**[Insert Hospital Name]**

**Department of Nursing**

**Nursing Matters!**

**A Message from [Insert name], Chief Nursing Officer**

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**Purpose: To share lessons learned and other “Hot Topics” identified that are related to Nursing Practice and/or Quality and Patient Safety**

**What we need you to do: Review and discuss with staff at your unit huddles/unit practice council meetings**

**Topic: Safe Use of Insulin Pens**

Process Issue: There have been reported issues highlighted in the media and from the Centers for Disease Control and Prevention (CDC) on improper use of insulin pens.

**Why is this important?**

* Cross contamination can occur when sharing the same insulin pen with more than one patient even when the safety needle has been changed. THIS IS A SAFETY CONCERN FOR OUR PATIENTS AND POSES A POTENTIAL RISK OF HEPATITIS C AND HIV TRANSMISSION.

**Key Reminders**

* Insulin pens are SINGLE PATIENT USE ONLY and should be NEVER used for another patient; the pharmacy labels them with the specific patient information.
* Perform patient verification as required prior to use of an insulin pen. For pediatric patients, a 2RNcheck is required.
  + For staff using bar code scanners for medication administration (Patient Safe Solution –PSS), you must scan the patient specific bar code label to ensure you have the correct insulin pen.
  + If the label is illegible or missing, the insulin pen should be DISCARDED and a new one requested from the pharmacy.
* Only remove insulin pens when needed; DO NOT PLACE insulin pens in uniform pockets to carry for use at later time.
* Do not attempt to draw out insulin from the pen; it damages the integrity of the pen and can lead to inaccurate dosing.
* For patients on contact isolation, the insulin pen should be cleaned with disinfectant wipe and when dry placed in a new plastic bag.
* Insulin pens should be stored properly in the secured patient specific medication bins within the medication cart (if used) during the shift or automated medication dispensing cabinet (AMDC) and returned to AMDC at end of shift. Insulin pens may not be left at a patient’s bedside.
* Make sure diabetic patients understand that they should NEVER share their insulin pen due to the safety risks in the potential transmission of infection. Provide appropriate patient education in the patient’s preferred language and assess level of understanding through repeat-back / teach-back demonstrations.

**Actions Required**

* Review the process with nurses ASAP on all shifts; use the CDC one-page summary and have your RNs confirm through read and sign that they have reviewed this.
* Conduct random observation of staff practices in use of insulin pen.

**References**

* <http://www.cdc.gov/injectionsafety/PDF/Clinical-Reminder-insulin-pen.pdf>
* [insert link to nursing department procedures for use of insulin pen delivery device]
* [insert link to nursing department procedures for use of insulin pen delivery device in pediatric patients]