

Medical Device/Equipment ALERT

Ref. MDEA(NI)2006/39

Issued: 18 July 2006

For:

IMMEDIATE ACTION	
ACTION	✓
UPDATE	✓
INFORMATION	



HEALTH ESTATES

creating healing environments

This notice replaces Medical Device/Equipment Alert MDEA(NI)2005/13.

	Section
Medical Device/Equipment: USE OF REUSABLE PEN INJECTION DEVICES BY HEALTHCARE WORKERS: RISK OF NEEDLESTICK INJURY	▶ ①
Problem: Healthcare workers remain at risk of sustaining needlestick injuries when removing needles from reusable pen injection devices.	▶ ②
Action by: This notice should be brought to the attention of all appropriate managers, staff and users.	▶ ③
Action: Healthcare workers should be informed of the risk of needlestick injury during the removal of pen needles from pen injection devices.	▶ ④
Distributed by NIAIC to: Chief Executive of each HSS Board Chief Executive of each HSS Trust Chief Executive of each Agency NIAIC Liaison Officers General Medical Practitioners Hospices	▶ ⑤
Contacts NIAIC contacts for technical aspects.	▶ ⑥
Feedback Requirements to NIAIC None Required	▶ ⑦

This Alert is on our web site: <http://www.dhsspsni.gov.uk/niaic>

1. DEVICE/EQUIPMENT:

USE OF REUSABLE PEN INJECTION DEVICES BY HEALTHCARE WORKERS: RISK OF NEEDLESTICK INJURY

2. PROBLEM:

Healthcare workers remain at risk of sustaining needlestick injuries when removing needles from reusable pen injection devices. Reusable pen injection devices are intended to be used by patients for the self-administration of medications such as insulin and growth hormone. The needles for these devices, often referred to as pen needles, are normally packaged with an outer and inner cap.

The outer cap is used to attach the needle to the pen injection device. The inner cap is then removed and disposed of. The outer cap is used again to remove the needle from the device following administration of the medication.

Consequently, removing the needle from a pen injection device involves re-sheathing a used needle by hand. Where this is done by a healthcare worker it exposes them to a risk of infection. This has been found to account for 5% of needlestick injuries and is inconsistent with best practice given previously in SN (NI) 2001/28.

In certain circumstances, it may be necessary for a healthcare worker to administer medication using the patient's pen injection device, e.g. training the patient to use a pen injection device. In addition, some medicines such as insulin are supplied only in cartridges for use with proprietary pen injection systems. Consequently, they are not readily available in vials for administration with a standard needle and syringe should the patient be unable to self-administer.

Devices such as needle removers may be available as part of proprietary pen injection systems to reduce the risks associated with removing used needles. In addition, needle clippers are available for pen needles.

3. ACTION BY:

This notice should be brought to the attention of all appropriate managers, staff and users of pen injection devices.

4. ACTION:

Healthcare workers should be informed of the risk of needlestick injury during the removal of pen needles from pen injection devices. Where practicable, healthcare workers should avoid the use of pen injection devices to administer medication to patients. A standard needle and syringe should be used instead.

Where it is necessary for healthcare workers to use pen injection devices:

- a) the patient should be encouraged to remove the needle, using the outer plastic cap supplied with it, OR
- b) the healthcare worker should use a device such as a needle remover or needle clipper.

Healthcare workers should only use the outer cap to remove a pen needle if the patient is unable to remove the needle and no needle remover/clipper is available. Needle removers and needle clippers should be used in accordance with the manufacturers' Instructions for use. Needle

manufacturers / suppliers should be contacted for information on the availability of needle removers and needle clippers.

All needles should be discarded safely in accordance with the advice contained in Safety Action Notice SN (NI) 2001/28.

5. ONWARD DISTRIBUTION TO:

Please bring this notice to the attention of all who need to know or be aware of it. This will include distribution to:

- Liaison Officers
- Risk Managers
- Health & Safety Officers/Advisors
- Clinical Governance Leads
- Device Managers
- Occupational Therapists
- Medical Directors
- Clinical Directors
- Nurse Directors
- Consultant Diabetologists
- Diabetes Specialist Nurses
- Endocrinology Specialist Nurses
- Endocrinology Units
- Medical, Nursing and Care Staff
- Supplies Staff (RSS)
- Special Care Baby Units
- Paediatric Units
- Practice Nurses
- Pharmacy Managers
- Directors of Public Health
- Social Care Staff
- Community Care Staff
- Day Care Centres
- Independent Health and Social Care Providers – Private Clinics, Residential and Nursing Homes through RQIA
- Sterile Services Departments
- Infection Control Staff
- Accident & Emergency Departments
- Allied Health Professionals
- All Wards and Departments
- All Community Nurses

6. CONTACTS:

Enquires to NIAIC should quote reference number MDEA(NI)2006/39 and be addressed to:

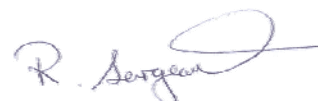
Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast BT16 1US

Tel: 028 9052 3868
Fax: 028 9052 3900
Email: NIAIC@dhsspsni.gov.uk

7. FEEDBACK:

None Required

Robert Sergeant
NIAIC Operational Manager



HOW TO REPORT ADVERSE INCIDENTS

Adverse Incidents relating to medical devices, non-medical equipment, plant and buildings should be reported to NIAIC as soon as possible. Advice on how to report is given in MDEA(NI)2006/01. If you are in doubt about how to report incidents, please speak to your liaison officer or contact NIAIC using the telephone number provided. Adverse Incident reporting forms and an on-line reporting facility are available on the NIAIC website at www.dhsspsni.gov.uk/niaic

Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety