

MEDICATION HARM SERIES · PART 2

The Barcode Didn't Save Him

Hospital Medication Errors

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Hospital medication errors are fast and the drugs are strong, so hospitals have built more safety systems around medication than almost anything else. Every one of those systems leaves a record, and every one can be bypassed. The first question in a hospital medication case isn't "what went wrong." It's "which safety system should have caught this, and what does the record say about why it didn't."

THE SYSTEMS, AND WHAT EACH ONE LOGS

- ◆ **Barcode scanning.** The nurse scans the wristband and the drug; the system checks against the order and warns on mismatch. Warnings and overrides are logged with the user and the reason entered. A chart full of overrides tells you the safety system was treated as an obstacle.
- ◆ **Smart pumps.** IV pumps carry a drug library with safe dose ranges and alert on programming outside them. The pump stores every program, rate change, alert, and override. In an IV overdose case, the pump log is the most important document and it is almost never in a standard records request. Ask for it by name, early, with a preservation letter if the case is fresh.
- ◆ **Pharmacist verification.** Most orders must be verified by pharmacy before administration. The system logs it. A drug given before verification is allowed in emergencies, not for routine orders.
- ◆ **Independent double-check.** High-alert drugs (insulin, heparin, opioid infusions, concentrated electrolytes, chemotherapy) require two nurses to verify independently. One signature on the MAR for a high-alert drug is a policy violation on its face.

WHAT ELSE WE LOOK FOR

- ◆ **Renal and liver function alongside the MAR.** A dose appropriate on admission can be toxic by day three if the kidneys are failing and nobody adjusted.
- ◆ **The monitoring the order required.** Opioid infusions require respiratory checks; insulin drips require glucose checks; anticoagulants require clotting labs. Gaps in the flowsheet against the ordered interval are the breach.
- ◆ **Time to reversal.** Most high-alert drugs have a reversal agent. The interval between the first sign of toxicity and the reversal is measurable, and it's often where the case sharpens.

ON CAUSATION

A patient who was improving, received the wrong dose, and crashed within the hour has a clear line. One who was already declining has a harder one, and we tell you which you have.

Episode 87 of Lexcura Clinical Insights covers hospital medication errors in full.

This newsletter is for education only and isn't medical or legal advice.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case that turns on what the medical record really shows, we'd welcome the conversation.

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