



...On The Pulse...

## Snapit The easy and safe ampoule opener



### The Need for Ampoule Openers

The veterinary profession use hundreds of thousands of ampoules annually. Breakages, cuts and contamination of content have always been a safety concern.

### Ampoule Injuries Statistics

- Opening Glass Ampoules was the most frequently reported cause of sharps injuries.<sup>1</sup>
- A study of 1162 nurses found that 33% of all nurses were injured from opening glass ampoules.<sup>2</sup>
- 54% of incidents to anaesthesia personnel were caused by glass ampoules.<sup>3</sup>

### Advantages of using Snapit

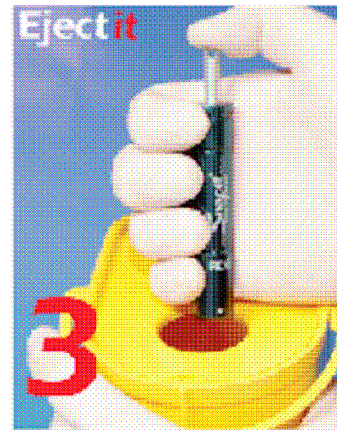
- ◆ Easy to use
- ◆ Compatible with common ampoule sizes
- ◆ Reduced sharps injuries
- ◆ An effortless open every time due to extended lever action
- ◆ Cleanest possible open without scoring
- ◆ Reusable and Washable
- ◆ No double handling
- ◆ No stress on wrist when snapping off ampoule top
- ◆ Happy staff!

## Easy to Use

With Snapit, anyone can open an ampoule without worrying about injuring themselves:

1. Insert the ampoule lid into Snapit
2. Snap open ampoule
3. Eject the ampoule lid

It's as easy as that!



## Technical specification

Regular Size:

Ampoule size: 1-2ml, 5-10ml, 10-15ml (common sizes)\*

Large Size:

Ampoule size: 5-10ml, 10-15ml, 20-25ml (large)\*

**“For a one off investment in Snapit – you can virtually eliminate the dangers of opening ampoules in your surgery – in these days of litigation this could be a very wise investment to help protect your staff and your practice.”**

\* Compatibility depends on the ampoule's geometry and the diameter of the ampoule lid. Ampoules of the same size can have a different geometry and ampoule lid diameter. The ampoule size in mls are only used as a guideline.

### References:

1. Smith D.R, Smyth W, Leggat P.A and Wang, R.S. (2005). "Needlestick and sharps injuries among nursing students." *Journal of advanced Nursing* 51(5), Pg 449-455.
2. Smith, D.R., M. Mihashi, et al. (2006). "Epidemiology of needlestick and sharps injuries among nurses in a Japanese teaching hospital." *J Hosp Infect*.
3. Pulnitiporn, A., W. Chau-in, et al. (2005). "The Thai Anesthesia Incidents Study (THAI Study) of anesthesia personnel hazard." *J Med Assoc Thai* 88 Suppl 7: S141-4.

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