**[Insert Hospital Name]**

**Formulary and Therapeutics Committee**

**DRUG ALERT**

**Critical and time-sensitive drug and drug therapy information disseminated by the Department of Pharmacy**

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**SAFE USE OF INSULIN PENS**

As a clinical reminder, the January 12, 2012, issue of the Institute for Safe Medication Practice (ISMP) Medication Safety Alert newsletter highlighted the inappropriate use of insulin pens and provided updates on the dangerous practice of using the same insulin pen on multiple patients. Repeated event reports suggest that an alarming and widespread misunderstanding that sterility can be maintained between patients by affixing a fresh needle on a pen device continues. ISMP has reported two nurses who knowingly used the same pen for multiple patients. In one case the original patient had HIV. All patients were treated for exposure. According to the CDC, evidence continues to mount that this dangerous practice is still affecting thousands of patients, which places individuals at risk of infection. The insulin pen box has a warning stating “Single Patient Use Only”, however, the pen itself carries no warning. Strategies for avoiding this problem and other problems associated with Insulin pens are noted below.

Additional information can be found at

* <http://www.ismp.org/Newsletters/acutecare/issue.aspx?id=12>
* <http://www.cdc.gov/injectionsafety/clinical-reminders/insulin-pens.html> [CDC - Blood Glucose Monitoring - Injection Safety](http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html)

| **Errors** | **Causes** | **Safe Practices** |
| --- | --- | --- |
| Use of pen for multiple patients | Cross contamination can occur when sharing the same pen with more than one patient even when the safety needle has been changed. This imposes a potential risk of hepatitis C and HIV transmission. | Pharmacy dispenses and labels insulin pens for specific patients. These pens should only be used for the labeled patient and NEVER used for a different patient. |
| Withdrawing insulin out of the cartridge  with a syringe | This practice damages the integrity of the pen and can introduce pockets of air, which can lead to inaccurate dosing. | NEVER use a syringe to draw insulin out of an insulin pen cartridge. |
| “Wet spots” noted on skin post injection | 1. One cause of “wet spots” may be that the air shot of insulin collects in the cylinder of the safety needle. | 1. When performing a 2 unit “air shot”, repeat until at least one drop of insulin appears on the tip of the needle. This ensures that no air is being delivered. Shake off any excess insulin that collects in chamber of safety needle. |
| 1. Another cause may be removal of the safety needle before all of the insulin is delivered. | 1. Push the plunger all the way down and wait 6 seconds before withdrawing the needle. |
| Needlestick injuries | When pinching the back of the arm of a thin patient, there is a greater risk of a needlestick injury to the nurse | 1. Nurses should maintain a 90 degree angle during the injection. 2. Inject pre-meal insulin in abdomen and long-acting insulin in thigh whenever possible |

More information on the use of insulin pens is available in the [insert hospital name] Nursing Procedure Manual [insert procedure number or link].

The current insulin pen on the [insert hospital name] formulary, Novolog FlexPens®, must be used in conjunction with the Novofine® Autocover™ Safety Needles that are available through General Stores/Materials Management.

**References**

Institute for Safe Medication Practices. Hazard alert: do not use an insulin pen for multiple patients! Acute Care ISMP Medication Safety Alert. 2012; 17(1): 1,4. http://www.ismp.org/Newsletters/acutecare/issue.aspx?id=12.

Institute for Safe Medication Practices. Considering insulin pens for routine hospital use? Consider this…. May 8, 2008. www.ismp.org/Newsletters/acutecare/articles/20080508.asp.

**For questions regarding this Drug Alert,** [insert appropriate contact in pharmacy department].