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Pharmacy Technician's Letter
Hospital

Keep Your Eyes Open for Incorrect Labeling and Packaging

You can help spot **dangerous issues with manufacturer labeling and packaging**.

We may think of med labeling and packaging from manufacturers as foolproof. But it isn't.

In a recent case, the labels on cartons of heparin **25,000** unit/500 mL drips didn't specify the concentration. This led to a mix-up with heparin **1,000** unit/500 mL, which could have been lethal.

Keep your eyes open to stop these problems in their tracks.

Always check labeling carefully and completely...by looking at med name, strength, volume, etc. Question anything that's suspect.

For example, **0.9**% sodium chloride 1 L bags have been labeled as **9**% sodium chloride...due to ink not adhering to the bags.

Don't rely fully on a med carton to tell you what's inside.

For instance, cisatracurium cartons have contained vials labeled as phenylephrine...although the vials actually contained cisatracurium.

And a doxorubicin carton contained an etoposide vial.

Plus if a carton is open, a colleague may have placed a different med inside by accident.

Consider this a reminder of the importance of barcode scanning to confirm you've chosen the right product.

Follow best practices, such as scanning each container rather than one container multiple times. And use strategies to reduce the risk of scanner overrides.

If you identify an issue with manufacturer labeling or packaging, notify a pharmacist, your admin, or med safety officer ASAP. They'll initiate a plan to assess the situation internally.

And they can report it through appropriate channels...to alert manufacturers and colleagues nationwide, if needed.

For instance, reporting the cisatracurium vials mislabeled as phenylephrine led to a nationwide alert and recall...which likely saved patients from deadly mix-ups.

Use our resource, *Managing Drug Shortages*, to find out how your pharmacy should handle recalls for incorrectly labeled products.

Key References:

-ISMP Med Safety Alert! Acute Care 2023;28(5):1-5
-ISMP Med Safety Alert! Acute Care 2023;28(4):1-5
-ISMP Med Safety Alert! Acute Care 2022;27(25):1-3
-ISMP Med Safety Alert! Acute Care 2021;26(3):1-5

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