Alberta Health Services

RESOLVED

Patient Safety Alert

Status

Resolved ■

Zone Application

Provincial ☐
North ■
Edmonton ☐
Central ☐
Calgary ☐
South ☐

Date Resolved:

25 April 2019

Use Insulin Syringes when Administering or Preparing Intravenous Insulin

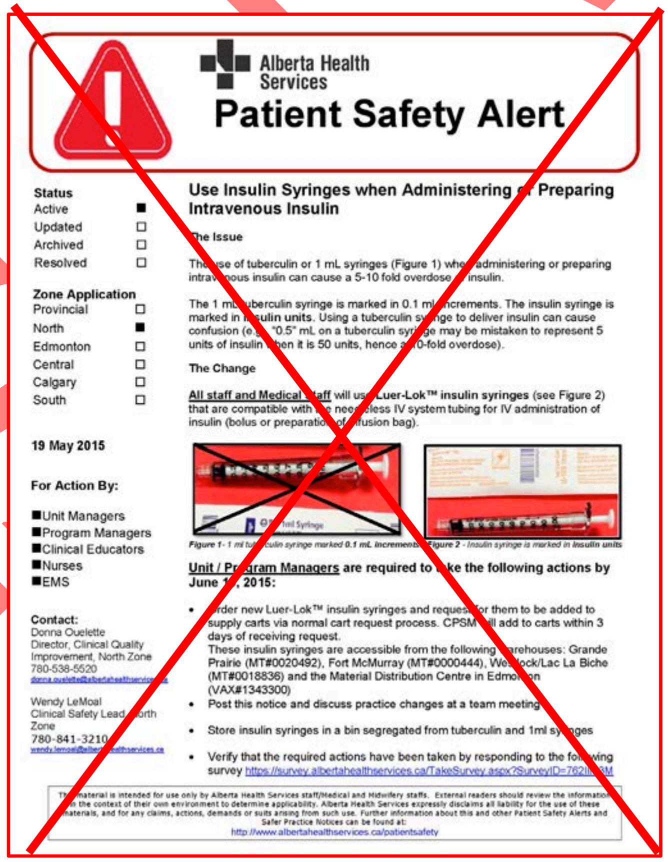
The PSA originally issued on 19 May 2015 is now considered resolved because:

☐ The equipment is no longer in use

■ The identified hazard no longer exists/ has been significantly reduced

☐ New policy is now in place

☐ Other



Alberta Health Services

Patient Safety Alert

Status
Active ■
Updated ☐
Archived ☐
Resolved ☐

Zone Application
Provincial ☐
North ■
Edmonton ☐
Central ☐
Calgary ☐
South ☐

19 May 2015

For Action By:

■Unit Managers
■Program Managers
■Clinical Educators
■Nurses
■EMS

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Use Insulin Syringes when Administering or Preparing Intravenous Insulin

The Issue

The use of tuberculin or 1 mL syringes (Figure 1) when administering or preparing intravenous insulin can cause a 5-10 fold overdose of insulin.

The 1 mL tuberculin syringe is marked in 0.1 ml increments. The insulin syringe is marked in insulin units. Using a tuberculin syringe to deliver insulin can cause confusion (e.g. "0.5" mL on a tuberculin syringe may be mistaken to represent 5 units of insulin when it is 50 units, hence a 10-fold overdose).

The Change

All staff and Medical Staff will use **Luer-Lok™ insulin syringes** (see Figure 2) that are compatible with the needleless IV system tubing for IV administration of insulin (bolus or preparation of infusion bag).

Figure 1 - 1 ml tuberculin syringe marked 0.1 mL increments *Figure 2 - Insulin syringe is marked in insulin units*

Unit / Program Managers are required to take the following actions by June 1?, 2015:

- Order new Luer-Lok™ insulin syringes and request for them to be added to supply carts via normal cart request process. CPSM will add to carts within 3 days of receiving request.
  These insulin syringes are accessible from the following warehouses: Grande Prairie (MT#0020492), Fort McMurray (MT#0000444), Westlock/Lac La Biche (MT#0018836) and the Material Distribution Centre in Edmonton (VAX#1343300)
- Post this notice and discuss practice changes at a team meeting
- Store insulin syringes in a bin segregated from tuberculin and 1ml syringes
- Verify that the required actions have been taken by responding to the following survey https://survey.albertahealthservices.ca/TakeSurvey.aspx?SurveyID=762I...M

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http://www.albertahealthservices.ca/patientsafety

Action

- Please remove the original PSA from bulletin boards