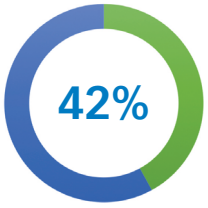
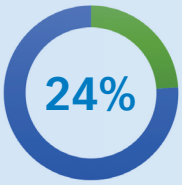
PHARMACY QI

Practical Tips for Quality Improvement — May 2018

Improving Medication Safety – Insulin

TYPE OF MEDICATION INCIDENT	INSULIN-RELATED EXAMPLE	QI PREVENTION MEASURES
Incorrect dose 	• Misinterpretation of insulin orders: Giving 10 times the dose due to 10 U interpreted as 100 units	• Avoid error-prone prescription abbreviations when writing orders or transcribing onto MARs (e.g., use "units" instead of "U").
	• Change of insulin orders without flagging insulin pens	• When processing an order change, flag all insulin pens in stock (i.e., in medication cart and fridge) with "Directions changed, refer to MAR." • Always refer to MAR for directions before administering insulin.
Dose omission 	• Missing a dose when the resident is not on the unit • A missing MAR signature	• Check MAR flags before the end of the medication pass to ensure residents have received their medications and documentation is completed.
	• Insulin not administered but MAR is signed	• Ensure MAR documentation is completed promptly during medication pass. Avoid late documentation.
Incorrect drug 	• The wrong insulin given due to look-alike and sound-alike products (e.g., Humulin®R instead of Humulin®N)	• Double check type of insulin and dose against the MARs. Independent double check (IDC) is recommended.
	• Administering a discontinued insulin	• Ensure all discontinued insulins are removed from all drug storage areas when processing a "Discontinue order."
Incorrect patient 	• Administering insulin to the wrong resident due to failure to check resident identification	• Use two patient identifiers before medication administration (e.g., picture, bracelet, confirming identity with another colleague).
Monitoring problem 	• Administering insulin to a resident with hypoglycemia due to lack of blood glucose monitoring	• Ensure monitoring of blood glucose; assess and document results prior to administration of insulin (especially with sliding scale and rapid-acting insulin).

All medication incidents can be reported 24/7 using MEDe*Report*® online reporting tool:
http://medincident.medicalpharmacies.com

References:
- ISMP Canada. Medication incidents occurring in long-term care. 2010. https://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2010-09-MedIncidentsLTC.pdf. Accessed January 25, 2018.
- Milligan F, Krentz AJ, Sinclair AJ. Diabetes medication patient safety incident reports to the National Reporting and Learning Service: the care home setting. Diabet Med 2011;28(12):1537-40.
- Medical Pharmacies Policy and Procedure Manual – Policy 9-1 (Medication Incident Reporting), Policy 3-6 (The Medication Pass), Policy 3-12 (How to Administer Insulin), Policy 4-10 (Change of Directions), Policy 4-11 (Discontinued Medications).

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