INTRODUCTION

• On 30th March 2011, the National Patient Safety Agency (NPSA) issued an alert to enhance patient safety with regards to insulin therapy [1]

• The alert encourages patients to take an active role in maintaining safety whilst on insulin therapy

• Data from the National Reporting and Learning System (NRLS) indicated that 16,600 patient safety incidents involving insulin were reported over a six year period (Nov 2003–2009), of which, 26% were due to wrong insulin dose, strength or frequency and 20% was due to omitted medicine. Patients being prescribed or dispensed wrong insulin products accounted for 14% of the incidents [2]

• From August 2011 the NPSA directed all NHS organisations in England and Wales to provide an ‘Insulin Passport’ (IP) to all adult patients on insulin therapy [1]

• This patient held record should hold accurate, up-to-date details of the individual patient’s insulin therapy which can be utilised across all healthcare sectors (primary care, secondary care and at pharmacies) and acts as a safety check for correct prescribing, dispensing and administration of insulin

• A patient information booklet must also be provided along with the IP to inform patients and support safer use of insulin treatment [1,2]

• Over a year on, from its introduction, the aim of this audit was to assess the use of IPs that were mainly provided to patients by primary care

Data collection:

• Setting: Diabetes Centre, Queen Elizabeth Hospital Birmingham

• All patients waiting for their appointment were approached and only individuals on insulin therapy were eligible to fill the 28-point anonymous patient questionnaire

• Trends in relation to the use of Insulin passports were assessed

RESULTS

Patient Demographics:

28 Males; 22 Females

Age range: 21–86 years (median age 46)

Type 1 DM (n=25); Type 2 (n=24); Gestational (n=1)

Received a patient information booklet when issued with an IP

68% (34/50) reported that the insulin therapy recorded in their passport accurately reflected their current prescribed use of insulin.

DISCUSSION

• This audit assessed the use of Insulin Passports by patients who attended outpatient diabetes hospital appointments at QEHB

• The audit standard used are the four points outlined in box 2 from the NPSA recommendations [1, 2]

• Most patients holding an insulin passport received one from the GP surgery and only 54% (n=27) recall receiving a patient information booklet with their passport

• Majority of the patients who owned insulin passports (n=43) claimed that they never actively presented their IPs to healthcare professionals at the GPs, Hospital or Pharmacy

• 41/50 patients reported that the doctor/nurse in their clinic did not ask to see their IP during their appointment on the day

• In 32% (n=16) the insulin therapy on their IP did not match the current treatment they were taking on the day they filled out the questionnaire

METHODS

Audit standards

• Derived from the National Patient Safety Agency (NPSA) alert NPSA/2011/PSA003 and its supporting information document which was released in March 2011. The points from Box 2 will be evaluated in this audit [1,2]

• 41/50 patients reported that the doctor/nurse in their clinic did not ask to see their IP during their appointment on the day they filled out the questionnaire

LIMITATIONS

• Small patient population

• Did not account for alternatives to the insulin passport eg. brand -specific insulin safety cards (which are used by our Diabetes Specialist Nurse Team; this is part of a second ongoing audit), medical jewellery which could have affected the use of the insulin passport

REFERENCES:


Box 1: Flow chart depicting how the patient population of the audit was derived

Box 2: Summary of the main guidelines audited in this project

Plan of Action

• Present findings at the departmental meeting to raise awareness regarding the importance of the IP as a key safety tool

• All patients who attend the clinic must be asked about whether they own an insulin passport by the doctor and if not, be issued with one along with a patient information leaflet. Our diabetes nurses ensure this in their consultations

• Re-audit cycle in one year to review any improvement

https://MujahidSaeed.com