Health and Social Care

May 2019

Insulin Safety Bulletin

Welcome to this Insulin Safety Bulletin which is intended to highlight issues relating to insulin safety and how this may be improved.

CHOOSE SAFETY #ThinkInsulin

INSULIN SAFETY WEEK 2019

National Insulin Safety Week is 20th - 26th May 2019. The campaign aims to raise awareness of the risks when prescribing, administering and dispensing insulin and to reduce the incidence of insulin errors. www.insulinsafetyweek.com

Look out for other information and resources that will be shared through social media and email. These include a quiz, a short video and a learning bulletin.

Insulin Errors – do you know what and how to report?

	Examples of incidents to report on DatixWeb	DatixWeb error code
RIGHT PERSON	* Insulin given to wrong patient	Mismatching between patient and medicine
RIGHT INSULIN	* Wrong insulin prescribed or administered e.g. NovoRapid® instead of Novomix 30® or sliding scale instead of regular insulin	Wrong drug/medicine
RIGHT DOSE	* Wrong dose of insulin prescribed or administered * Accidental overdose administered by patient * Evening insulin dose given in the morning	Wrong dose
RIGHT DEVICE	* Wrong type of insulin device used e.g. syringe instead of pen	Wrong drug/medicine
RIGHT TIME	* Meal time insulin not given within 30 minutes of a meal * Basal (long acting) insulin not administered * Insulin not prescribed in time for dose * Unable to obtain the correct insulin in time	Omitted medicine

Top Tips for Insulin Safety

ALWAYS prescribe by brand name on the insulin prescription chart and reference on the main kardex

ALWAYS prescribe and administer regular doses of rapid or short acting insulins, or mixed insulins with meals

ALWAYS prescribe and administer long or intermediate acting insulins at the usual time for that patient **DO NOT omit**

ALWAYS use an insulin syringe to measure insulin from a vial

NEVER use abbreviations e.g. ‘U’ or ‘IU’

NEVER draw up insulin from a prefilled pen device or a cartridge