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Educating the Healthcare Community About Safe Medication Practices

# Reel to Real: What "The Pitt" Got Right About Medication Safety

In a recent episode of the popular HBO Max series, *The Pitt* (Season 2, Episode 12, Original Airdate March 26, 2026), there was quite a notable medication safety moment that merits our mention. The episode involved the identification of a potential medication-related contributor to a patient's symptoms through a careful medication review by a clinical pharmacist. For those of us working in medication safety, the role of pharmacists in the medication-use process is neither new nor surprising. Yet it often remains underrecognized, both by consumers and sometimes within our own healthcare systems. What made this moment notable was not just the acknowledgment, but the context in which it occurred: a clinical pharmacist's expertise helped connect the patient's symptoms to a possible medication-related cause.

Across a few scenes within the show, an older woman was brought to the ED after being struck by a car driven by her husband. While the team evaluated her injuries, clinicians noticed the husband appeared unsteady. Further assessment and additional history from the couple's daughter revealed his gradual functional decline and increasing medical complexity. Recognizing the need for a more complete picture, the ED physician requested a medication list, prompting pharmacist involvement. A clinical pharmacist reviewed his medication regimen and identified medications such as meclizine, metoclopramide, and methocarbamol that might have contributed to his unsteady gait. What initially appeared to be an isolated tragic event turned into something more concerning: a likely manifestation of medication-related harm identified through an interdisciplinary evaluation.

Medication-related harm rarely presents in obvious ways. It emerges gradually, often disguised as nonspecific symptoms such as dizziness, fatigue, confusion, or gait instability. In older adults, these symptoms are frequently attributed to aging or an underlying disease rather than being recognized as potential adverse drug effects. When new symptoms appear after starting a medication, they may be misinterpreted as a new condition, requiring additional medications, and a prescribing cascade can develop, increasing both medication burden and the likelihood of serious harm.

At the center of this case, and many like it, is a familiar but persistently underperforming process: medication reconciliation. It is often incomplete, rushed, or treated as a checkbox activity. Lists are copied forward without validation, discrepancies go unaddressed, and opportunities to assess the regimen for appropriateness, duplication, and potential harm may be missed. In older adults with polypharmacy, medication reconciliation should extend beyond verifying medication lists and include a structured clinical review of medication appropriateness. Pharmacists are uniquely positioned to identify high-risk medications, prescribing cascades, drug interactions, and medications contributing to symptoms such as dizziness, confusion, or gait instability. Yet, pharmacists are frequently engaged only after a problem has already emerged, rather than as part of routine care. When responsibility for reconciliation is assumed rather than clearly assigned, opportunities to identify and prevent medication-related harm are lost.

**Safe Practice Recommendations:** The 2026–2027 ISMP Targeted Medication Safety Best Practices for Hospitals, released earlier this year, includes a substantially expanded Best Practice 21 dedicated entirely to medication reconciliation. It is one of the most operationally specific reconciliation frameworks ISMP has published and provides recommendations for organizations seeking to move from documentation formality to a genuine clinical process. The Best Practice includes the following recommendations.

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## SAFETY briefs

**Milrinone Almost Administered Instead of niCARdipine.** A nurse obtained a bag of what she thought was ni**CAR**dipine 40 mg/200 mL injection (Hikma) from an automated dispensing cabinet (ADC). The nurse read the label on the overwrap and discovered it was actually a bag of milrinone 20 mg/100 mL injection (Eugia US LLC). A pharmacy technician had mistakenly stocked the milrinone bag in the ni**CAR**dipine bin in the ADC. Both products are supplied in foil overwrap bags with similar red, white, and black label designs (**Figure 1**).

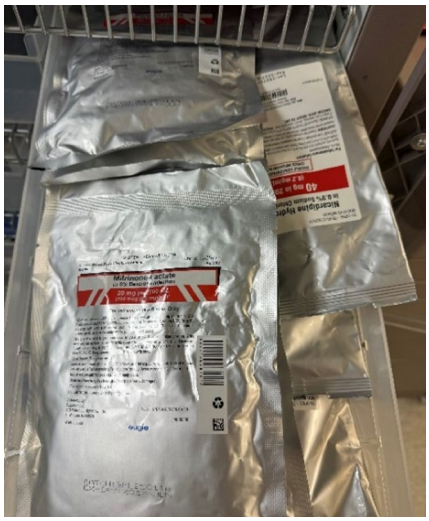

**Figure 1.** Bags of milrinone 20 mg/100 mL injection (left) and ni**CAR**dipine 40 mg/200 mL injection (right) have similar appearances.

The hospital found that a pharmacy technician had scanned the barcode on one of the ni**CAR**dipine bags to access and refill the ni**CAR**dipine ADC bin (following their pharmacy's restocking process of scanning only one product) and then placed a milrinone bag in the ni**CAR**dipine bin in error. The pharmacy found five additional milrinone bags in the ni**CAR**dipine bin. The two medications were stored in bins on different shelves, but behind the same tower door.

When pharmacy receives a new product, conduct a review to identify potential risks with the product's design, including look-alike labeling and packaging (e.g., foil overwrap).

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**Establish medication reconciliation as a formal three-step process.** Complete medication reconciliation at admission, at all changes in the level of care (including transitions to and from the perioperative setting), and at discharge. Ideally, the best possible medication history should be collected before admission orders are written, before the first dose of medication is administered.

- Assign dedicated practitioners (e.g., medication reconciliation technicians) to collect a complete medication history at every admission and appropriate encounter, including all prescription and over-the-counter medications, supplements, and nonenteral formulations such as patches, injections, nasal inhalations, and implantable devices.
- Clarify the history as needed using at least one outside resource, such as a pharmacy record or clinic note, to verify what the patient or caregiver reports.
- Reconcile the verified history against the current care plan. Have the prescriber compare the medication history with medication planned for admission, making and documenting appropriate changes as needed.

**Design medication reconciliation workflows that are specific to each care setting and clearly assign accountability for every step.** Organizations should develop distinct processes for inpatient, perioperative, ED, and ambulatory environments, with explicit designation of responsibility for obtaining histories, verifying information, and completing final reconciliation rather than relying on shared or assumed ownership.

**Invest in dedicated personnel and infrastructure to support reliable medication reconciliation as a clinical safety function.** Prioritize the need for funded and trained staff supported by formal competency standards, recognizing that effective reconciliation cannot be achieved through informal workflows or under-resourced processes.

**Integrate pharmacists proactively into medication reconciliation at high-risk transitions and for high-risk patients.** Pharmacists should be embedded in admission, transfer, and discharge workflows and engaged in medication review for populations at elevated risk, such as older adults and patients on complex regimens, rather than being consulted only after problems emerge.

**Apply the same level of rigor to discharge medication reconciliation as is used at admission.** This includes verifying the accuracy of the final medication list, clearly communicating all changes to patients with written and verbal instructions, and ensuring timely transmission of the reconciled list to outpatient pharmacies and receiving providers.

The scenario in *The Pitt* may be fictional, but cases like this happen every day in hospitals and in ambulatory care settings. This is precisely why ISMP publishes the Targeted Medication Safety Best Practices: because these errors are not isolated events. They are repeated, across facilities and across years, despite decades of warnings and recommendations. What a television drama may accomplish, in ways that safety bulletins sometimes cannot, is to make these risks feel immediate and personal. Viewers relate to the patient. They relate to the clinicians. They recognize the failures. Perhaps that connection and realization is what finally makes the lesson land. Let it be a lesson learned on screen and not at your facility!

*Contributing author Kara Jensen, PharmD, BCPS; 2025-2026 ISMP Safe Medication Management Fellow, supported by the US Army*

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If risks are identified, consider purchasing one product of a problematic pair from a different manufacturer. Maximize the use of locked-lidded pockets or single-access compartments.

Use barcode scanning technology in the pharmacy when placing drugs in storage (including when returning unused product to pharmacy storage) and to confirm that medications chosen for distribution to the ADC match the medications listed on the ADC fill report. Ensure each individual product is checked. Segregate and secure all medications designated for an individual ADC during transport. Determine whether your ADC has the functionality for practitioners to scan each individual product when refilling the ADC, and for organization-defined products, consider requiring scanning of each medication container/packaging before placing it in the ADC. Review the ISMP Guidelines for the Safe Use of Automated Dispensing Cabinets (Core Safety Process #6). Employ bedside barcode scanning technology to confirm that medications selected for administration match those included on the patient's medication administration record. Educate nurses to carefully review individual product labels after removing the medication from the ADC (as was done by the nurse in this case), when spiking an IV bag, prior to administration, and when discarding or returning unused drug to storage.

**Good Catch Identified Similar-Looking Vials of Pain Medication.** A certified registered nurse anesthetist (CRNA) working in an ambulatory surgery center reported concerns related to similar-looking vials of 60 mg/2 mL ketorolac and 2 mg/mL morphine. Both products are made by Fresenius Kabi. They are packaged in similar vial sizes and have purple on the labels and caps (**Figure 1,** page 3). The hospital typically purchases ketorolac in 1 mL vials and morphine in prefilled syringes, but due to both being on backorder, they recently purchased both of these alternative products. The CRNA escalated the concern to the pharmacy team at the main hospital, and education about the risk of mix-ups was shared throughout the health system.

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# Worth repeating...

## Provide Access to Oral/ENFit Syringes!

A prescriber ordered oral acetaminophen suspension for a child in the ED. A nurse documented that the medication had been administered, and the child was transferred to the pediatric intensive care unit (PICU). Once in the PICU, the child's family handed a PICU nurse an unlabeled parenteral luer lock syringe containing a purple liquid. The family reported that the ED nurse had instructed them to inform the PICU nurse that the syringe contained acetaminophen and should be administered. The PICU nurse did not administer the contents of the unlabeled parenteral syringe, prepared a dose in an oral syringe, administered it, and reported the event through the organizational error reporting system.

The medication safety officer investigation revealed that it was common practice for nurses to prepare oral liquid medications using parenteral syringes, which were readily available in utility carts in the patient rooms. However, oral syringes were only stored in the medication room. Nurses explained that they preferred to prepare doses after scanning the patient and the medicine at the bedside instead of in the medication room. Discussions also revealed that there was a lack of understanding among nurses about the risks of wrong route errors associated with preparing oral medications in parenteral syringes.

In response, nursing leadership provided education to staff about the risks of wrong route administration errors when using parenteral syringes for oral medications. However, pharmacy staff reported continued resistance after education was completed, primarily because oral syringes were not available at the bedside, which disrupted workflow. Although the organization discussed adding oral syringes to utility carts within the patient rooms, nursing leadership cited insufficient space to support an additional item.

At another organization, a patient hospitalized with pneumonia was prescribed **ROBITUSSIN DM** (100 mg guai**FEN**esin and 10 mg dextromethorphan per 5 mL) for coughing. Although the order was for 5 mL, pharmacy supplied the product in 10 mL unit dose cups. The nurse used a parenteral syringe to draw up more than 5 mL, intending to discard the excess, but accidentally administered the entire volume intravenously (IV). The nurse immediately recognized the error and notified the prescriber, who contacted Poison Control. The prescriber ordered IV fluids, and the patient underwent an electrocardiogram (EKG) and telemetry monitoring per Poison Control recommendations. The patient was discharged 30 hours later.

The organization reported that although they purchase ENFit syringes for enteral/oral liquid medications, the syringes are stored in a separate area away from the medication rooms; however, parenteral syringes are stored in the medication rooms and are easily accessible. The organization has since shared this event with staff, educated nurses about the rationale for using an ENFit syringe, and taken steps to ensure that ENFit syringes are readily available in all medication rooms. Based on drug use evaluation data, they have also switched from the 10 mL to a 5 mL Robitussin DM cup size systemwide.

Organizations should purchase, store, and maintain an adequate supply of oral/ENFit syringes in all patient care areas where oral/enteral medications are prepared and/or administered. Pharmacy staff should verify that oral/ENFit syringes are in stock and readily available during monthly unit inspections. Educate staff about why parenteral syringes should never be used to prepare oral medications and explain the wrong route administration risk. If a medication is not administered immediately by the individual who prepared it, the syringe should be labeled (e.g., medication name, dose, route, beyond-use date). If a syringe is handed to another practitioner for administration, the preparer needs to verbally communicate this information and the syringe needs to be labeled. Never hand unlabeled prepared syringes to patients or family members to transport and hand over to another healthcare practitioner.

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**Figure 1.** Similar-looking vials of ketorolac (left) and morphine (right) injection from Fresenius Kabi.

This demonstrates how reporting and sharing of good catches supports the development of a learning culture. When the pharmacy receives a new product, conduct a review to identify potential risks with the product's design, including look-alike labeling and packaging concerns. When problems are recognized, consider purchasing one of the products from a different manufacturer. Use barcode scanning when receiving, dispensing, filling the automated dispensing cabinet (ADC), and prior to administration. To prevent misidentifying medications by viewing only the vial caps, store injectable medications in a way that always keeps their labels visible. Communicate look-alike labeling and packaging concerns to staff, including any additional actions needed.

## Special Announcement

**CHEERS AWARDS Nominations Open**

Each year, ISMP honors various healthcare disciplines that have demonstrated an exemplary commitment to medication safety through innovative projects with an ISMP **CHEERS AWARD**. Nominations for this year's **CHEERS AWARDS** are now open and will be accepted through **August 15, 2026**. For more details and to submit a nomination, click here.

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