

OBSERVATIONS

Sharing Insulin Pens: Are You Putting Patients at Risk?

Ease of administration, accuracy, and convenience are among the hallmark characteristics of insulin pens. These devices, which have gained popularity over the past 10 years, are designed to be used multiple times for a single person, using a new needle for each injection. Unfortunately, reports of the misuse of insulin pens also have been growing.

Backflow of blood and other biologic material into the insulin cartridge or reservoir can occur after injection (1). For this reason, insulin pens, like other injection devices, must never be used by more than one person. Reports of insulin pen sharing have come from a variety of U.S. health care settings. Since 2011, there have been at least six separate incidents in which patients were contacted and given advice to test for bloodborne pathogens because individual insulin pen devices were reused for multiple patients (Table 1).

In all of these events, reuse of pens may have occurred over a period of years before it was identified and corrected. Because these unsafe practices had gone unnoticed for so long, thousands of patients were placed at risk for infection. These incidents occurred in spite of clear package instructions stating that pens are not to be shared and a series of alerts issued by the U.S. Food and Drug Administration, the Centers for Disease Control and Prevention, and other groups such as the Institute for Safe Medication Practices (2). In response to recent incidents identified at Veterans Health Administration (VHA) facilities, the VHA issued a patient safety alert that, with few exceptions, prohibits the use of multidose pen injector devices, including insulin pens, on patient-care units in the VHA system (3).

To help educate both health care personnel and patients, the Safe Injection Practices Coalition, led by the Centers for Disease Control and Prevention, has developed an educational campaign and materials addressing the safe use of insulin pens (4). Anyone using insulin pens should adhere to the following practices to ensure that they do not place themselves or patients in their care at risk for infection.

Table 1—Patient notification events resulting from multipatient use of insulin pens in U.S. health care settings, 2011–2013

Setting	Persons notified (n)	Time period during which insulin pens might have been used for more than one patient	Source
Primary care clinic ^{a,b}	2,345	2006–2011	http://www.deancare.com/about-dean/news/2011/important-patient-safety-notification/
Hospital ^a	57	2001–2011	Wisconsin Division of Public Health, unpublished data
Hospital	716	2010–2012	http://www.buffalonews.com/apps/pbcs.dll/article?AID=/20130111/CITYANDREGION/130119728/1002
Hospital	1,915	2009–2013	http://www.cbsnews.com/8301-204_162-57565678/second-n-y-hospital-warns-of-hiv-infection-risk-from-insulin-pens/
Hospital	205	2010–2013	http://www.wbtv.com/story/21546682/salisbury-va-insulin
Hospital	NA	2007–2013	http://www.recordonlin.com/apps/pbcs.dll/article?AID=/20130521/NEWS/130529929

^aInsulin demonstration pens were reused. ^bNotification also included patients that were potentially exposed to reused finger-stick devices. NA, not available.

- Insulin pens should never be used for more than one person, even when the needle is changed.
- Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used exclusively on one individual.
- Hospitals and other facilities that use insulin pens and similar devices must have policies addressing safe use, with an active program to ensure that staff are appropriately educated, in advance of introducing these products, with active monitoring to ensure strict adherence to safe practices.
- If multipatient use is identified, exposed persons should be promptly notified and offered appropriate follow-up including bloodborne pathogen testing.

The Centers for Medicare & Medicaid Services has instructed surveyors to evaluate the use of insulin pens when conducting facility inspections and to cite facilities that fail to follow safe practices (5). However, facilities should not wait for an inspection and should immediately evaluate current practices. After all, protection from infections, including those caused by bloodborne pathogens,

is a basic expectation anywhere health care is provided.

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DOI: 10.2337/dc13-1522

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Acknowledgments—No potential conflicts of interest relevant to this article were reported.

M.K.S. wrote the manuscript and researched data. R.A.K. and J.F.P. researched data and reviewed and edited the manuscript. M.K.S. is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

