Strengthening Med Safety in Long-Term Care

ISMP CANADA

Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

Volume 3 • Issue 2 • March 2025

After-Hours Ordering Contributes to Insulin Overdose

Reported Incident (details are modified to ensure confidentiality of the home and reporter)

A resident was transferred back to the long-term care home (LTCH) late on Saturday night. Given the late hour, certain medications were not available, including the resident's specific types of rapid-acting and long-acting insulins. To manage the resident's blood sugar, periodic small doses of a different insulin, available from the emergency medication supply, were ordered for use until the usual insulins could be delivered. When the resident's usual insulins arrived on Monday, the order for the temporary insulin was not discontinued by the prescriber. As a result, both the insulin ordered on a temporary basis and the resident's usual insulins were administered. The resident received an overdose of insulin and had a prolonged episode of hypoglycemia.

Disclaimer: ISMP Canada staff determined the following key contributing factors and considerations for improvement. It is the responsibility of medication safety leaders in long-term care to determine what, if any, actions for improvement are needed in their medication management processes.

Key Contributing Factors:

- The late-night transfer prevented the pharmacy service provider from supplying the resident's usual medications.
- The inability to supply the usual insulins necessitated temporary orders using insulins available in the LTCH's emergency medication supply.
- The order for the temporary insulin did not include a clear instruction as to when it should be stopped.

Considerations for Improvement:

- Ensure that the LTCH has a reliable process to order and receive critical medications, even after hours and on weekends.
- Periodically review contents of the emergency medication supply to ensure they reflect the needs of the LTCH. For more information, see the ISMP Canada Model Policy on Emergency Medication Supply*.
- Add clear directions for when to stop an order for temporary medications (e.g., "stop drug X when drug Y is available for administration").

Resource:
*ISMP Canada Emergency Medication Supply Model Policy 5 https://ismpcanada.ca/wp-content/uploads/LTC-Model-Policy-5-Emergency-Medication-Supply.pdf

Report an Incident

Sign Up for Med Safety Signals