

# Medicine Matters



Issue 2  
October  
2009

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Insulin Incident

### Improving patient safety – recent insulin incidents

#### Insulin incidents

Six medication incidents involving insulin have been reported during September 2009. These have primarily involved the wrong units being prescribed or the wrong insulin. Great care must be taken when taking a drug history and prescribing insulin.

Recently a patient was prescribed Humalog 25units bd when the insulin should have been Humalog Mix 25. Two patients were prescribed 100units of insulin due to the repeat prescription being misread (from 100units/ml). The patients' usual doses were 5units and 12units. Finally, a prescription for NovoMix 30 was prescribed at 10pm, which should have been written for an evening meal dose. Previous incidents have also occurred where U has been abbreviated for units. This has led to prescriptions being misread as ten fold overdoses.

#### Learning points:

- Prescribe insulin by brand name and in full. Check carefully as many branded insulin products contain a number within their name eg Humalog and Humalog Mix25,
- Specify the type of insulin device eg vial, pre filled pen
- **Never prescribe U or IU.** Always write UNITS in full
- Check the insulin and dose with the patient if possible
- Read repeat prescriptions carefully. These and summary print-outs are unlikely to specify the current dose. Check with the GP if necessary

#### Example of correct insulin prescription:-

Regular Prescription		Month and date							
Start Date <b>05.10.09</b>	DRUG <b>NovoMix 30 flexpen</b>								
Dose <b>4 units</b>	Route <b>sc</b>	Signature NBurns blp109	<b>8</b>						
			<b>13</b>						
Pharm	Additional Instructions <b>With meals</b>		<b>17</b>						
			<b>22</b>						

#### Storage points for NURSING STAFF

- Mark opened insulins with the date of opening
- Do not discard outer cartons/packaging
- Store opened/in use insulin pens in the patient's locker
- Label opened/in use insulin pens with an addressograph label
- Store unopened insulins in drug fridge
- Ensure that the drug fridge is in working order and cleaned regularly

For any concerns or comments please contact Naomi Burns, Medicines Safety Pharmacist on ext 5751

