The point of good injection technique

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In the UK it is estimated that there are 2.6 million people with diabetes (Diabetes UK, 2009). Of that number it is also estimated that there are 800 000 people who are using injectable therapies. Following advances in the past 3 years, other injectable therapies have emerged alongside insulin, i.e. the glucagon-like peptide-1 (GLP-1) receptor agonists.

People who are using injectable therapies have the right to the best start when moving to this stage of their treatment algorithm. It is a huge step for some people to move from oral therapy to an injectable therapy, which is one of the reasons why a number of people within this group put it off for as long as possible. Just before writing this editorial, I was in a consultation with a person who needed to intensify their treatment regimen to improve their glycaemic control, but, because of weight issues, chose to try a GLP-1 receptor agonist. It took this person over half an hour to pluck up the courage to self-inject, but eventually they managed it, only to declare: "I didn't feel it!"

I can honestly say that in my 20 years of diabetes nursing I have never given an insulin injection to anyone other than myself. I see my role being to teach the correct injection technique and support the individual to self-inject, and to provide the information to support the move to injectable therapy.

During the past 20 years we have seen many changes in the way insulin is administered. The angle of injection has changed from 45 degrees to 90 degrees, and do any of you remember the three different strengths of insulin? We had 20-strength, 40-strength and 80-strength – I wouldn't like to estimate how many errors were made with the different strengths. If you were giving a injection of 40 units it would be 40 units using the 20-strength, 20 units using the 40-strength and 10 units using the 80-strength! There has also been a reduction in needle length over the past few years and, based on a demonstration on one of the stands at the Diabetes UK Annual Professional Conference, in the near future they are to become smaller still!

Fortunately, in the mid-1980s we moved over to using 100-strength insulin, which made calculating the dose much simpler. In the 1990s nurses working in general practice became more involved in providing diabetes care, and some practices that developed an interest in diabetes care took on the role of insulin initiation.

In Enfield in 2008 we wanted to ensure that wherever a person with diabetes commenced injectable therapy they would receive the same level of choice, education and support. To achieve this we organised a working group of DSNs both from primary and secondary care, as well as practice nurses who initiated insulin, and developed our district Injectables Care Pathway. This pathway ensures that a choice of regimen and injection device is offered, and also that the same educational topics are covered to assist in self-management. The process allows consistent, standardised practice at the highest level.

With hindsight, we now realise that we should have included ongoing management of someone using injectable therapy, such as how often to check injection technique and how often to examine injection sites. We will be updating the care pathway very soon. How often do you check peoples' injection technique or injection sites? I am a co-author on a study, which is awaiting publication, that suggests we, as nurses, don't do this as often as we should.

Forum for Injection Technique

Given these revelations and more, a small group of experienced DSNs have formed FIT – Forum for Injection Technique in diabetes management. FIT's overarching vision is to help all those with diabetes using injectable therapies achieve the best possible health outcomes by ensuring that the dose is delivered to the right injection site, using the right technique, every time. ■

Diabetes UK (2009) Diabetes in the UK 2009: Key statistics on diabetes. Diabetes UK, London

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