Packaging and labelling problems and solutions

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Hospitals

- Drug administration - small part of a nurse’s day; smaller part of a doctor’s
- Human factors, system factors
- Huge number of drugs, limited familiarity
- Time pressure, interruptions, multiple tasks, miscommunication, handovers
- Independent double check
  – Packaging and labelling should help make it clear and easy to do the right thing
Similar packaging – easy to select wrong strength or formulation (Retard/not)
Strengths of same product looking very similar – 50mg, 75mg, 100mg
Contribution to reported incidents
What have we achieved in Ireland?

- Notify manufacturers and regulators when errors occur relating to packaging and labelling
- Manufacturers – often respond with positive changes
- Regulators – enforce legal requirements, may support safety changes but not require
In our experience, EVERY product containing more than 1 mL which is labelled only with mg/mL, units/mL etc, results in patient overdoses.
Dalacin® C Phosphate
150 mg/ml
Concentrate for Solution for Infusion or Solution for Injection
Clindamycin (as phosphate)

5 x 4 ml ampoules
For intravenous use after dilution
or intramuscular use only
Dalacin® C Phosphate

150 mg/ml

Concentrate for Solution for Infusion or Solution for Injection

Clindamycin (as phosphate)

600 mg/4 ml

5 x 4 ml ampoules

For intravenous use after dilution or intramuscular use only
Alert

To: All anaesthetists, anaesthetic nurses, theatre nurses
From: Aileen O’Brien, Shane Russell CNMs, Anaesthetics
      Ciara Kirke, Drug Safety Coordinator
Date: 1st March 2010
Re: Similarity between ephedrine and morphine ampoules

A new formulation of Ephedrine hydrochloride 30mg in 1mL is now stocked in Theatres and Pharmacy. This is because it is a licensed product. The previous, unlicensed, product is no longer available.

Ephedrine and morphine ampoules are now very similar in appearance:

- Take care to ensure you have selected the correct ampoule.
- Take care to return unused ampoules to the correct box.
Inaugural IMSN Conference 1st Oct 2010 -
‘Networking for safety’

Safe Use of Sound-Alike Look-Alike Drugs
SALAD

Gillian Oates

Briefing Document on
Sound-Alike Look-Alike Drugs (SALADs)
A better way

- Design in safety (NPSA series)
- Failure Modes & Effects Analysis
- Consult users (e.g. Med-ERRS)
  - BEFORE finalise packaging and labelling

- Respond rapidly and effectively to problems in use