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Outpatient insulin-related adverse events due to mix-up errors: findings from two national surveillance systems, United States, 2012-2017.

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Geller AI, Conrad AO, Weidle NJ, et al. Outpatient insulin?related adverse events due to mix?up errors: Findings from two national surveillance systems, United States, 2012–2017. Pharmacoepidemiol Drug Saf. 2021;30(5):573-581. doi:10.1002/pds.5212.
https://psnet.ahrq.gov/issue/outpatient-insulin-related-adverse-events-due-mix-errors-findings-two-national-surveillance

The Institute for Safe Medication Practices (ISMP) classifies insulin as a high-risk medication. This study examines insulin mix-up errors that resulted in emergency department visits or other serious adverse events. Most cases of medication mix-up involved rapid-acting insulin. Recommended prevention strategies include increased patient education and human factors engineering.