Transfer of Care – Management of Insulin on Discharge

Amy Bradley - Senior Clinical Pharmacist
Why focus on insulin discharge?

- Insulin – high risk medicine
- Discharge – high risk situation
  - As highlighted in latest WHO Global Patient Safety Challenge, focus on Transitions of Care
Background

- Started in 2014
- Review of CSBU incidents 2013/14 (District Nursing)
  - 54 medication incidents involving insulin
  - 24% as a direct result of failures on discharge from secondary care
  - Incidents included…
Patient discharged. Currently insulin dependant diabetic and long term daily Tinzaparin injection.

Upon discharge of the patient the **DN team were not notified of the appropriate dose(s)** of prescribed medication required to be administered by the DN team.

Patient was discharged home earlier today, he was admitted with hypoglycaemia. The patient was **discharged home with no paperwork** regarding his admission or discharge. I contacted the ward and spoke to a staff nurse who apologised to me and stated that the paperwork would be ready tomorrow when the patient attended for outpatient dialysis. I explained that we needed the paperwork in order to administer insulin so verbal handover taken regarding discharge and insulin dose.

Patient discharged from ward - patient was self caring with regards to diabetes management prior to admission, doing own blood sugars and administering her insulin twice daily. Staff nurse spoke to ward about leg dressings but **no information was passed over for DN team to visit and administer insulin** twice daily. Nurse visited to do leg dressings to find that patient needed insulin administration and that the night before had been missed.
What did we do?

- Multidisciplinary working group
  - Pharmacy, District Nurses, Diabetes Consultant, Diabetes Specialist Nurse, Hospital Nurses
- Development of Discharge Paperwork
  - Piloted 2014
  - Rolled out 2015
  - Completed for any patient who needs district nursing input for insulin administration
### Prescribed Insulin

- **Type of diabetes**
- **Changes during admission**

### Insulin Given Prior to Discharge

- **Checklist for discharging nurse**

### Patient Details

- **Contact details for hospital team**
- **Contact details for community team**
Recent Review

- Analysis of incidents 2018
- Figures very similar re. discharge
  - 50 incidents total
  - 22% due to discharge

- Additionally – a serious incident. District nurses not informed of discharge, insulin missed for 16 days
What now?

- In depth review of the whole insulin process is on-going
- Key findings re admission/discharge
  - Form is not being used!
  - Variation in processes between DN teams and localities
  - Unclear referral pathway from hospital
What now?

- **Plan:**
  - Re-launch of Insulin Discharge Form
  - Standardisation of processes across teams

- Robust process for reminders and re-education at regular team meetings

- Key learning – don’t assume!
### Record of Insulin Prescription

<table>
<thead>
<tr>
<th>Date</th>
<th>Insulin Time</th>
<th>Insulin Type</th>
<th>Dose in Units</th>
<th>Dose In Words</th>
<th>Site</th>
<th>Signature</th>
<th>Date Discontinued &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM Insulin (black)</td>
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<td></td>
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<td>AM Insulin (Black)</td>
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<td>PM Insulin (red)</td>
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</tbody>
</table>

General guidance e.g. frequency of BM test etc.

### Drug Administration Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Drug</th>
<th>Dose in Units</th>
<th>Batch No &amp; Expiry Date</th>
<th>Administration Route</th>
<th>Signature</th>
<th>Print Name</th>
<th>Date of Discontinuation</th>
</tr>
</thead>
</table>

- Other work – administration form
What did we do?

• Developed new administration paperwork for the community…
## Community Services Insulin Administration Record

### Details of monitoring

- **Allergies:**
  - Affix patient label or
  - Surname:
  - Forename(s):
  - Date of birth:
  - Address:

### Prescribed Insulin

<table>
<thead>
<tr>
<th>Initiated (Date)</th>
<th>Insulin Name (and Brand)</th>
<th>Device (V / C / D)</th>
<th>Dose and time (or select as required)</th>
<th>Signature of prescriber / transcriber</th>
<th>Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breakfast ............ units</td>
<td></td>
<td>PRINT:</td>
<td>Initial:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evening Meal ........... units</td>
<td></td>
<td>PRINT:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As required ........... see over</td>
<td></td>
<td>PRINT:</td>
<td>Date:</td>
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*V = (10ml Via)  C = (3ml Cartridge)  D = (Disp. Device – state name)*

### Codes for non-administration

1. Patient refused.
3. Insulin drawn up and left in home for later administration.
4. Other (document on page 4).

### Blood Glucose Monitoring

- Patient's usual / target glucose range:...
- Frequency of blood glucose monitoring:

Please clearly cross through discontinued medications / dose changes and begin new chart.

### Safer Medical Practice

- Never write dose as XX lU or XX u – always write as XX units.
- Write legibly – use full name of insulin (usually prescribed by brand name).
- Ensure the full correct name is used (some insulins have similar names but are NOT the same. For example Actrapid and Novorapid).
- Many insulin preparations have a number after the name e.g. Novomix 30. This refers to the ratio of short and long acting insulins in the preparation not the number of units.
- If you are not familiar with the type of insulin, look it up e.g. use BNF.

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*builting a caring future*
## Daily Subcutaneous Insulin

Before administration, double check the name of the insulin and number of units against the front of the chart.

### Breakfast
- **Insulin Name and Brand:**
- **Date:**
- **Blood Glucose:**
- **Initals (or code):**
- **Time given:**
- **Expiry:**
- **Site of admin:**

### Evening Meal
- **Insulin Name and Brand:**
- **Date:**
- **Blood Glucose:**
- **Initals (or code):**
- **Time given:**
- **Expiry:**
- **Site of admin:**

### Sliding Scale Insulin
- **Insulin Name and Brand:**
- **Dosing Instructions:**
- **Date:**
- **Blood Glucose:**
- **Initals (or code):**
- **Time given:**
- **Expiry:**
- **Site of admin:**

When starting a new vial, check expiry date, record date of opening, store out of the fridge and discard after 4-6 weeks (check product information). Record expiry date on System One template, once only for each vial used.

Clearly cross through discontinued medications / dose changes.

Completed on first visit

Completed for each administration

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### Other Instructions

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Reason Insulin Not Given</th>
<th>Action Taken</th>
<th>Signature</th>
</tr>
</thead>
</table>

**INSULIN NOT ADMINISTERED: CODE 4**

### Record of Date New Vials Opened

<table>
<thead>
<tr>
<th>Date Opened</th>
<th>Name and Brand of Insulin</th>
<th>Signature</th>
</tr>
</thead>
</table>

### Patient Specific Instructions

Please document any patient specific instructions in relation to insulin administration (e.g. time of dose, administration site, insulin to be drawn up and left in home):

- Any illness such as cold, flu or an infection may upset diabetes control.
- Patients should never stop taking their insulin due to the above illnesses.
- A patient's blood glucose may rise even if they are unable to eat their normal food or drink.

If your patient is unwell:
1. Refer patient to the "Sick Day Rules" patient information (Please ensure that the patient has a copy of the "Sick Day Rules" document, available on SystmOne).
2. Contact the GP or Out of Hours Doctor if:
   - The patient is persistently vomiting (unable to hold down any food or drink for more than 6 hours).
   - The patient's blood glucose remains elevated.
   - You are unsure how to proceed.