‘How to guide ’

Safe use of insulin: Inpatients

Example 2 Patient self-administration

Aim
To help trusts put systems in place to enable hospital inpatients to self-administer insulin where feasible and safe, as required by NPSA/2011/PSA003 The adult patients’ passport to safer use of insulin (link).

Background
The NICE quality standard for inpatient care requires that people admitted to hospital are given the choice of self-monitoring and managing their own insulin (link).

All diabetes patient groups advocate this and your organisation will perform poorly on patient surveys if self-administration is not well implemented. Patients are the experts in managing their insulin. Self-administration can improve patient safety, reducing errors in diabetes management and insulin use.

Current performance
1) Read through your trust policies on self-administration of medicines and any specific policies on diabetes and insulin. Is it clear that patients who want to administer their insulin and are well enough to do so should be allowed to? Your trust may have polices in place already for self-management which include self-monitoring of blood glucose (e.g. patients use their own testing equipment) and insulin administration.

2) Assuming a self-administration policy is in place, how many patients actually do self-administer? Quantify this by doing a simple audit of all drug charts on 2 or 3 separate days. The audit can be done on any number of wards (try for as many as possible). Use a simple tally chart showing:

- Number of patients on each ward prescribed insulin
- Number of patients who are or have been self-administering insulin during their inpatient stay
- Make sure everyone collecting the data knows what’s required; pilot your data collection form with a few staff before using more widely

3) If your trust took part in the annual National Diabetes Inpatient Diabetes Audit, look through the patient experience results and see what proportion of patients reported feeling able to take control of their diabetes whilst in hospital. In 2013, the most recent audit available at the time of writing, most Trusts in England did take part (link).

4) Missed doses of insulin are recorded on the Medication Safety Thermometer (link). If your trust contributes to this thermometer, look at the number of missed doses of insulin. Increasing insulin self-administration could help reduce the number of missed or delayed doses.

Implementation

Policy agreement If changes to the current medicines self-administration policy are needed this will have to be agreed through the relevant channels before starting. A policy for self-management of diabetes which includes blood glucose monitoring is desirable and requires additional input from the biochemistry department or point-of-care testing committee. Patient information will be necessary together with signed patient consent. For example policies and patient documents see Useful information 1 below.
**Ward staff** Implementation of medicines self-administration is very dependent on the staff that explain self-management options to patients on admission and assess patients’ suitability for this. This is usually a nursing task so ownership by nursing leads is essential together with specific support from the diabetes specialist team. If the assessment presents problems or staff are doubtful about the safety benefits, this needs to be resolved with nursing and diabetes leads.

**Medicines storage** Ideally patients are provided with a secure cabinet to store their insulin. The patient has access to their insulin at all times and is responsible for keeping the key secure. However, if cabinets are not available, self-administration should still be possible. The patient needs to know the potential risks of leaving insulin, syringes, needles etc within reach or sight of others. Also, the patient should not remain in the same area as other patients who, for example, are at risk of deliberate self-harm, have a history of drug or alcohol abuse etc and will also need access to a sharps disposal bin (Useful information 1 below). Storage issues can prove obstructive as requirements on trusts to ensure safe medicine storage can be difficult to align with insulin self-administration. Nevertheless, the choice to self-manage is required by NICE quality standards and the NPSA, so the trust will have to agree a pragmatic means of implementation this whilst minimising potential risks.

**Recording and checking** Clear recording systems are needed to show insulin doses administered by patients. Doses should be recorded as being self-administered on the prescription chart. Nursing staff can confirm doses administered; any errors should be reported via normal incident reporting systems.

**Audit** The simple audit in the earlier current performance section can be carried out regularly (e.g. monthly, quarterly) to measure the uptake of self-administration. Obviously some patients will not be well enough to self-manage or may prefer not to do this whilst in hospital. Thus another important measure is whether patients feel they are allowed to maintain control of their own diabetes management whilst in hospital. Questions on this are included in the National diabetes inpatient audit and the same questions could be used to regularly audit patient experience (see Useful information 2 below).

**Service Contracts** Your commissioning organisation may want to support self-administration of insulin. Commissioners can do this by including specific requirements in the contract or using other incentives such as CQUINS. [The Commissioning for Quality and Innovation Payment Framework enables commissioners to link a proportion of the trust’s income to the achievement of local quality improvement goals.] For example, the trust might be required to have policies in place which enable patients to self-manage their diabetes and support this with patient experience data collected post discharge on whether patients were offered self-management.

### Tips for success

* **Insulin self-administration is a positive step to improve patient safety and patient experience**

* **Pharmacy cannot do this alone; support from diabetes specialists, nurses and managers is vital. Practical implementation problems need to be promptly addressed by a multi-professional team**

* **Soap box what you are doing: tell everyone you see, get the message in bulletins, e-mails, screensavers, etc. Very important, keep on telling everyone – reminders are essential to keep things on the agenda**

### Useful information

1) Self-management of diabetes in hospital. NHS diabetes March 2012 ([link](#))

2) National Diabetes Inpatient Audit ([link](#))

There are additional specific ‘How to guides’ for tackling:
1) Prescribing abbreviations – Insulin (link)
2) Patient self-administration – Insulin (link)
3) Reducing the incidence of omitted doses (link)

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