

## ISMP Canada Safety Bulletin

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### ALERT: Look-Alike Labelling and Packaging for Diphenhydramine and Phenylephrine

A facility reported concerns regarding the look-alike labelling and packaging of parenteral diphenhydramine and phenylephrine products manufactured by Omega. Diphenhydramine is an antihistamine that is used in the treatment of allergic reactions, whereas phenylephrine is a vasopressor used to treat low blood pressure.<sup>1,2</sup> A mix-up between these 2 medications could lead to serious patient harm.

Staff at the facility had found vials of phenylephrine in a bin that was labelled and intended to hold vials of diphenhydramine. Omega was the organization's usual supplier of diphenhydramine, but the facility had previously obtained phenylephrine from a different manufacturer. The labelling of the phenylephrine product from the previous manufacturer was readily distinguishable from the labelling of Omega's diphenhydramine product. However, because of circumstances beyond the facility's control, it had received Omega's phenylephrine product, which created an opportunity for the mix-up.

For both medications, the outer box and vial labels have the generic name printed in burgundy in capital letters on a white background (Figure 1). The layout of information is the same for the 2 medications. In addition, the 2 vials are the same size and contain the same volume of solution (1 mL), and both have a white cap.



**Figure 1:** Labelling and packaging for vials and outer boxes of Omega's diphenhydramine 50 mg/mL (at left) and phenylephrine 10 mg/mL (at right).

The reporter wanted information about the look-alike packaging to be shared widely, to help other organizations identify potential risks and manage the situation proactively. ISMP Canada contacted Omega to encourage a label change. The manufacturer has been working to revise the labelling of the phenylephrine product which should be available in early 2014.

In the interim, facilities that are currently obtaining these 2 parenteral products from Omega may want to consider purchasing one of the products from a different manufacturer to reduce the potential for mix-ups.

Look-alike issues are a particular concern when institutions change suppliers of pharmaceuticals,

especially when a high-alert medication is involved. Regardless of the reason for a change in supplier, the potential impacts must be examined from a broad

perspective, including reviewing the risk for medication error.

*This segment of the bulletin describes a recent SafeMedicationUse.ca publication from ISMP Canada's Consumer Program.*

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November 2013 Newsletter:

### **An Important Question - Does this new medicine replace one of my current medicines?**

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SafeMedicationUse.ca received a report about a consumer who was mistakenly given two different medicines to treat the same problem. A physician prescribed dabigatran intending it to replace the consumer's warfarin, but the dabigatran was dispensed and taken in addition to the warfarin. The consumer experienced a severe hematoma.

The SafeMedicationUse newsletter provides tips for consumers, including the importance of asking whether any new medicines prescribed are intended to replace other medicines. The newsletter also provides tips for practitioners, including the importance of ensuring that patients understand new instructions, and of communicating changes to other healthcare providers.

Read more at:

[www.safemedicationuse.ca/newsletter/newsletter\\_NewMedicineReplaceOneOfMyMedicines.html](http://www.safemedicationuse.ca/newsletter/newsletter_NewMedicineReplaceOneOfMyMedicines.html)

For useful tips and resources for safe medication use visit:

[www.safemedicationuse.ca](http://www.safemedicationuse.ca)



**Consumers Can Help Prevent  
Harmful Medication Incidents**

**SafeMedicationUse.ca**

## References

1. DrugPoint summary: diphenhydramine hydrochloride. In: Micromedex 2.0 healthcare series [Internet database]. Greenwood Village (CO): Truven Health Analytics; updated periodically [cited 2013 Nov 13]. Available from: <https://www.micromedexsolutions.com/home/dispatch>. Subscription required to access content.
2. DrugPoint summary: phenylephrine hydrochloride. In: Micromedex 2.0 healthcare series [Internet database]. Greenwood Village (CO): Truven Health Analytics; updated periodically [cited 2013 Nov 13]. Available from: <https://www.micromedexsolutions.com/home/dispatch>. Subscription required to access content.



The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.



The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.



The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

## Report Medication Incidents

(Including near misses)

**Online:** [www.ismp-canada.org/err\\_index.htm](http://www.ismp-canada.org/err_index.htm)

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