Naming, labelling and packaging of medicines put patients at risk

Case studies from
The UK

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Insulin, hospitals and harm: a review of patient safety incidents reported to the National Patient Safety Agency

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Table 1. The degree of harm from incidents involving insulin.

Degree of harm	Incidents	Percentage (%)
Death	6	<1
Severe	12	<1
Moderate	1,042	6
Low	2,914	18
No harm	12,626	76
Total	16,600	100

Table 2. The medication error type involving incidents with insulin.

Medication error type	Incidents	Percentage (%)
Wrong dose, strength or frequency	4,256	26
Omitted and delayed doses	3,390	20
Wrong insulin product	2,390	14
Other	6,564	39
Total	16,600	100

Selection of the incorrect insulin product was described in 2,201 incidents (14% of the total) due in large part to the 'look alike' and 'sound alike' proprietary names, for example:

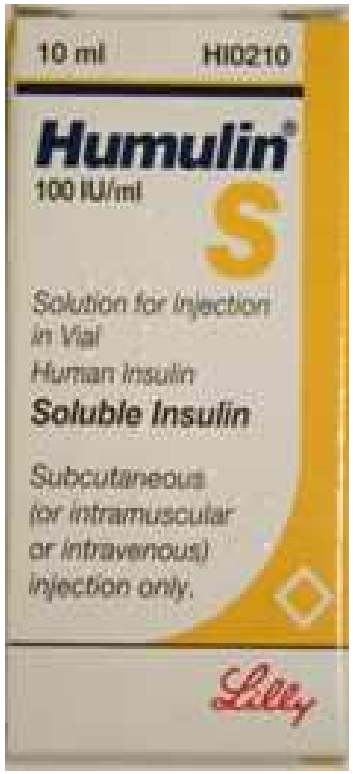
- Novorapid and Novomix
- Humalog and Humalog Mix
- Humulin S, I and M3
- Humalog and Humulin
- Glulisine and Glargine
- Lantus and Lente
- Hypurine – neutral, isophane, lente


NovoMix® 30
FlexPen®


NovoRapid®
FlexPen®
100 U/ml


3 ml
5 cartridges
Humalog


3 ml
5 cartridges
Humalog
Mix25


10 ml
HI0210
Humulin®
100 IU/ml
S
Solution for Injection
in Vial
Human Insulin
Soluble Insulin
Subcutaneous
(or intramuscular
or intravenous)
injection only.
Lilly


10 ml
HI0310
Humulin®
100 IU/ml
I
Suspension for Injection
in Vial
Human Insulin
Isophane Insulin
Subcutaneous
(or intramuscular)
injection only.
Lilly


Humulin
M3
Lilly

Nurse who 'misread' medical notes sacked after pensioner dies from massive insulin overdose

An inquest heard how great-great-grandmother Mrs Worrall - who was diabetic and also suffering from stomach cancer and heart disease -regularly received six units of insulin in the mornings.

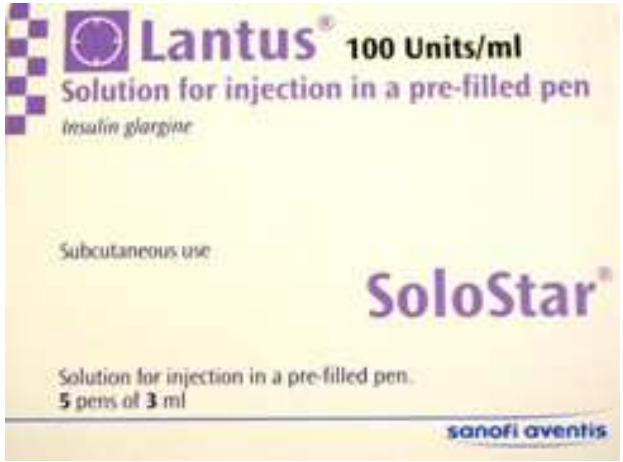
But when Mrs Burke visited the pensioner's home on her rounds, she administered a dose of 60 units - 10 times more than normal.

Her solicitor said the overdose happened after she mistook the letter 'U' for units for a zero.

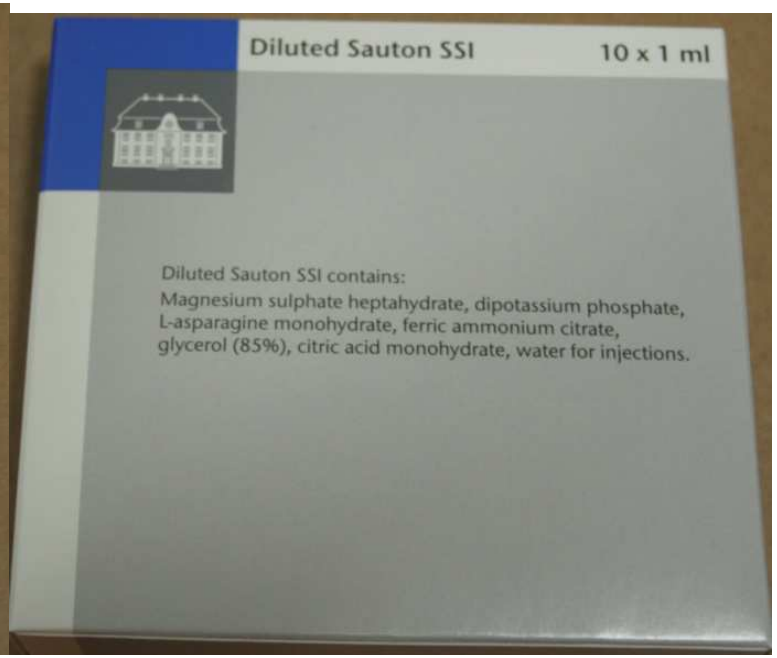
Expression of Insulin Units

X

X



Yes



Baby was immunised with a BCG vaccine but actually only received the BCG solvent as the solvent was never added to the BCG powder prior to administration The error was highlighted when the SHO checked a vaccination with a senior midwife who identified that the solvent had not been mixed with the powder on [date]. This error was immediately reported and NICU identified and several other babies were identified to have been incorrectly vaccinated