Problem:

What: Patients infected with hepatitis

When: November 2009 - January 2013

Where: New York, Hospital Insulin pens

Task being performed: Insulin testing, follow-up, potential treatment

Impact to the Goals:

- Patient Safety: Possibility of contraction of communicable disease
- Compliance: Re-use of insulin pens against FDA/CDC recommendation
- Organization: Lawsuit against hospital
- Patient Services: 1,915 patients received insulin through improper sharing of pens
- Environmental: Potential spreading of communicable disease
- Property, Equip, Mtls: Patient testing, followup, potential treatment

Possibility of spread of communicable disease exists

After a similar incident at a Veterans Hospital, a hospital in New York reviewed its insulin injection procedures and discovered that insulin pens may have been used for more than one patient, resulting in a risk of exposure to communicable disease.

“We are very aware that while the risk of infection from insulin pen re-use is extremely small, cross contamination from an insulin pen is possible.” - Health system President & CEO

Analysis:

Basic Level Cause Map - Start with simple Why questions.

More Detailed Cause Map - Add detail as information becomes available.

Solutions:

<table>
<thead>
<tr>
<th>No.</th>
<th>Action Item</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discontinued use of insulin pens</td>
<td>Use of insulin pens to deliver insulin</td>
</tr>
<tr>
<td>2</td>
<td>Reviewed, reinforced policies, procedures related to insulin injections</td>
<td>Issues with policies, procedures</td>
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