Institute for Safe Medication Practices
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Hospitals Should Reconsider Insulin Pen Use, Says ISMP

Horsham, Pa--- As a result of persistent, ongoing safety issues, the Institute for Safe Medication Practices (ISMP) is calling for hospitals to closely reexamine their policies regarding insulin pen devices, and consider transitioning away from insulin pens for routine inpatient use.

Studies have shown a risk of infection when insulin pens are reused for more than one patient, since blood and tissue can travel back into the cartridges after injection. It was announced early this year that almost 2,000 patients in a New York hospital may have been inadvertently exposed to HIV, hepatitis B, or hepatitis C because of the reuse of insulin pens on multiple patients, even after changing the disposable needle.

Another New York hospital also announced possible exposure of more than 700 patients to bloodborne pathogens due to improper sharing of pens among inpatients, and similar cases in Texas and Wisconsin have been covered in the *ISMP Medication Safety Alert!* newsletter. ISMP has received multiple additional reports involving smaller numbers of patients.

Insulin pens offer convenience and may help prevent certain types of medication errors; however, they were originally developed for use in ambulatory care, not hospitals. Placing a label on an insulin pen for a single patient is difficult. In addition, the use of insulin pen cartridges as multiple dose vials, the risk of needlestick injuries, and user technique errors have all been identified as serious concerns with pen use in hospital settings.

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The U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) caution insulin pen users to remove the needle immediately after injection and warn against sharing the device between patients. However, despite educational efforts and monitoring, reports of patients placed at risk of infection continue to surface.

Based on the risks associated with reusing insulin pens on multiple patients, some hospitals have never transitioned to using them, or have reverted back to using vials of insulin instead. Most recently the Veterans Health Administration (VA) National Center for Patient Safety prohibited use of multi-dose pen injectors on patient care units at VA facilities, with only a few exceptions, which ISMP supports.

ISMP hopes that the ongoing safety issues with insulin pens will lead to recognition that lack of understanding regarding their safe use is more widespread than initially thought, and cannot be easily solved with education alone or fairly dealt with by punishing individuals who have never learned the correct way to use these devices. The Institute believes that the risk of patient infection is best mitigated by removing insulin pens from use in inpatient settings.

For a copy of an article on this issue in this week's ISMP Medication Safety Alert! newsletter that addresses insulin pen use, visit:
http://www.ismp.org/newsletters/acutecare/issues/20130207.pdf

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org

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