Insulin error leads to medication safety improvements

Peter Couper has had type 1 diabetes for more than 40 years. He has managed it through a combination of insulin medicine and healthy food choices.

He had been using his latest vial of insulin for a number of days. Then one morning Peter collapsed and was found unconscious by his wife, who immediately called an ambulance. He had hypoglycaemia caused by a dangerously low blood sugar level.

'The paramedics gave me glucose to bring me round and they insisted I go to hospital,' explains Peter.

Peter spent a day in hospital where his blood sugar was tested to make sure it was ok and he was discharged home.

But Peter noticed that his insulin medicine looked cloudy, which was different to usual. So he decided to check with the pharmacy that it was ok to use.

Because Peter had been in hospital and was unwell, he stayed in the car while his wife took it into the pharmacy and spoke to a pharmacist.

The pharmacist looked at the insulin pen and compared it against another of the same type of insulin in the fridge to check that it was normal for it to be cloudy, which it was. However, Peter's dispensing history was not checked to determine if he had received the correct insulin.

What was not picked up was that Peter had been given the wrong insulin by mistake.

Peter's usual medicine was a rapid acting insulin. Instead he had mistakenly been given a mix of rapid and intermediate acting insulin. The medicines were next to each other in the pharmacy fridge, and both had a similar appearance and name.

Not knowing it was the wrong insulin, Peter went home and continued to use it. A couple of days later, Peter was still worried, so he took it back to the pharmacy again himself.

A different pharmacist checked it and realised that Peter had mistakenly been given the wrong insulin, and arranged for Peter to receive his usual insulin.

Pharmacy staff were dismayed to learn about the error. Not only did the pharmacy apologise to Peter, but they immediately made improvements in the pharmacy to prevent it happening again.

This included separating all plain and mixed insulin formulations in the fridge and adding warning stickers to them as an alert.

An insulin chart has been placed on the front of the fridge listing the different types of insulin to encourage pharmacy staff to stop and think before selecting the medicine.

Prompts on the pharmacy computer add an extra reminder to ensure that everyone double checks it is the correct insulin for the patient.

Medication safety tips

Medication safety is a priority and there is always room for improvement. Sometimes it is the simple changes that can make a big difference to safety.

Pharmacists

- Be vigilant when dispensing high-risk medicines.
- Always check the medicine against the patient's script and history. Double check the medicine. Ask questions if you need to. When it gets busy, slow down. Be confident that you are giving the correct medicine.
- Talk to the patient and educate them about the medicines they receive.
- Improve how you store high-risk medicines such as insulin. Separate any that look similar, have similar names, or are a similar type.
- Develop 'safety alerts' to prompt staff to double check the medicine is correct.

Patients

- Don't be afraid to ask questions about your medicine. Speak to your health professional directly and make sure you are happy with the answers. It is important you have a clear understanding about the impact of the medicine you are prescribed.

For more information about medication safety visit **www.open.hqsc.govt.nz.**

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