Medication Safety Today

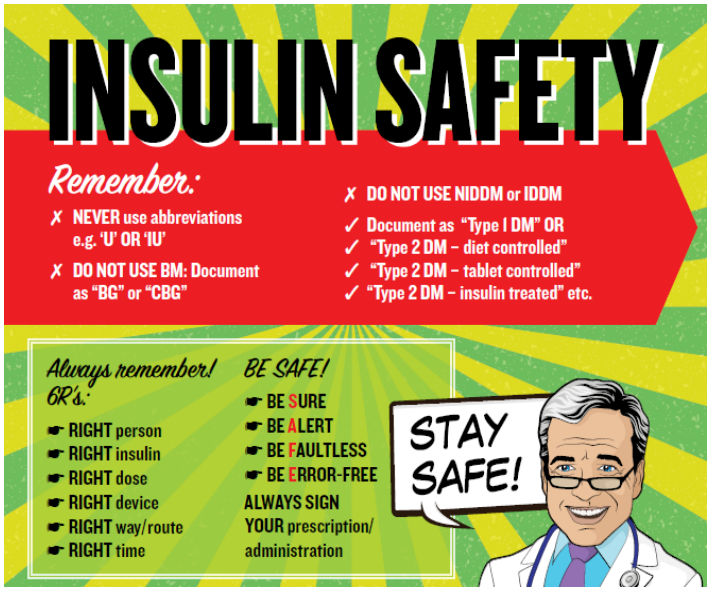
Insulin Safety Week: 14th – 20th May 2018

Insulin Safety Week 2018

The first-ever national insulin safety week aims to raise awareness to improve insulin safety. For further information visit:

www.insulinsafetyweek.com

#think insulin



In November 2016 diabetes teams within the 5 Health and Social Care Trusts took part in an audit. 601 patients were reviewed in a total of 13 hospital sites. Some of the key findings included:

- 18.4% of beds were occupied by a person with diabetes. This is just less than 1 in every 5 beds and an increase of 4% from previous audit.
- Over 91% of these patients had type 2 diabetes.
- Nearly 50% of patients with type 2 diabetes in the audit received insulin.

How do we improve the care of people with diabetes in hospital?

- ✔ Involve patients in treatment decisions
- ✔ Refer appropriate patients to diabetes team at the earliest opportunity

What's the time? It's insulin time!

Most hospitals have a separate prescription and administration chart for subcutaneous insulin so that insulin is prescribed on a daily basis. The prescription chart is combined with blood glucose monitoring. Medication incidents continue to occur where insulin has not been prescribed leading to delay and sometimes omission of insulin doses and hyperglycaemia. Unless a patient is very unstable, insulin should be prescribed each day for the next 24 hours. This should be done during the working day by the team looking after the patient and not left for night staff to do.

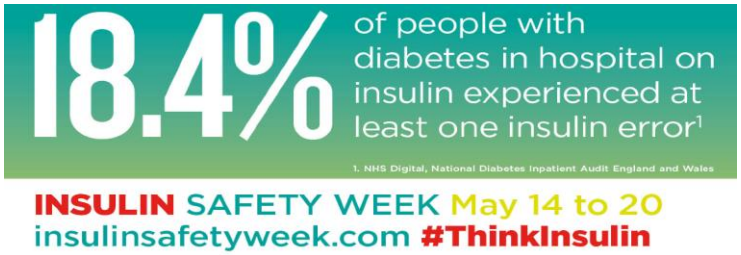
Safety tips:

- ✔ Have a set time each day when insulin doses are prescribed for the next 24 hours.
- ✔ Identify which patients are on insulin and ensure these are highlighted to medical staff.
- ✔ Where a patient's blood glucose control is unstable and you are unsure what insulin to prescribe, contact a member of the diabetes team for advice.

Free E-Learning modules are available at:

www.diabetesonthenet.com

This can be accessed after free registration and cover many modules, including 'The 6 steps to insulin safety.'



Insulin Safety

In 2016, the Department of Health issued two Patient Safety Alerts related to insulin.

Alert 1 - 'Safe Administration of Insulin' highlights:

The extraction of insulin from pen devices using an insulin syringe is <u>not</u> permitted.

- Extraction of any strength of insulin from a pen device using an insulin syringe and needle damages the mechanism of the pen device. Subsequent use of the damaged pen device can result in dosing errors and causes patient harm.
- A number of high strength insulins are now available as pen devices (see table below). Extraction of high strength insulin from pen devices using an insulin syringe, which is graduated in 100units/ml, results in the incorrect dose of insulin being administered to patients.

Alert 2 – 'Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulins'.

A number of high strength, fixed combination and biosimilar insulin products are now available

Differences in strength, formulation and dosing of these new insulin products when compared with the existing standard strength insulins means there is potential for medication errors.

Key Feature	Active substance	Brand name	Strengths available (units/ml)
High Strength	Insulin degludec	Tresiba®	100 & 200
	Insulin lispro	Humalog®	100 & 200
	Insulin glargine	Lantus®	100
		Toujeo®	300
Fixed combination	Insulin degludec and liraglutide	Xultophy®	100 units/mL of insulin degludec and 3.6mg/mL of liraglutide
Biosimilar	Insulin glargine	Abasaglar®	100

Actions required to minimise the risks include:

- ✓ Prescribe insulin by brand, specifying the strength, device and dose in units.
- ✓ Provide patients with written (insulin passport or safety card) and verbal information on their prescribed insulin, strength, dose, how to use the device and monitoring of blood glucose.
- ✓ Ensure storage arrangements for insulin facilitates correct selection.

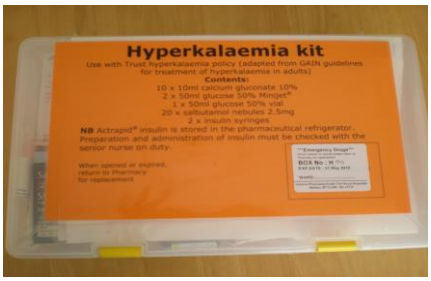
The full alerts can be found at: Insulin Safety Alerts

Hyperkalaemia - a refresher

Serious overdoses of insulin have occurred in the treatment of hyperkalaemia, particularly where too much insulin has been administered. Hyperkalaemia kits and treatment guidelines were implemented across Northern Ireland a number of years ago to reduce the risk of recurrence.[1]

To ensure safety when treating hyperkalaemia in adults:

- Hyperkalaemia kits (shown below) are available and readily accessible. Use the kit every time you are treating hyperkalaemia in adults.
- Make sure a replacement kit is reordered from Pharmacy when the kit on the ward has been used.
- Remember the dose of soluble insulin to treat hyperkalaemia is **10 units**.
- The 10 unit dose of insulin must be second checked by the senior nurse on duty.
- If you know that somebody is being treated for hyperkalaemia, ensure the kit is being used and challenge anybody treating hyperkalaemia without the kit.
- Make sure all staff in your ward/department know where the kit and treatment guidance is located.



1. Guideline for the treatment of hyperkalaemia in adults. Available at GAIN Guidelines[accessed 11th May 2018]

Is this yours?

Medication incidents continue to be reported where patients are administered the wrong insulin. Wherever possible patients should be;

- ➢ Shown the insulin to be administered, and
- ➢ Asked to confirm that it is their usual type of insulin before a dose is administered.