Incidence of omitted doses versus harm due to patient storing insulin

Background

At the September meeting, the MSC considered a risk assessment for delayed administration of subcutaneous insulin during inpatient admissions. The assessment quoted NRLS data for insulin errors, including the statistic that omitted and delayed doses accounted for 20% of these errors. The NPSA and Think Glucose campaign both promoted self-administration of insulin by patients in hospital as a means to reduce these errors.

The current STHFT policy for self administration requires medicines to be locked away, but lack of appropriate storage facilities is a barrier to this on many wards. Therefore MSC were presented with an options appraisal of possible storage solutions. Many of the options were not suitable. Others were too expensive to provide one for every bed space. A pilot on a diabetes ward with engaged staff, demonstrated a failure to allocate the storage facilities appropriately if there were only a couple available on the ward.

The assessment also highlighted that it is common practice currently for patients to keep their own insulin (unlocked) which is against current Trust policy.

MSC asked to review reported insulin incidents within the Trust, to compare the incidence of omitted and delayed insulin doses against unintended administration or misappropriation of insulin.

Datix reports July 2013 – June 2014

Total number of inpatient insulin incidents (includes IV)	51	**% of total**
Omitted sc doses	10	20
Delayed sc doses	0	0
Patient self administered correct dose but prescription wrong	2	4
Preventable if patient had been self-administering (assumes patient capable)	20	40
Duplication of dose (nurse administration and self administration)	2	4
Patient self administered wrong dose / insulin	4	8
Unintended administration (wrong patient)	0	0
Misappropriation of insulin	0	0

On Datix there is a code for ‘omitted dose’ but not a separate code for ‘delayed dose’. All the incidents reported under the code ‘omitted doe’ described an omitted dose. Although the percentage matches the NRLS data for ‘omitted and delayed dose’ it is likely that there are many delayed insulin doses in the Trust which are not reported.

The data shows that a total of 43% of errors could be prevented if the patient was self administering their insulin.

There are no incidents of misappropriation of insulin or administration to the wrong patient despite insulin not always being locked away, but the prevalence of this practice is unknown.

Patient access to their own insulin resulted in 6 incidents. It is not clear whether these patients had been assessed to self administer their own insulin.

MSC members are asked to consider:

1) Is it reasonable to accept the risks associated with insulin not being locked away for patients who are self administering?

2) If the answer to question (1) is ‘no’, which storage option to recommend and should funding be sought at a Trust level or by individual wards/Directorates?

3) If the answer to question (1) is ‘yes’, what control measures are required? Examples may include:
   changing policy to require patients to keep insulin with them or out of sight at their bedside
   promoting the assessment of patients for self administration and documenting the decision
   ensuring it is clear on the prescription chart whether insulin administration is by the patient or the nurse.

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