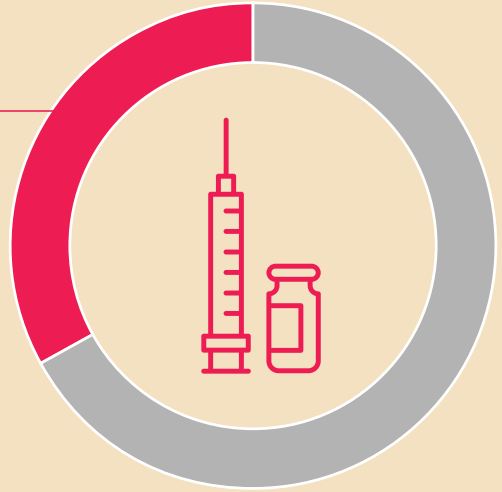
Large-Scale Insulin Overdoses From Syringe-Related Errors: Analysis and Insights Across 47 Hospitals

35.4%

More than one-third of the events that reached the patient resulted in a serious event.



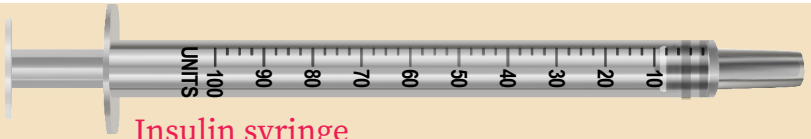
Reported Issues

- Improper syringe storage
- Similar appearance
- Lack of provider experience
- Variability in hospital insulin protocols and formularies

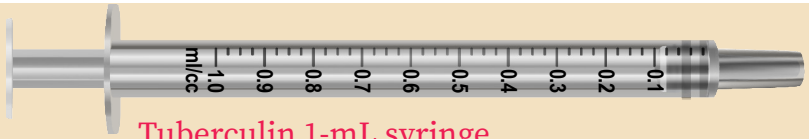
Safety Strategies

- Use a luer-lock insulin syringe to prepare and administer intravenous insulin.
- Store insulin syringes distinctly apart from other syringes.
- Consider different suppliers for 1-mL syringes that offer distinct packaging from insulin syringes.

Wrong syringe involved most frequently was a 1-mL syringe.



Insulin syringe



Tuberculin 1-mL syringe

Ro M, Jones R. Large-Scale Insulin Overdoses From Syringe-Related Errors: Analysis and Insights Across 47 Hospitals. *Patient Safety*. 2026;8(2):146624. doi:10.33940/001c.146624

PSA PATIENT SAFETY