NHS
Dorset
Clinical Commissioning Group

MEDICINES STANDARD A4:
INSULIN PRESCRIBING

In June 2010, the National Patient Safety Agency (NPSA) issued a Rapid Response Report, "Safer administration of insulin". The report identified that errors relating to the prescribing and administration of insulin were common. The alert identified that the most common errors for administration of insulin are:

- the inappropriate use of non-insulin (IV) syringes, which are marked in ml and not in insulin units;

- the use of abbreviations such as 'U' or 'IU' for units. When abbreviations are added to the intended dose, the dose may be misread, e.g. 10U is read as 100.

In March 2011, the NPSA released an additional patient safety alert "The adult patient's passport to safer use of insulin", to complement existing systems for safe prescribing and administration of insulin, which identified three main types of error:

- Getting the wrong insulin product(s);
- Having insulin omitted or delayed;
- Getting the wrong dose of insulin.

The March 2011 alert describes the use of an "insulin passport" for all adults prescribed insulin therapy, to improve patient safety by empowering patients to take an active role in their treatment with insulin, and to ensure that key information about their insulin therapy is accessible to all healthcare providers.

The insulin passport documents the patient's current insulin products and facilitates a safety check at prescribing, dispensing and administration of insulin. The passport has been designed as a single, double-sided sheet that folds up to credit-card size so that it additionally functions as an alert card that can be easily carried at all times.

Death or severe harm from maladministration of insulin has been defined as a "Never Event" by the NPSA. "Never Events" are incidents that are considered unacceptable and eminently preventable. For more information, please refer to the most recent "Never Events" list.

RECOMMENDATIONS IN THE ALERTS

The NPSA alert "Safer administration of insulin" recommends that:

- All regular and single insulin (bolus) doses are measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration.

- The term 'units' is used in all contexts. Abbreviations, such as 'U' or 'IU', are never used.

- All areas and staff treating patients with insulin have adequate supplies of insulin syringes and subcutaneous needles, which can be obtained at all times.

- A training programme should be put in place for all healthcare staff expected to prescribe, prepare and administer insulin. An e-learning programme is available from: www.diabetes.nhs.uk/safe_use_of_insulin

- The NPSA released an additional patient safety alert "The adult patient's passport to safer use of insulin" recommends that adult patients who are 18 years or over:

    - are offered the use of an Insulin Passport to record information on the insulin products they use;

    - are given a patient information booklet which describes known error-prone situations and actions that might minimise harm;

    - receive support from healthcare professionals to put the risk of error in context and complete details in the Insulin Passport;

    - benefit from greater vigilance by healthcare practitioners that the correct insulin products are prescribed and dispensed.

SAFE PRESCRIBING OF INSULIN

- The doctor initiating insulin is responsible for issuing the patient with the patient information booklet and insulin passport. The doctor should explain to the patient the importance of carrying the insulin passport and keeping it up to date.

- There should be a process in place in the practice to ensure that requests for repeat prescriptions for insulin are brought to the attention of a GP to ensure that the correct insulin product and the correct dose has been prescribed. A template standard operating procedure for the management of insulin prescribing can be found in appendix 1.

SAFE DISPENSING OF INSULIN

- Prior to dispensing insulin, the pharmacist must ask to see the patient's insulin passport and check that the prescribed insulin product and dose correspond with the prescription. Any discrepancies should queried with the prescriber.

- Any patient who has not been issued with an insulin passport must be referred back to the prescriber.

INTERACTIONS WITH OTHER DRUGS

- Systems should be in place to identify and deal with medicines (including over the counter preparations) that might adversely interact with insulin therapy.

- If a new drug (or change in dosage) is to be prescribed for a patient on insulin the potential for change in glycaemic control should be checked in information resources (BNF, summary of product characteristics etc).

- If an interacting drug is to be used then all involved (patient, consultant, GP, pharmacist and specialist nurse as appropriate) should be informed of the additional blood glucose monitoring requirements until glycaemic control is stabilized.

- The insulin passport includes a space to record the patient's current medication (in addition to insulin), and this should be updated if there are any changes to the patient's prescribed medication.

DUTIES/RESPONSIBILITES AND ACCOUNTABILITY

- The prescriber who initiates the insulin will

    - ensure all monitoring has been completed until the patient is stabilised on a therapeutic dose

    - issue the patient with the information booklet and insulin passport

    - contact the patient's GP to request shared care of the patient (if insulin is initiated in secondary care or by other specialist services)

- Healthcare professionals who prescribe insulin are responsible ensuring that patients prescribed insulin have a patient information booklet and insulin passport, and for issuing patients with these resources if necessary. They are also responsible for issuing a replacement Insulin Passport when there is no space left for new information, it has been lost or it has become unreadable.

- Healthcare professionals must be available to assist patients in completing the Insulin Passport, and specifically in how to describe their insulin products so that there is no ambiguity in what they are using.

- Changes in patients' circumstances, their insulin products, other drug therapy (if recorded) needs to be recorded accurately as soon as practicable in the insulin passport.

- Before dispensing a prescription for insulin, community pharmacists and dispensing doctors must ask to see the patient's insulin passport and check that the prescribed insulin product and dose correspond with the prescription. Any discrepancies should queried with the prescriber.

PATIENT COMMUNICATION AND SUPPORT

- Healthcare professionals should use every opportunity to provide patients with adequate information about insulin therapy (verbal and written).

- Patients should be adequately counselled and educated to ensure understanding of the dose of insulin to be taken, and the potential risks associated with insulin.

- In addition, patients should be advised of the requirement for regular blood glucose checks (and any situations where increased testing may be required, such as illness or changes to therapy).

- Patients should be instructed to ensure they have the insulin passport with them whenever they see their consultant or GP, when requesting a prescription or having one dispensed, or when admitted to hospital.

- Any patient who is prescribed insulin but who does not have the information booklet or insulin passport should be issued one as soon as possible. Supplies of these materials can be obtained from Shared Business Services. Telephone: 01202 89300.

- Patients should be advised to consult their doctor/pharmacist prior to taking over the counter medicines.

REFERENCES

Safer Administration of Insulin alert and supporting documents *(*National Patient Safety Agency (NPSA), March 2011)

Adult patient's passport to safer use of insulin (NPSA)

APPENDIX 1 STANDARD OPERATING PROCEDURE FOR SUPPLY/ ADMINISTRATION OF INSULIN

Standard Operating Procedure for Supply/Administration of Insulin in …[insert practice/pharmacy]

Note this is a template for pharmacies/practices to use for modification to their operational area. It is not exhaustive, and managers should ensure that they complete the SOP, filling in the areas in italics prior to use.

OBJECTIVES
This procedure outlines the safety precautions and arrangements for the safe administration / supply of insulin.

SCOPE
This procedure covers the activities surrounding insulin administration / supply in…practice/pharmacy.

THE STAGES OF THE PROCESS

Prescribing: Insert here the prescribing mechanisms for insulin in your practice/pharmacy taking into account the CCG protocol.

Patient information: Insert here the patient information systems available in your area taking into account the CCG protocol, e.g. who issues the insulin passport, who fills it in, who informs patient of changes etc.

Supply: Insert here how insulin is supplied in your area e.g. pharmacy, wholesaler, specials supplier, acute trust, etc. Add how to order and any additional information needed.

Storage: Where and how is insulin stored (dispensing practices)?

Training: Insert here what training staff should have received in order to be able to prescribe/dispense insulin and details of staff training resources/updates on insulin

RESPONSIBILITY

All staff involved in insulin prescribing/dispensing/administration must be familiar with the NPSA *Safer Administration of Insulin* alert and the NPSA *Adult patient's passport to safer use of insulin* alert at:

http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287
http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=130397

It is the responsibility of the manager to ensure that appropriate training has been undertaken for staff who are expected to prescribe/dispense insulin.

Insert here any additional information including:
Who is responsible for carrying out each stage of the process in your area?

- under normal operating conditions
- in different circumstances e.g. when staff are sick/on holiday

Insert here the required qualifications/training of those undertaking any of the above tasks.

RECORD KEEPING

Who checks the insulin passport before releasing a prescription for a further supply?
Who updates the insulin passport?

OTHER USEFUL INFORMATION

Guidance for handling insulin can be found: *insert location in your area.*
Medicines policy can be found: *insert location in your area*

Insert here any other information you think could usefully be included in the procedure?

Mechanisms for audit of insulin policy in your area:

REVIEW

This SOP will be subject to review on a yearly basis or sooner in the light of new local or national guidance.

How are you going to ensure that the procedure continues to be relevant, useful and up to date?

Date of preparation	
Review date	

Author name	
Author signature	
Authorising manager Name (PRINT)	
Authorising manager signature	

I have read and understood the SOP for [insert subject]

Name (PRINT)	Sign	Date