Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.96, November 2014

Insulin Pen Mix-up

Two cases have been reported involving the mix-up of an insulin pen meant for one patient with that meant for another when administering insulin to patients (information collection period: from January 1, 2011 to September 30, 2014). The information is compiled based on “Individual Theme Analysis” (p.83) in the 20th Quarterly Report.

Cases have been reported in which an insulin pen meant for another patient was picked up in error because the patient’s name was not clearly noted on the insulin pen or was not written on it at all.

Case	Location of Patient’s Name on Insulin Pen		Background	Details of Mix-up
	Patient A	Patient B		
1	Name noted on pen: on a sticker on the cap of the pen	Name noted on pen: on a sticker on the cap of the pen	The caps of the pens for Patient A and Patient B had been mixed up	Patient B’s insulin was administered to Patient A
2	Name not noted on pen: stored with docket	Name not noted on pen: stored in drug bag	No check to confirm whether the pen without a name on it was Patient A’s insulin pen	

Image of case 1

Patient’s name was written on the cap of the pen

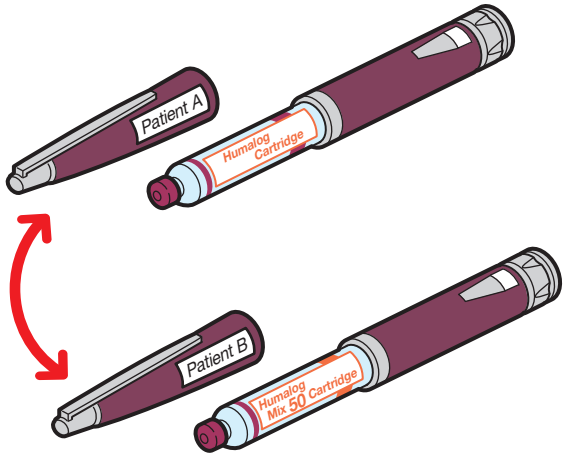
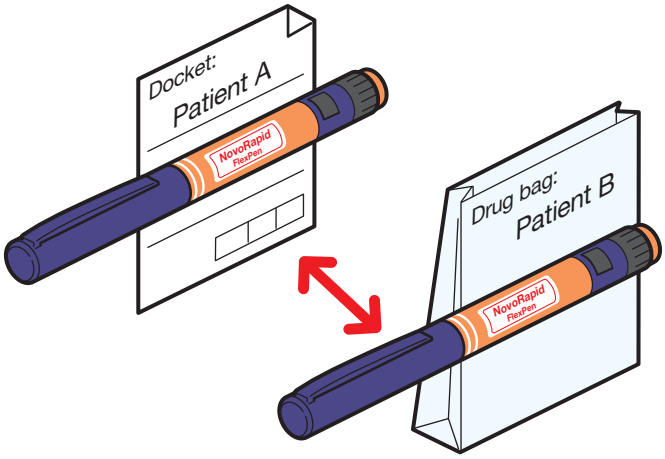


Image of case 2

Patient’s name was not written on the pen



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Case 1

An order had been given for a subcutaneous injection of 3 units of Humalog Cartridge to Patient A. After checking the order on the injection form, Nurse X checked the insulin pen and found that a Humalog Mix 50 Cartridge had been attached to the barrel of the pen whose cap bore the name of Patient A. This was a different type of insulin from that ordered, so Nurse X showed the insulin pen to Nurse Y, who had accepted the order, and asked, "Is this OK?" Nurse Y looked at the name written on the cap and replied, "It's OK," so Nurse X administered a subcutaneous injection of Humalog Mix 50 Cartridge to Patient A. The insulin pens for several patients had been stored together and the cap of Patient A's insulin pen had been mixed up with that of Patient B's insulin pen.

Case 2

During the night shift, an order was issued to start administering injections to Patient A with a NovoRapid FlexPen the following morning, so Night Nurse X obtained it from the pharmaceutical department. The procedure for unused insulin pens was to store them with the docket (attached with an elastic band), and the pen was stored without affixing a sticker bearing the patient's name to it. Patient B's NovoRapid FlexPen was stored inside Patient B's drug bag, but a sticker bearing the patient's name had not been affixed to the insulin pen. On the morning in question, Nurse X measured the patient's blood glucose level and then used a NovoRapid FlexPen without a patient's name on it, assuming it to be Patient A's insulin pen. Subsequently, Day Nurse Y noticed that there were no signs of Patient A's NovoRapid FlexPen having been used and realized that the preparation for Patient B had been used in error.

Preventive measures taken at the medical institutions in which the events occurred.

- **Staff members will write the patient's name on the barrel of the insulin pen, to ensure that the patient's name can be identified even when the cap is removed.**
- **Staff members will check the patient name, patient's insulin pen, and injection order sheet without fail before administering an injection.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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