

Notes from Insulin Passport meeting with Nurse Consultants and David Cousins and David Garrett from the NPSA at RCN 16/8/11

Formal minutes are after these notes

Introduction

There was universal agreement that it was important to take action to reduce the large number of errors related to insulin prescribing and administration and that the NPSA initiative had raised awareness and provided a platform for further work.

Concerns were expressed about the current format of both the patient information leaflet and the passport itself.

- The information leaflet was very wordy, would be difficult for some to understand and could be frightening for some patients.
- There was an implication in the information leaflet that the responsibility for ensuring that insulin was prescribed and administered correctly lies with the patient, whereas the cause of errors is known to be lack of knowledge amongst HCPs.
- The passport included more information than considered necessary by the group, particularly in relation to other medications, which would not be relevant to many people with diabetes.
- Diabetes UK and NHS Diabetes had expressed concerns which had not been addressed.

Outcome of discussion

It was agreed that the current leaflet/passport is the default version which is available for services which do not want to develop an alternative (either individually or in collaboration). Individual areas will need to decide whether they wish to use the NPSA version or an alternative. Any alternative must meet the criteria specified in the alert of March 2011.

• Patient information leaflet

June James (Leicester) has been working on a patient information leaflet which was circulated at the meeting and received a lot of support. Some minor amendments need to be made but it should be possible to produce it as cheaply as the NPSA version. June is happy to make this widely available and further development will involve the Nurse Consultants, ABCD and other interested professional bodies.

• Passport

It was agreed that a variety of 'passports' may be required to meet the needs of different patients. Lilly produce a series of plastic cards which indicate which insulin and device the patient is using and David Cousins agreed to speak to the other insulin producing companies to see if they would be prepared to do the same. HCPs could then hand the card to the patient at the time insulin was initiated. Some people may prefer to have a single card on which they can write

the names of their insulins. Older patients may prefer the current NPSA version, which would allow them to record other medications.

Additional points

- **Documentation of provision of information**

The NPSA is working with GP software providers to add a box to the diabetes template to record whether patients have been given an information booklet and passport. PCTs will be able to request this information from GPs. It is not clear what will happen if the patient is given the information by secondary care or community diabetes teams as this may not be recorded on the GP system

- **HCP training**

HCPs need to be more involved in ensuring that insulin errors are reduced. This is a training issue – the safe use of insulin e-learning module is a good start but more needs to be done. A working group will be set up by the Nurse Consultants to look at this

Anne Kilvert 17/8 2011

NPSA Insulin Passport Meeting
Notes 16th August 2011
Room 213 - RCN Headquarters London
10.30 am –1200 pm

Present	Representing	Apologies
<i>Grace Vanterpool (Chair)</i>	RCN Diabetes Forum (committee Chair) Trend UK NHS diabetes	Caroline Lekko RCN Patient Safety Advisor
<i>Fiona Kirkland</i>	Primary Care Diabetes Society National nurse Consultant Group Institute of Diabetes in the Older Person	Anna Morton NHS Diabetes (Information forwarded and included in debate)
<i>Siobhan Pender</i>	RCN Diabetes Forum committe member and Diabetic Nurse Sepcialist	Rebecca Thompson (Paediatric Diabetes Information forwarded and included in debate)
<i>Anne Kilvert</i>	ABCD	
<i>David Cousins</i>	NPSA	
<i>David Gerrett</i>	NPSA	
<i>Amanda Cheesley</i>	RCN Long Term Conditions Advisor	
<i>Simon O Neill</i>	Diabetes UK	
<i>June James</i>	NHS Diabetes TREND UK Diabetes UK	
<i>Debbie Stanisstreet</i>	Diabetes Inpatient Specialist	
<i>Jill Hill</i>	Community Consultants in Diabetes	

11 National Diabetes Organisations working together with the National Patient Safety Agency to improve patient safety when using insulin

Item	To lead item
Welcome and Introductions	Grace Vanterpool
<p>NPSA Overview</p> <p>David Cousins gave an overview of why the Insulin Passport was devised – started in 2009 following over 16,000 reported incidents in relation to insulin.</p> <p>Main issues:</p> <ul style="list-style-type: none"> • Wrong dose • Omission or delay • Wrong product <p>The Rapid Response report was written following this and NHS Diabetes began working on the e-learning module ‘ Safer Use of Insulin’</p> <p>Discussed the reasons for errors Design of packaging and confusing similarity of names of insulin Generalists standing back from being involved feeling it is specialist role</p> <p>In May 2010 engagement material went out to a large number of organisations and groups including the RCN, Diabetes UK and ABCD there were said to be few responses this was discussed. June James did send comments.</p> <p>The draft of the passport was ready by December 2010 and sent for further consultation although it apparently was not as well disseminated as had been hoped.</p> <p>Diabetes UK commented that comments forwarded were not included. The Nurse Consultant Group commented that they were not asked and so a large group of nurses weren’t asked not represented</p> <p>The feedback that was received did not indicate the document would not work for most people. All the changes that were requested were incorporated in the final document that was issued in March 2011</p> <p><u>Group Discussion – Main concerns</u></p> <p>Three different members of the group (Jill Hill, Fiona Kirkland, Simon o Neill) identified concern that what has been identified as a problem caused by professional issues was being given a</p>	NPSA

patient focused solution. This was considered to only part of a multi faceted strategy to improve safety and alone may not reduce risk.

The meeting discussed the current concerns with the document – the main issues were:

- The leaflet was thought to have an authoritarian approach
- The inclusion of the case studies was thought to be likely to have a negative impact on the health care professional relationship with the patient. Trust.
- That the document had the potential to increase risk of error as there was a huge emphasis on patient responsibility and less on professionals.
- Patients may have more than one passport with risk of incorrect prescribing information
- The passport is too complicated and wordy- reading age in line with NHS guidance was discussed
- Better education and training for professionals was considered essential to improve care.
- improved processes, documentation and prescribing practice
- The e-learning module should be mandatory for staff working with people who inject insulin
- Staff also need training on how best to support patients to take more responsibility for their own care.
- Why aren't doses written on the Passport? They were in original docs but because they can change so frequently it was thought it could cause too much confusion
- PCT's worried about the cost of the passport and supporting information 23p initially and then 13p thereafter

Responses from the NPSA

The insulin passport concept and design was suggested to the NPSA by a patient group. Patients can provide a very effective barrier to errors working collaboratively with healthcare professionals.

It is the view of the NPSA that patients and carers can only be empowered to help prevent wrong insulin and omitted doses if they are adequately informed about risks and what they can do to help minimise them. Empowering patients to be vigilant for errors is a central tenant of the Alert NPSA PSA 2011/003.

It is acknowledged that patients could have more than one passport and that there is a risk of communicating the wrong

information about their insulin. However, this risk is still present with insulin cards supplied by industry. The risks of duplicate information are also present for other NPSA patient held information for anticoagulants and lithium, and this has not proven to be a significant problem in practice.

It is not the view of the NPSA that the passport booklet is too complicated and wordy – however, it was stated that local organisation could develop their own booklet, provided it covered the key principles identified in the NPSA Alert and Support Document. These principles underpin the NPSA Insulin Passport and patient information booklet.

The NPSA had received feedback in the early consultation that Insulin dose information changed to frequently to be included in the passport. Patients articulated a wish to limit the proliferation of Alert Cards and to consolidate these in one place.

The costs of the producing information about insulin had been minimised (Insulin Passport 10p, patient information booklet 13p). These costs compared to the cost of hospital admission, A&E attendance, additional clinic appointments and wasted insulin – were negligible.

Local organisations were free to implement alternative strategies in addition but not instead of the NPSA guidance.

Where are we now?

The NPSA will cease to exist in March 2012 – no information about who might replace it. NHS Commissioning Board will have ultimate responsibility once it is established. The passport cannot be withdrawn however Trusts are at liberty to devise one locally as long as it incorporates the key messages and is called a patient information booklet – NPSA able to provide forms of words that might be used.

GP's will need to record that patients have been given a leaflet in order to meet QOF targets. NPSA are in the process of agreeing a 7 point recording mechanism that will be incorporated into GP recording system EMIS that will include information given, errors etc.

The passport is for adults only as the Paediatric infrastructure is better in insulin dependent diabetic management

<p>PCT's have been given 18 months to implement the recommendations from March 2011</p> <p>June James shared with the group a leaflet she had devised in Leicestershire which was felt to be useful but might need additional information. She was congratulated on the work so far as it was thought to be very patient centred</p> <p>The group also looked at the information cards that Lilly give out to patients on each type of insulin which were felt to be extremely useful although other companies do not provide these. The pharma companies cannot be mandated to provide these but pressure from Patient organisations and others could be brought to bear to suggest wider use of these.</p> <p>Training and support is being given to Community pharmacists to enable them to support patients better and to give advices</p> <p>NPSA did request that Units of insulin should be written in full but because the products are not country specific the description of the units has to reflect the global market</p> <p><u>Agreed Actions</u></p> <p>The Group accepted that disappointingly the passport cannot be withdrawn but that there were some things that could be done:</p> <ol style="list-style-type: none"> 1. Fiona Kirkland suggested that this forum could be developed into a working group with all of the organisations continuing to work together to improve patient care through safety issues 2. To encourage the development of information cards like the Lilly ones, 3. To encourage the use of the passport or locally devised leaflet and its safe implementation within a strategic approach 4. To improve the uptake of the e-learning 5. David Cousins offered to write something for Trusts to reflect the discussion regarding the implementation of the passport and the key messages 6. Group members to ask for incidents and near miss recordings in own Trusts to help show the importance of using an Insulin Passport to reduce incidents 7. Group to encourage improved documentation and record keeping – to include annual review templates to include – insulin type, dose, timing and device. 8. Packaging on insulin was also included to support 	<p>June James Amend insulin leaflet so possible to use nationally</p> <p>Fiona Kirkland</p> <p>To contact insulin companies to see if a joined up approach in relation to insulin cards is possible</p>
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appropriate prescribing of amounts	
Meeting closed at 1200	

**NPSA Insulin Passport Meeting
Tuesday 16th August 10,30 am 2011
RCH Head Quarters Room 211**

AGENDA

Chair: Grace Vantapool
Minutes- Amanda Cheesley

Welcome

It is very positive that so many National Diabetes Groups are present here around the concern of patient safety

Chair

Purpose of the insulin passport

Adults only?

Implementation of insulin passport- Time frame/ Pilot outcomes

What is the vision?

How was the vision agreed?

Concerns identified in letters

Incorrect naming of insulin

Wording

Repeating of errors in sharing reports

NPSA concerns

Time pressures??

- *Use of feedback for further development of passport*
- *Progress with other LTCs passports that are being developed / implemented?*
- *How can the concerns be addressed?*
supporting strategies?
- *Different models of addressing the same problem*
Documentations in letters and notes
Annual review templates
- *Agreeing away forward*