SAFETY WHEN GIVING INSULIN IN HOSPITAL

A Rapid Response Report by the National Patient Safety Agency outlines how risks associated with insulin administration can be minimised to prevent harm.

Why do we need to change practice? Using insulin is generally safe. However, there is a potential for serious harm if it is not administered and handled properly. Diabetes affects about 2.3 million people in the UK, the National Service Framework for Diabetes (2003) estimates that 15% of people with diabetes in England have type 1 disease. Common errors are inaccurate dosing and administration of insulin, which can lead to too much circulating glucose (hyperglycaemia) or too little circulating glucose (hypoglycaemia).

The National Patient Safety Agency (NPSA) received 3,881 wrong dose incident reports involving insulin between August 2003 and August 2009. These included one death and one severe harm incident caused by tenfold dosing errors that had resulted from abbreviating the term “unit”. The abbreviation “U” for units can be misread as “O”, which can lead to 10 times the required dose of insulin being given; “1 U” can be read as a requirement for “10” units. Similarly, “IU” can be read as either “1 U” or “10” units. Three deaths and 17 incidents reported were the results of an intravenous syringe being used instead of an insulin syringe to measure and administer insulin. In June 2010, the NPSA issued a Rapid Response Report (RRR) on the risks of administering insulin, with the aim of making practice safer. The report is aimed at all healthcare professionals who are involved with the prescribing, preparation and administration of insulin. Nurses are the most likely profession to be involved in the final process of insulin administration and so play a vital role in ensuring the recommendations of the report are implemented in practice.

Serious reported incidents include:
Intravenous syringes have graduations in ml, unlike insulin syringes which have 0.1 ml, which can lead to 10 times the required dose of insulin being given.

How to use the Rapid Response Report to change practice

The NPSA rapid response report identified key actions for organisations and frontline staff to make practice safer.

The NPSA has asked your organisation to:

1. Ensure that all clinical areas and community settings have adequate supplies of insulin syringes and subcutaneous needles, and that these can be obtained at all times;
2. Ensure that training programmes are in place for all healthcare staff who are expected to prescribe, prepare and administer insulin;
3. Review policies and procedures for the preparation and administration of insulin and insulin infusions to ensure compliance with the recommended actions. This should include considering the supply and use of insulin products that are ready to administer.
4. Test equipment regularly to ensure that all automated blood glucose monitoring equipment is subject to regular testing and calibration.

WHAT SHOULD MY TRUST BE DOING?
The NPSA rapid response report highlighted that the organisation has a vital role in ensuring the recommendations are implemented in practice. It is the first report to be published with actions that must be completed by trusts, rather than simply recommended. It is the first report to be published with actions that must be completed by trusts, rather than simply recommended. The trust has the opportunity to look at other ways to reduce errors in insulin administration and has been undertaking this as part of its mandatory training. The issue of insulin administration is highlighted in all training sessions, such as within staff induction, for all staff including doctors and pharmacists. We have attempted to reduce errors by using the term “unit” – and write it out in full. Use of the term “unit” in all situations is recommended.

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The NPSA rapid response report has been circulated to all trusts and is available at tinyurl.com/diabetes-inpatient-audit.

Every reported incident counts

The NHS has a vital role to play in identifying and assisting patients with diabetes. The NPSA has received 3,881 wrong dose incident reports involving insulin between August 2003 and August 2009. These included one death and one severe harm incident caused by tenfold dosing errors that had resulted from abbreviating the term “unit”. The abbreviation “U” for units can be misread as “O”, which can lead to 10 times the required dose of insulin being given; “1 U” can be read as a requirement for “10” units. Similarly, “IU” can be read as either “1 U” or “10” units. Three deaths and 17 incidents reported were the results of an intravenous syringe being used instead of an insulin syringe to measure and administer insulin. In June 2010, the NPSA issued a Rapid Response Report (RRR) on the risks of administering insulin, with the aim of making practice safer. The report is aimed at all healthcare professionals who are involved with the prescribing, preparation and administration of insulin. Nurses are the most likely profession to be involved in the final process of insulin administration and so play a vital role in ensuring the recommendations of the report are implemented in practice.

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