Precautions in Handling of Insulin Injectors

Key points for safe use

(Case 1) When preparing multiple insulin injectors at the same time, a cap was accidentally put on another patient’s injector. A mix-up occurred.

1 Cases of insulin injector mix-up

- Make sure to check each patient’s injector one by one when preparing insulin injectors (including setting up of insulin cartridges).

There is a risk of mix-ups if you prepare insulin injectors of multiple patients! Make sure to handle each patient’s injector individually using trays.

It is another patient’s cap!
A patient, who had been receiving rapid-acting insulin 3 times a day before meals and long-acting insulin once before bedtime, went into a hypoglycaemic coma after accidentally setting up a rapid-acting insulin cartridge and using it before bedtime instead of a long-acting one.

Dosing errors can be prevented via placing a patient identification label on the injector itself rather than the cap.

**Case 2**

A patient, who had been receiving rapid-acting insulin 3 times a day before meals and long-acting insulin once before bedtime, went into a hypoglycaemic coma after accidentally setting up a rapid-acting insulin cartridge and using it before bedtime instead of a long-acting one.

### Cases of insulin cartridge mix-up

<table>
<thead>
<tr>
<th>Before breakfast</th>
<th>Before lunch</th>
<th>Before dinner</th>
<th>Before bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid-acting insulin</td>
<td>Rapid-acting insulin</td>
<td>Rapid-acting insulin</td>
<td>Long-acting insulin</td>
</tr>
</tbody>
</table>

**“Sliver” pen before bedtime**

**“Blue” pen before meals**

Rapid-acting insulin was accidentally set up!
Precautions when using insulin injectors

In cases when several insulin injectors are used at home or in a ward, there is a risk that a cartridge will be set up in the wrong injector, which leads to dosing errors if injectors are distinguished just by color. Make sure to check the drug name on the cartridge before administration!