

# DON'T DO IT

## Sharing Insulin Pens and Other Injection Equipment Harms Patients

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration issued an alert reminding healthcare providers that insulin pens are meant for use on a single person only and are not to be shared. Unfortunately, there have been continuing reports of patients placed at risk of bloodborne and bacterial pathogen transmission through sharing of insulin pens.



### A SIMPLE RULE

Injection equipment (e.g., insulin pens, needles and syringes) should **never** be used for more than one person.



### About the Safe Injection Practices Coalition

The Safe Injection Practices Coalition (SIPC) is a partnership of healthcare-related organizations led by the Centers for Disease Control and Prevention. The SIPC developed the *One & Only Campaign*—a public health effort to eliminate unsafe medical injections by raising awareness of safe injection practices.

For a list of SIPC partners, for more information about the campaign, and to view additional resources including videos and other materials, please visit:

[www.cdc.gov/injectionsafety/1anonly.html](http://www.cdc.gov/injectionsafety/1anonly.html)



# BE AWARE DON'T SHARE



## ONE INSULIN PEN, ONLY ONE PERSON



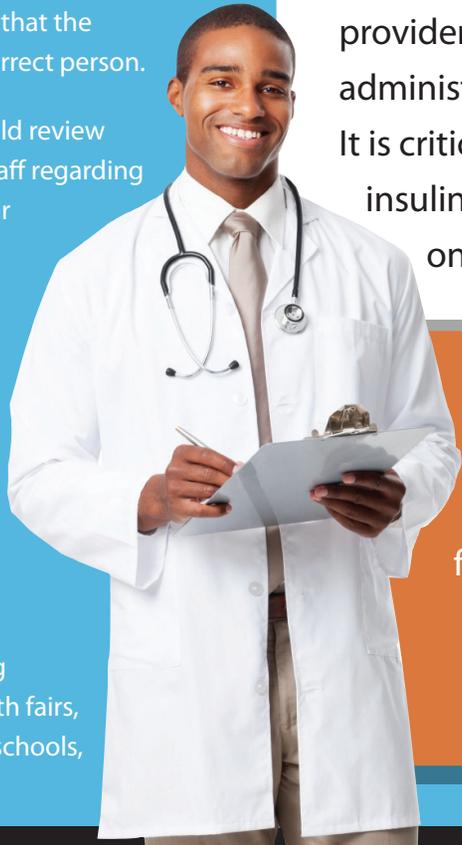
**What Every  
Healthcare Provider  
Needs To Know**

# Insulin Pens: Recommendations For Safe Use

Protecting your patients from infection is a basic standard of care. Reusing insulin pens and other injection equipment for more than one person can spread infections to your patients.

- Insulin pens and other injection equipment are meant to be used on one person only.
- Insulin pens should never be used for more than one person, even when the needle is changed or when there is leftover medicine.
- Insulin pens and other injection equipment should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used only on the correct person.
- Hospitals and other facilities should review their policies and educate their staff regarding safe use of insulin pens and similar devices.
- If reuse is identified, patients should be promptly notified and offered appropriate follow-up including bloodborne pathogen testing.

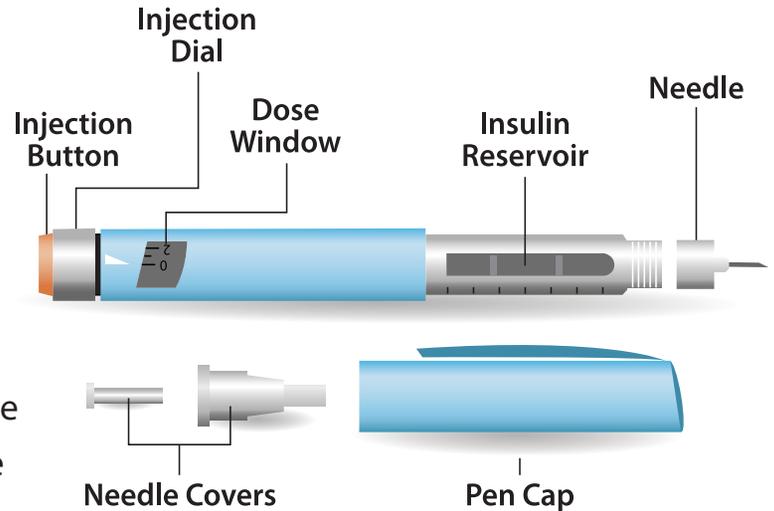
These recommendations apply to any setting where insulin pens and other injection equipment are used. This includes hospitals, assisted living facilities, nursing homes, clinics, health fairs, shelters, detention facilities, homes, schools, and camps.



# ONE INSULIN PEN, ONLY ONE PERSON

## Insulin Administration

Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and require that a new needle be used for each injection. In some healthcare settings, healthcare providers use insulin pens to administer insulin to patients. It is critical to remember that insulin pens are meant for only one person.



Although invisible to the eye, back flow of blood into the insulin pen can happen during an injection. This creates a risk of bloodborne and bacterial pathogen transmission to patients if the pen is used for more than one person, even when the needle is changed.

The Safe Injection Practices Coalition created an easy-to-use checklist for facilities. Similar to a risk assessment, the checklist allows facilities to quickly assess their practices.

**A copy of the checklist can be found at:**  
[www.cdc.gov/injectionsafety/1anonly.html](http://www.cdc.gov/injectionsafety/1anonly.html)

