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PATIENT SAFETY NETWORK

Is one-pen, one-patient achievable in the hospital? A quality improvement project to reduce risks of inadvertent insulin pen sharing at a large academic medical center.

January 29, 2020
Ho S, Stamm R, Hibbs M, et al. Is One-Pen, One-Patient Achievable in the Hospital? A Quality Improvement Project to Reduce Risks of Inadvertent Insulin Pen Sharing at a Large Academic Medical Center. Jt Comm J Qual Patient Saf. 2019;45(12):814-821. doi:10.1016/j.jcjq.2019.09.002.
https://psnet.ahrq.gov/issue/one-pen-one-patient-achievable-hospital-quality-improvement-project-reduce-risks-inadvertent

Recent guidelines from the Institute for Safe Medication Practices have warned of the risk of blood-borne disease transmission associated with insulin pen sharing in hospitalized patients and provide recommendations for safe practices. This paper describes the impact on insulin pen sharing after the implementation of safe practice recommendations (e.g., label redesign, patient-specific bar coding on pens) at a quaternary academic medical center. Institutional efforts resulted in a less frequent pen-sharing events and a decrease in latent errors found during medication drawer audits, such as retained pens after discharge and illegible or missing label.