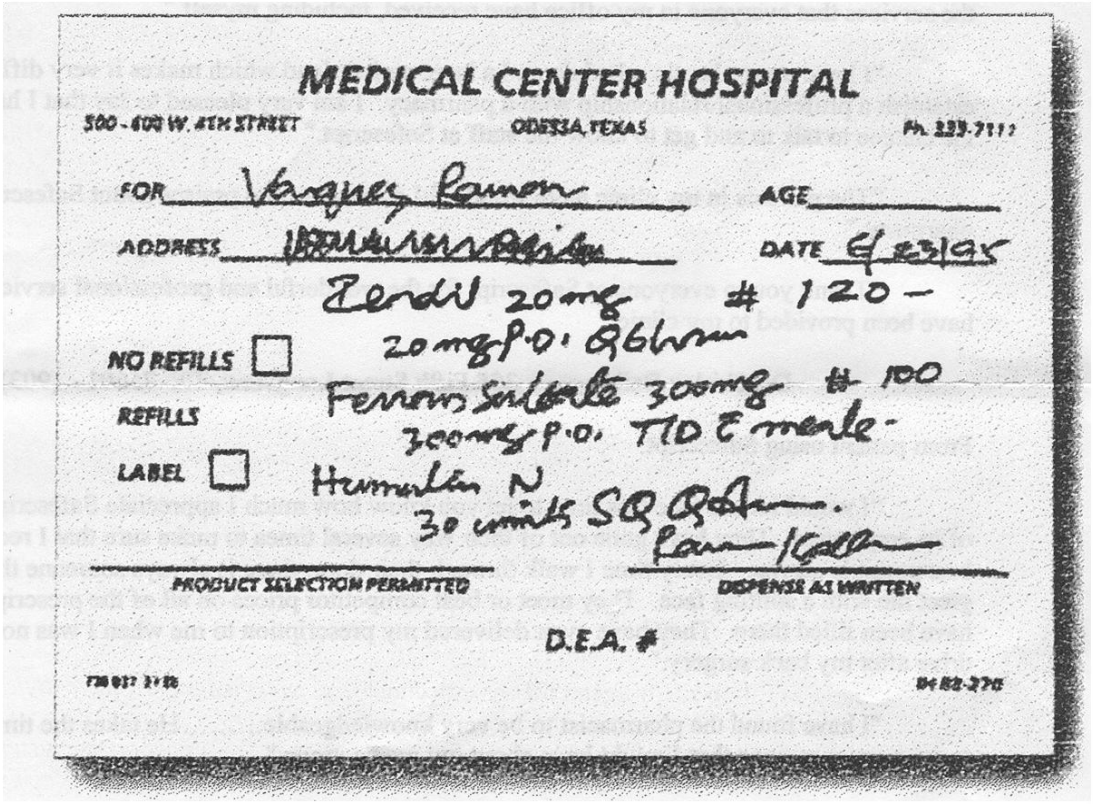
Look A-Like Sound A-Like

NovoLIN	NovoLOG
NovoLOG	NovoLIN



Illegible Handwriting
Unclear Electronic Orders



MEDICAL CENTER HOSPITAL

500 - 600 W. 4TH STREET ODESSA, TEXAS Ph. 333-7111

FOR Vasquez Ramon AGE

ADDRESS [illegible] DATE 6/23/95

Zerdi 20mg # 120 –
20mg p.o. Q6hrs

NO REFILLS ☐ Ferrous Sulfate 300mg # 100
300mg p.o. TID c meals

REFILLS

LABEL ☐ Humulin N
30 units SQ Q[illegible].
Ramon [illegible]

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

D.E.A. #

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Distractions & Workload Pressures

Inadequate Training & Communication Breakdowns

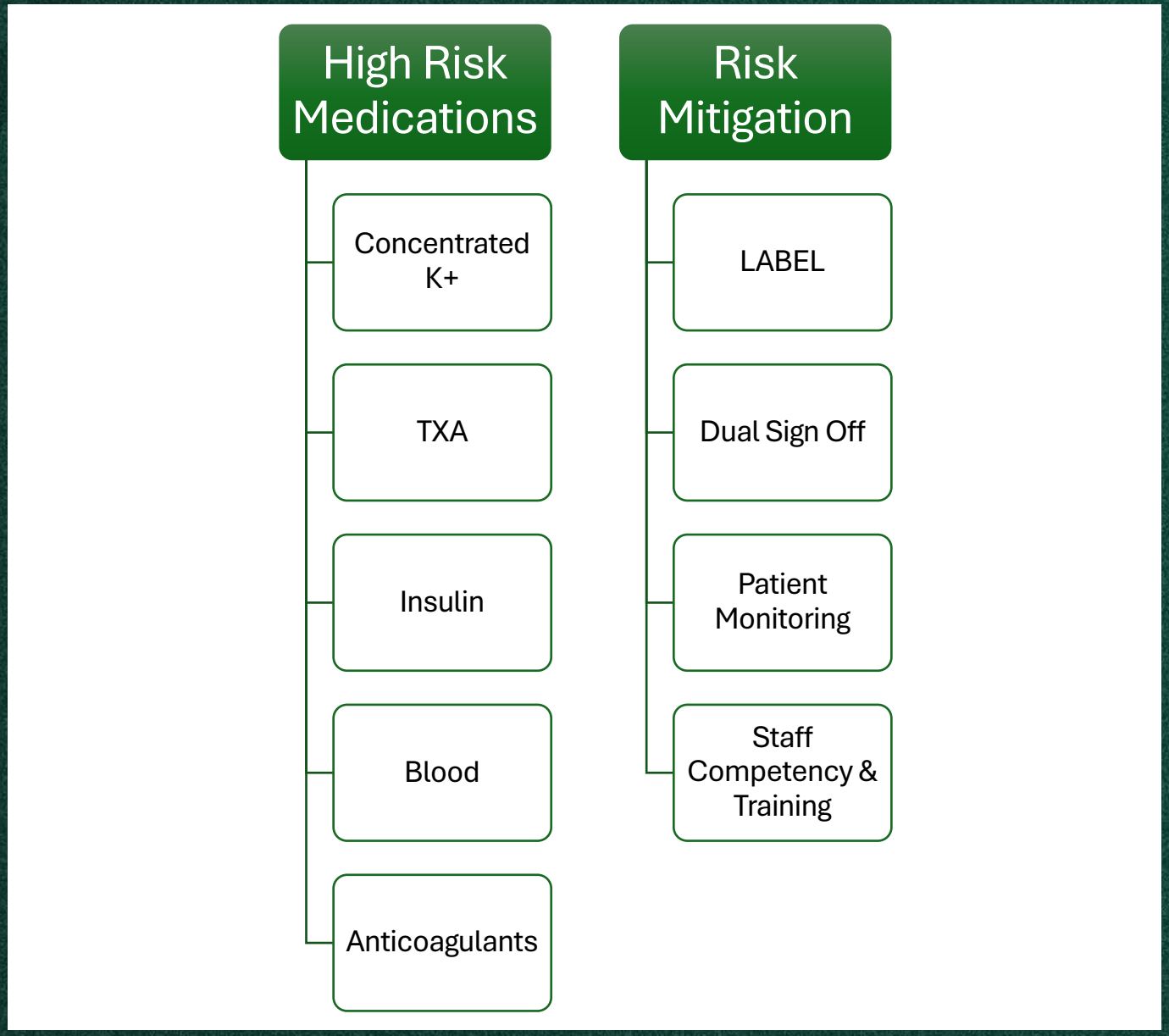
Same Meds

Different Preparations

Verbal Orders

Safety & Risk Strategies - Controlled Substances

Safety & Risk Strategies
High Risk Medications



A Patient Safety Measurement Tool for Healthcare

PressGaney

WHITE PAPER

HPI SEC & SSER

Patient safety measurement system for healthcare

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Figure 2

Safety Event Decision Algorithm

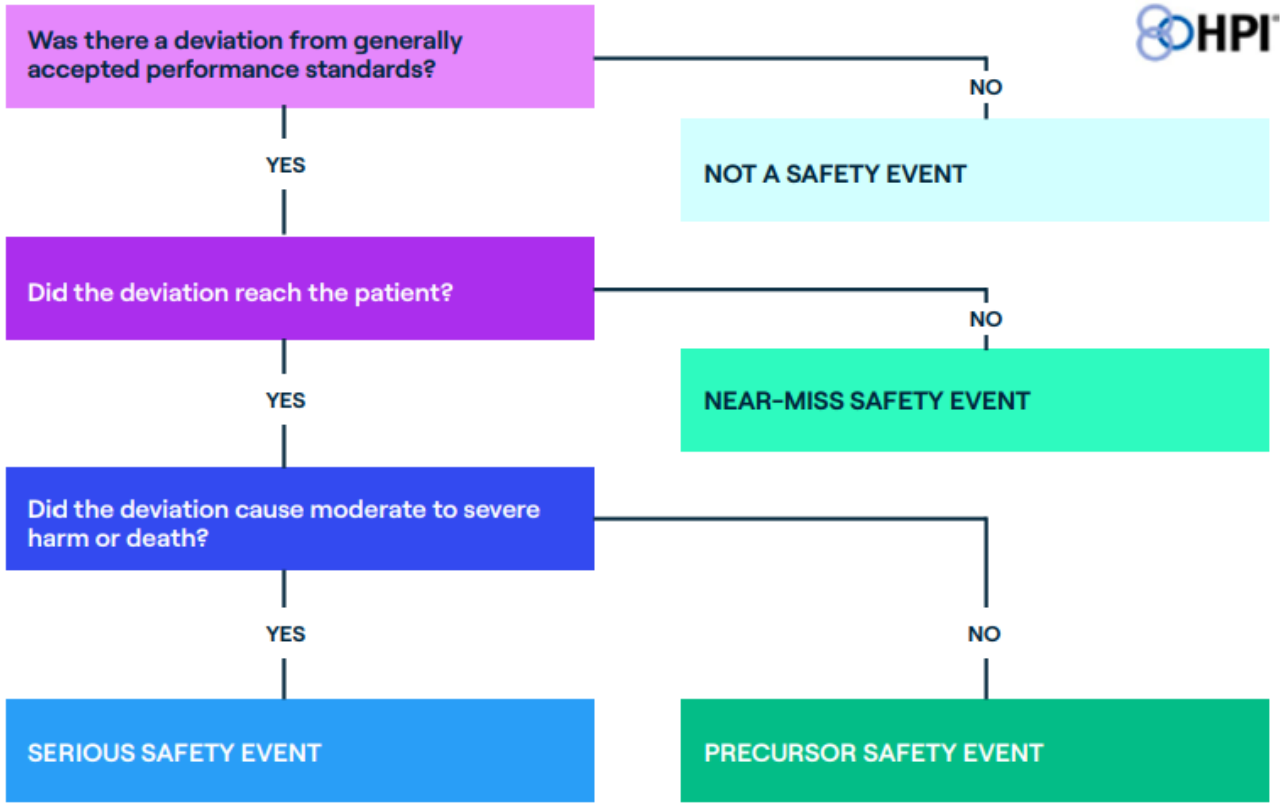
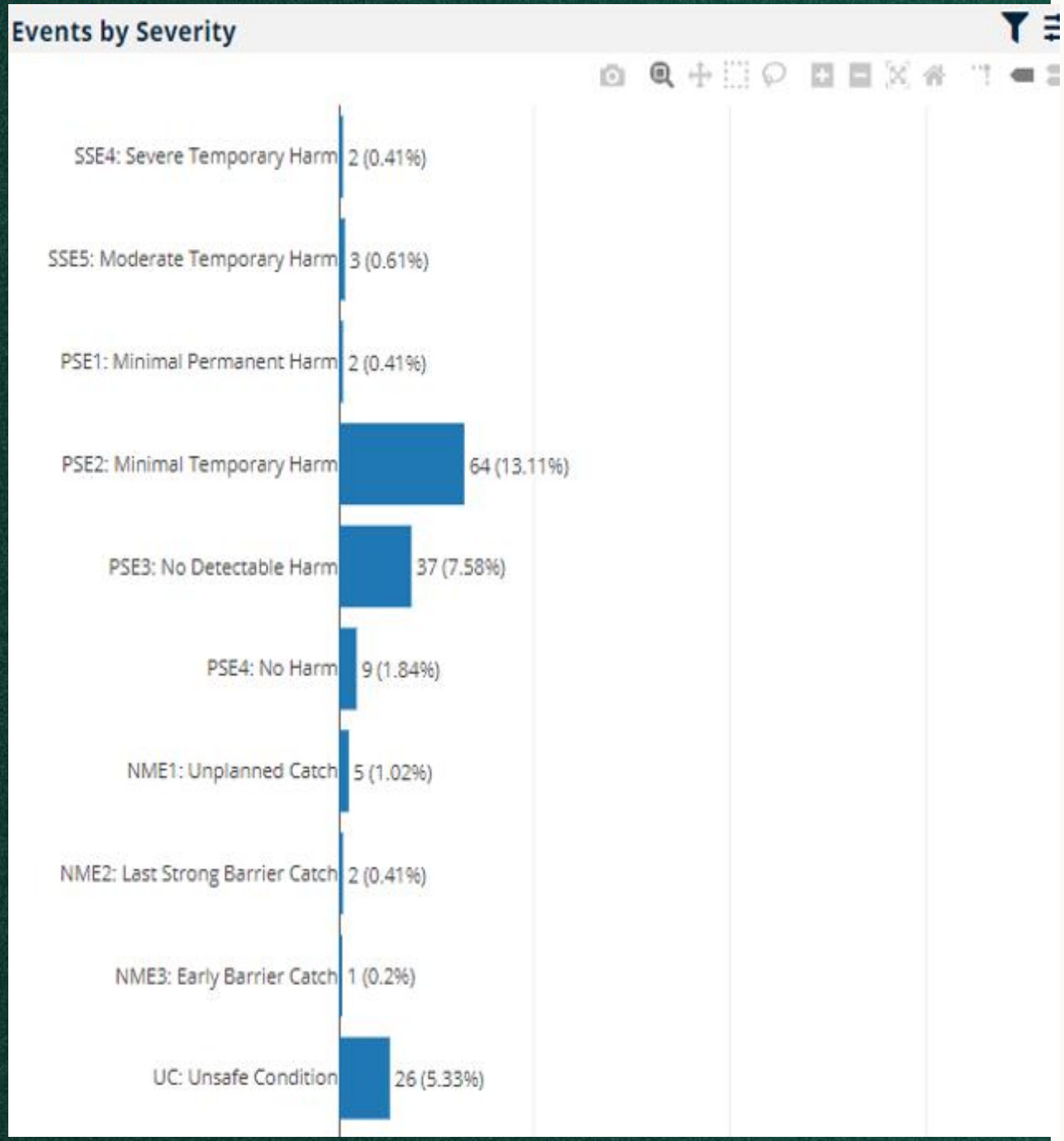


Table 2

HPI SEC	CODE	LEVEL OF HARM
SERIOUS SAFETY EVENT	SSE 1	Death
	SSE 2	Severe permanent harm
	SSE 3	Moderate permanent harm
	SSE 4	Severe temporary harm
	SSE 5	Moderate temporary harm
PRECURSOR SAFETY EVENT (PSE)	PSE 1	Minor permanent harm
	PSE 2	Minor temporary harm
	PSE 3	No detectable harm
	PSE 4	No harm
NEAR-MISS SAFETY EVENT (NME)	NME 1	Unplanned catch
	NME 2	Last strong barrier catch
	NME 3	Early barrier catch



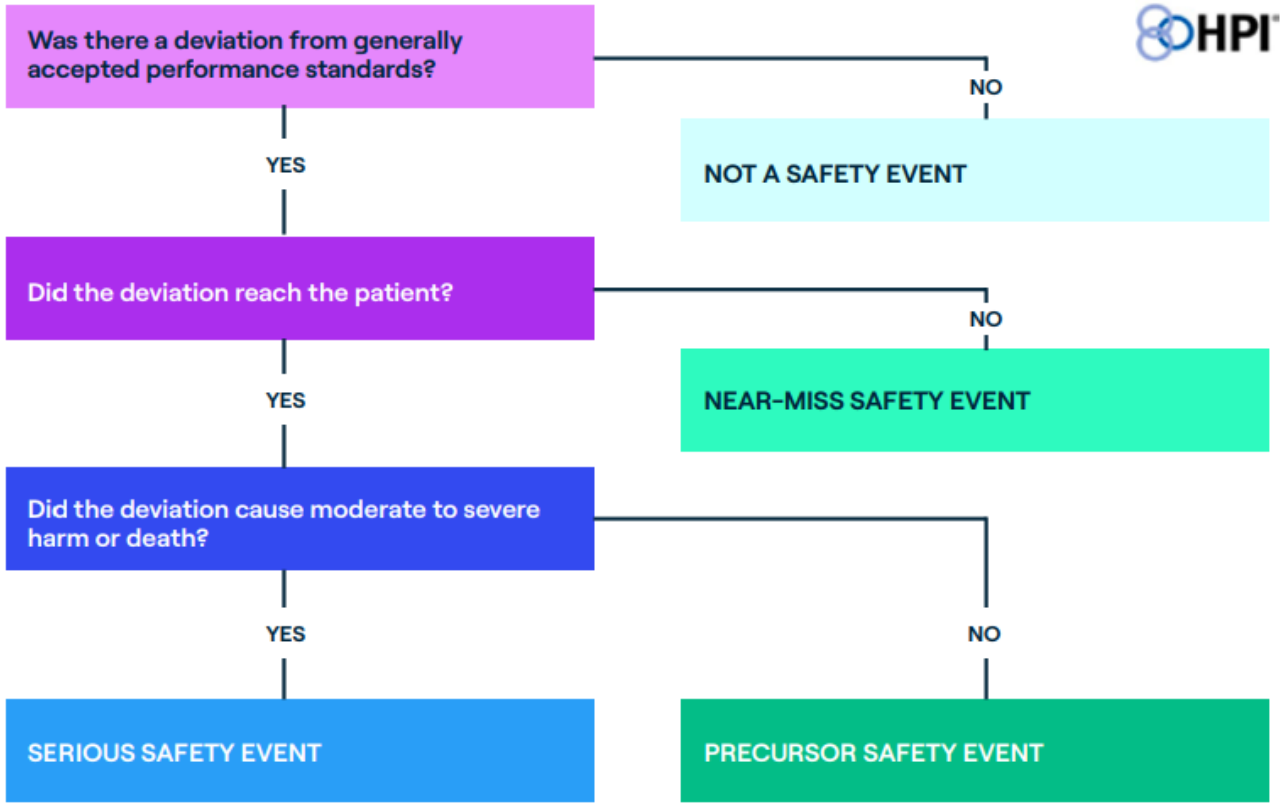
Ranking Medication Events Utilizing Safety Event Classification (SEC)

Case Study

- A patient was admitted on the med-surg unit for GI complaints. Diagnostics revealed gastric ulcers. Sucrulfate PO was ordered on the MAR. After administration, the patient began to complain of shortness of breath. The other RN on shift overheard the discussions between the patient and the nurse. The other RN asked the patient's nurse what happened and come to find out, the RN administered the Sucrulfate but administered it IV instead of PO.
- The second nurse immediately notified the ordering physician, put the patient on continuous telemetry, pulse ox monitoring, applied oxygen and obtained vital signs.
- After a few minutes, the patient's shortness of breath subsided and there were no subsequent reactions.

Figure 2

Safety Event Decision Algorithm



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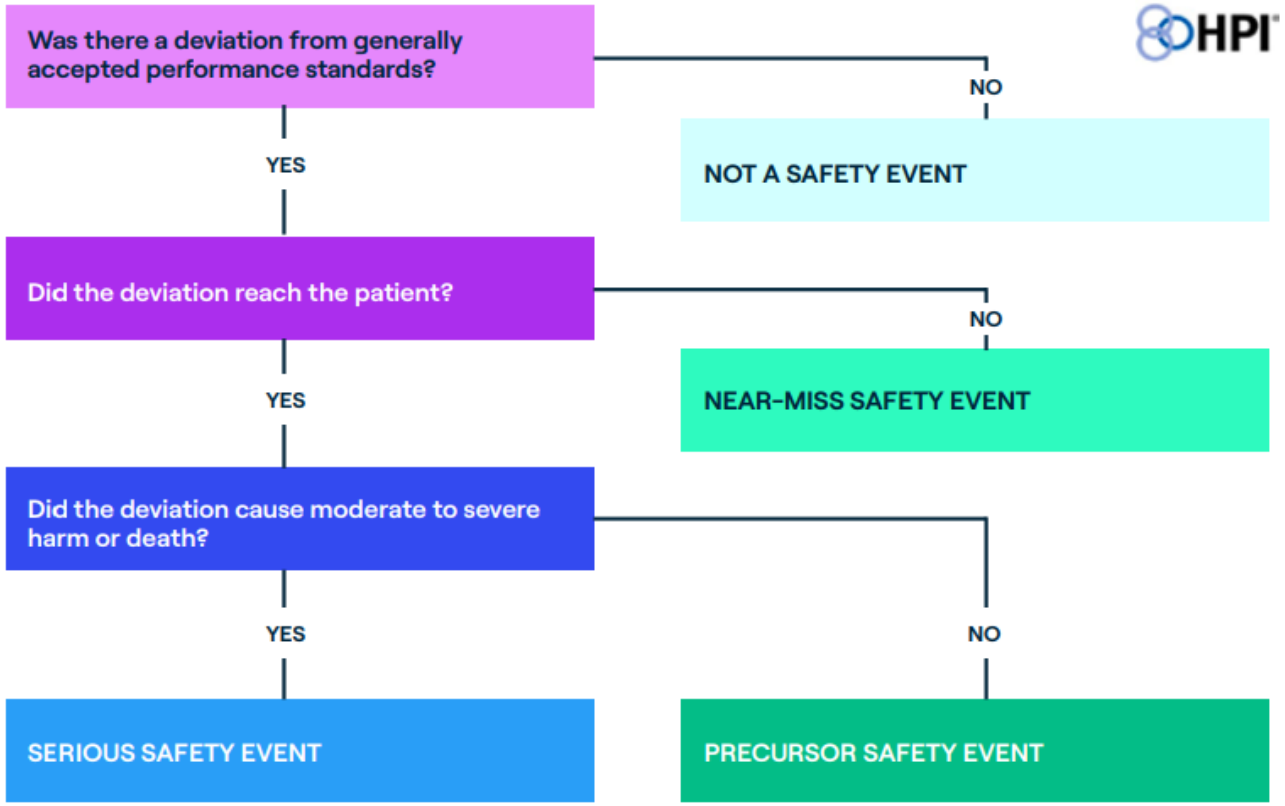
Case Study

- Antibiotics ordered in the ER: A patient was being transferred to a higher level of care from a level 4 ER, EMS communicated their ETA was 20 minutes but showed up 5 minutes after they were on the radio. Patient needed IV antibiotics hung prior to transfer, no unit clerk so RN was also compiling all transfer paperwork. RN went to pyxis to pull ordered antibiotic, RN grabbed piggyback bag from pyxis, used BCMA and alert popped up, RN acknowledged, scanned again, alert came up, RN acknowledged– overrode and administered. After EMS took the patient, RN realized why the BCMA system kept alerting and went back into the Pyxis and noticed the correct antibiotic was in the pocket next to the one she grabbed.
- Cefazolin vs. Ceftriaxone

Figure 2

Safety Event Decision Algorithm



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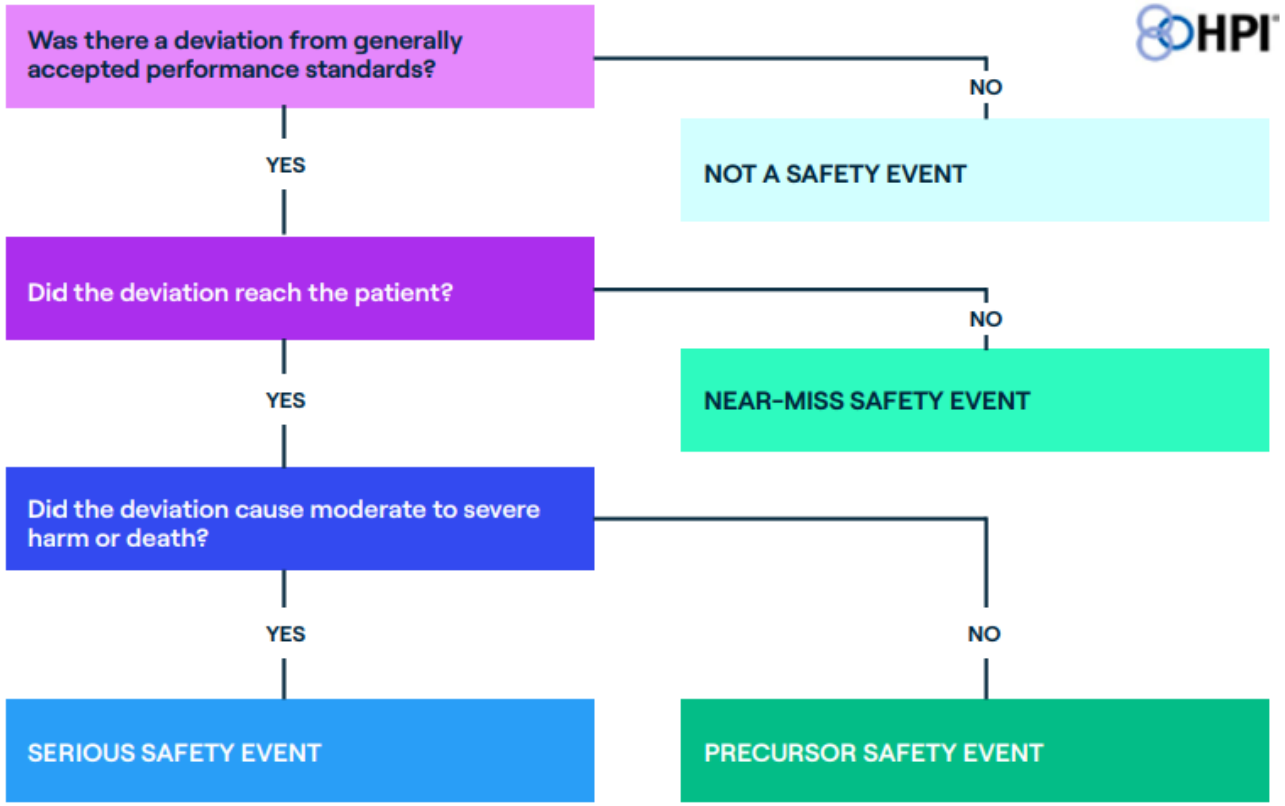
Case Study

- A 68-year-old male patient was admitted to the hospital for management of congestive heart failure. He had a complex medication regimen, including anticoagulants, diuretics, and antihypertensives. The patient was transferred from the ICU to a medical-surgical unit after stabilization.
- During the transfer, the patient's medication reconciliation was not completed accurately. A transcription error occurred when the nurse entered the medication orders into the electronic health record (EHR). The anticoagulant **warfarin** was mistakenly entered at **10 mg daily** instead of the intended **1 mg daily**.
- The error went unnoticed for three consecutive days. On the fourth day, the patient developed signs of internal bleeding, including hypotension, hematuria, and altered mental status. Lab results revealed a critically elevated INR of 9.5. The patient was transferred back to the ICU and required reversal agents, blood transfusions, and intensive monitoring.
- The patient survived but experienced significant harm, prolonged hospitalization, and long-term complications.

Figure 2

Safety Event Decision Algorithm



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General Trends

- Increase in claims
- Claims often involve high-alert medications
- Frequently linked with diagnostic errors
- Under reporting is still an issue

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Copic Closed Claims

- Alleged pain medication interaction with Benadryl resulting in death
- Overdosing Lovenox and failure to enforce guidelines regarding anticoagulant medication causing ischemic and hemorrhagic stroke
- Alleged overdose of cancer medication leading to death
- Patient in for anaphylactic shock, epinephrine error resulting in cardiac arrest
- Patient suffered severe brain damage due to medication given to relax them prior to CRNA attempting intubation

Copic Closed Claims

- Negligent medication administration leading to anaphylactic shock
- Medication error and negligent monitoring leading to patient demise
- Alleged negligent administration of medication, failure to obtain informed consent, resulting in kidney injury and renal failure
- Improper medication administration resulting in cardiac arrest

Published November 14th, 2025
UF Health Faces Lawsuit

2-year-old died after hospital missed a decimal point in medication dosage, leading to overdose, lawsuit says

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“Because of these errors, De’Markus received two consecutive doses of a massive overdose of oral potassium phosphate,” the lawsuit states.

The lawsuit says the lack of oxygen caused De’Markus to suffer irreversible brain damage, as well as “catastrophic” damage to other organs.

De’Markus’ potassium levels rose to a fatal level, which caused him to go into cardiac arrest.

He spent the next two weeks on life support and showed no signs of improvement. He was taken off life support and died on March 18, 2024.

The lawsuit also alleges that medical professionals failed to respond to De’Markus’ cardiac arrest in a timely manner, and he went without breathing for at least 20 minutes.

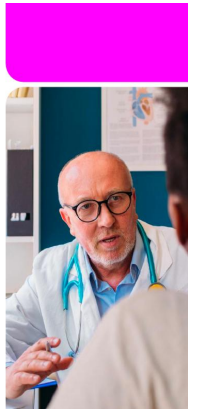
The lawsuit claims that several other supervising physicians, colleagues and pharmacists failed to catch and correct the mistake, despite the hospital’s pharmacy system issuing a “Red Flag” warning that alerted them to the excessive dosage.

“It’s been extremely difficult since the passing of my son because to this day, I still have not known what happened.”

“I was never told. When I asked, it was always a vague, ‘I do not know. I do not know.’ I still have nightmares about what happened.”

- Dominique Page

Resources



- Most Common Types of Medication Errors Article

https://www.pharmaceuticalpress.com/resources/article/what-are-the-most-common-types-of-medication-errors/

- ISMP/ECRI List of Look Alike/Sound Alike Medications

https://www.ismp.org/sites/default/files/attachments/2017-11/tallmanletters.pdf

- ISMP/ECRI Minimizing Distractions

https://home.ecri.org/blogs/ismp-alerts-and-articles-library/minimizing-distractions-and-interruptions-during-medication-safety-tasks

- Press Ganey White Paper on HPI SEC/SSER

https://info.pressganey.com/e-books-research/the-hpi-sec-sser-patient-safety-measurement-system-for-healthcare#main-content

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Questions?

Thank you!

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