The seventy-two year-old patient was scheduled to be discharged from the hospital to a skilled rehab facility for physical therapy.

On the night before his discharge a hospital nurse gave him 80 rather than the prescribed 8 units of NPH insulin for his Type II diabetes.

Although NPH insulin is considered by the facility to be a high-alert medication requiring a second nurse’s check-off, the nurse did not consult with anyone before injecting it.

After injecting the insulin the nurse reportedly remarked, “Whew. That was a lot of insulin.” It was only at that point that another nurse checked the medication administration record and discovered the massive overdose. It was too late. The damage was already done. The patient coded, but was revived and lingered several days before he died.