



30<sup>th</sup> January 2011

Dr David Gerrett  
Senior Pharmacist  
National Patient Safety Agency,  
4-8 Maple Street,  
London  
W1T 5HD

Dear Dr Gerrett

**NPSA Draft Patient Safety Alert - Empowering patients for the safer use of insulin**

**Response from the Guild of Healthcare Pharmacists**

Thank you for the opportunity to respond to this consultation. The Guild of Healthcare Pharmacists represents UK wide around 4,000 pharmacists including the majority of hospital pharmacists, pharmacists employed by Primary Care Trusts (PCTs) and pharmacists employed by other public bodies such as the Commission for Social Care Inspection and the Healthcare Commission. The Guild is part of the health sector of the union Unite.

Having reviewed the:

1. Patient Safety Alert ‘Empowering patients for the safer use of insulin’;
2. ‘Supporting Information’ that provides guidance for implementation of the Alert;
3. ‘Insulin Passport’; and,
4. the patient booklet ‘Information to help you use your insulin safely’,

Our comments on the proposed changes to medicines legislation re as follows:

Please answer the following questions to structure your feedback. Expand the comment area as required. Alternatively you may wish to provide general comments at the end of the document. All feedback is welcome.

*President: David Miller*

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Q1) Do you agree that there is a significant risk to patient safety from patients being prescribed and/or dispensed the wrong insulin product(s)?

*Yes*

Q2) Do you agree that there is a significant risk to patient safety from patients being administered the wrong dose of insulin?

*Yes*

Q3) Do you agree that there is a significant risk to patient safety from patients' insulin therapy being omitted or delayed?

*Yes*

Q4) Do you agree that patients-self administration of their insulin in hospital as a way of reducing omission and delay should be supported by this Patient Safety Alert?

*Yes*

Q5) Do you agree that there is a significant risk to patient safety from patients being administered the wrong dose of insulin?

*Yes*

Q6) Do you agree that steps should be taken to empower patients by providing them with an Insulin Passport that confirms their insulin products, the current insulin dose and gives emergency information?

*Yes*

***There is a danger that patients will still use the passport as a daily record, as a result we believe that the passport needs revision to request specific information (see response to Q9)***

Q7) Do you agree that Insulin Passports and a copy of the patient-information booklet 'Information to help you use your insulin safely' should be made available to all diabetic patients using insulin in England and Wales?

*Yes*

***We believe that if a diabetic service provider or a patient decides to use their own system this must be supported as an alternative. As a result both the passport and the supporting information booklet should be provided in a format that supports customisation while highlighting the essential information that must be included.***

Q8) Do you agree that patients should be supported in their use of the Insulin Passport by healthcare professionals providing healthcare services in England and Wales?

*Yes*

***We believe that patients should be supported in their use of the insulin passport by healthcare professionals providing healthcare in but as empowerment is at the heart of this patient safety alert, the responsibility for showing the insulin passport at the time of prescribing or dispensing must lie with the patient. However healthcare professionals prescribing (or dispensing) the insulin must be responsible for issuing the passport and promoting its use.***

Q9) Please use this space if you wish to comment on the Insulin Passport content and/or design.

*We would support the use of the insulin passport, but feel that some revisions will be required to improve its effectiveness. The changes recommended are as follows:*

- *Instructions on how to use the passport should be minimal on the passport to maximize the use of the space available for vital information.*
- *A sheet should be provided with expanded information to help patients complete the passport.*
- *The passport needs to include the facility to record the use of insulin pumps.*
- *For DAFNE regimens the passport should support the facility to record the dose to carbohydrate ratio (e.g. 1 unit of insulin to 40g of carbohydrate) for each meal.*
- *For DAFNE regimens the passport should support the facility to record the time of administration around meals and whether this varies e.g. delayed dosing in meals with high proportions of complex carbohydrates or high proportions of fat and carbohydrate.*
- *For DAFNE regimens the passport should support the facility to record whether dose is administered as a split dose e.g. in meals with high proportions of complex carbohydrates or high proportions of fat and carbohydrate.*
- *For DAFNE regimens the passport should support the facility to record the dose adjustment required for raised glucose levels before meals e.g. 1 unit for each 3mmol above a blood glucose level of 7mmol.*
- *The section for treatment of hypos should be customised to allow patients to enter their treatment of choice that they carry and customise the quantity to be routinely administered.*
- *There should be a section to allow contact details to be provided about the secondary care team who are managing the patient (in some cases this may be more important than the GP information).*
- *The other medication section should be sectioned to request information on the medicine, strength, dose, frequency etc. This will also need to include start and stop dates if it is to reduce the requirement to replace the passport more frequently.*

*Given the above comments it may not be possible to have a one size fits all passport so passports may need to be developed to support different regimens. Additionally most patients are treated with U100 insulin with 100 units per millilitre but very occasionally patients are treated with U500 insulin with 500 units per millilitre. As a result these patients need completely different management to avoid errors and mistakes being made with their treatment. The passport should be designed to alert healthcare professionals to their treatment.*

Q10) Please use this space if you wish to comment on the patient booklet 'Information to help you use your insulin safely' content and/or design.

Please note that the information is very specific to patient safety and known error-prone situations that patients on insulin may encounter. The booklet is not designed to be a source of general information on diabetes.

*We would support the use of the on the patient booklet 'Information to help you use your insulin safely', but feel that some revisions will be required to improve its effectiveness. The changes recommended are as follows:*

- *The booklet should contain instructions on how to use the passport so that instructions on the passport can be kept to a minimum to maximise the use of the space available for vital information.*
- *There are some errors and typos within the current document that will need revision.*
- *We are unsure that the examples given add to the empowerment process and are more likely to cause alarm and anxiety. Perhaps the key actions (the text in green boxes) could be*

*expanded slightly and patients referred to a website with greater supporting information or their healthcare professional for further information.*

- *On page 5 – What can go wrong – there is a statement ‘There are even dedicated insulin syringes in 30, 50 and 100 units per ml’. This is incorrect and should state (as later in the document that) ‘There are dedicated insulin syringes with measurements in units on the barrel for doses up to 30 units (0.3 ml); 50 units (0.5 ml) and 100 units (1 ml) of insulin’.*
- *There are a number of areas that are giving general advice about the treatment of diabetes with insulin that would have been covered in other areas. Given that this is not the purpose of the patient booklet this could be removed. We believe that the book should contain concise information on dos and don’ts supported by healthcare professional education, which would fit with Q8 and our response.*

Q11) Do you agree that the NPSA should issue guidance in the form of a Patient Safety Alert as advised?

*Yes*

Q12) Do you agree that NHS Trusts, independent organisations and dispensing contractors should develop procedures and policies in line with the Alert’s Actions?

*Yes*

*This would additionally be required should a diabetic service provider wish to use their own system which would support safe customisation while ensuring the essential information is included.*

*General comments - While we would support the use of the passport in its current form, we feel that the use of technology should be investigated to establish if cards or memory stick devices could be developed that would store the information electronically. These would need allow access and editing by both the patient and healthcare professionals. If incorporated onto a card essential (non variable) information could be included on the card*

We hope these comments are of assistance

Our reply may be made freely available.

Yours faithfully

Barry Corbett  
Professional Secretary  
Guild of Healthcare Pharmacists

Graeme Richardson  
Chair of Practice  
Guild of Healthcare Pharmacists