Ward:	Date:	Prescriber name:	Prescriber grade:

	Number	Correct	%correct
Insulin correctly prescribed	17	11	64.7%
	Number	**Errors**	**%errors**
Errors on prescription (please specify) e.g.			
• Insulin **not written up** (including omission of long acting insulin whilst on GKI)	17	1	5.9%
• **Name** of insulin incorrect (e.g. Humalog)			
• Number (**dose**) unclear	17	1	5.9%
• **Units abbreviated** to 'u' or written unclearly			
• Insulin or prescription chart **not signed** by prescriber			
• Insulin given/prescribed at the **wrong time**	17	3	17.6%
• **Device** not specified / device incorrect			
• Prescription **amended** without being re-prescribed			
• **Different doses** on same prescription	17	1	5.9%
• Other (please specify)	17	1	5.9%
Errors with insulin management (please specify) e.g.			
• Insulin **not increased** when persistent **BG >15 mmol/L** and better glycaemic control appropriate for this patient			
• Insulin **not increased** when persistent **BG >11 mmol/L** and <=15 mmol/L and better glycaemic control appropriate for this patient			
• Insulin **not reduced** if unexplained BG <4mmol/L			
• Inappropriate **omission** of insulin after episode of hypoglycaemia			
• Other (please specify)			

Examples of exemplary prescribing observed:

1. Frequency and times of dosing correct for inpatients

2. Device specified on inpatient prescriptions

Example errors (from above period)

1. 3 TTO where rapid acting insulin was prescribed for "night" instead of teatime → for teatime doses select "once a day at 6pm" option. Did state "15 mins before meals" in notes section.
2. One TTO written by technician – Novomix 30, patient was on 2 different doses but prescribed dose "as directed" frequency twice daily. Should have been written up as 2 different prescriptions with the dose specified in each one.
3. Insulin pump – initially missed off TTO then prescribed as "100 units/ml over 24 hours via pump". Prescribe as "as directed over 24 hours via pump".