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Don't Count on Med Labeling and Packaging to Be Foolproof

You'll hear more about **risky med labeling and packaging**.

Industry regs and technology (bar-code scanning, etc) aren't stopping serious errors. Safety groups are pushing for more premarket review, standardization, and other improvements. But these take time.

Watch for problems that can lead to product mix-ups.

Unclear labeling. Inspect labeling and packaging carefully to ensure you have the right med, strength, formulation, and size.

Some labels are notoriously hard to read, such as those with embossing on nebules. But any labeling or packaging could trick the eye.

For example, oxytocin 1 and 10 mL vials have been confused when strength, not total amount, was most prominent on their labels.

Check expiration dates closely. A standard format is mandated for 2023...but confusing formats are still circulating.

If labeling is unclear, add labels or circle or highlight info for clarity...or put the med in a sealed bag that displays the info.

Look-alike packaging. Stay alert for meds that could be mistaken for each other...especially those kept in the same area.

For instance, product mix-ups have happened when meds had similar cartons...the same size vials with the same color caps...or the same size IV bags with the same color lettering.

Ask about ordering a different version of a med, if possible.

And ensure strategies, such as eye-catching labels and separate storage, are used to distinguish products when appropriate.

Missing warnings. Help avoid mishaps when important safety info isn't shown...or prominent.

For example, if neuromuscular blocker (rocuronium, etc) vial caps don't say "PARALYZING AGENT: CAN CAUSE RESPIRATORY ARREST," place labels with this warning over the caps.

Keep in mind that some meds require dilution before administration...but the label may not say so. Use safeguards, such as dispensing with dilution instructions and an appropriate diluent.

Tell your admin or med safety officer about any labeling or packaging risks you identify. They can help with mitigation...and report the problem appropriately to alert colleagues nationwide.

Use our *Look-Alike/Sound-Alike Meds* chart and *Optimizing Safety With Bar-Code Scanning* checklist to help ensure patients get intended meds.

Key References:

-ISMP Med Safety Alert! Acute Care 2021;26(9):1-4
-ISMP Med Safety Alert! Acute Care 2021;26(12):1-5
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