

Time to prepare for passport control

In March 2011, the National Patient Safety Agency (NPSA) published an alert which applies to all organisations prescribing insulin to adults over the age of 18 (NPSA, 2011a).

The drive for the alert is that insulin frequently features in the top 10 high alert medicines worldwide and errors can result in costly hospital admission (NPSA, 2011a). To improve insulin safety, the alert focuses on three main problem areas which together account for 60% of reported errors:

- Using the wrong insulin product.
- Giving the wrong insulin dose.
- Having insulin delayed or omitted.

To comply with this alert, by August 2012 health organisations must have in place a mechanism to minimise insulin errors and to facilitate the use of the insulin passport and patient information leaflet (PIL) (*Table 1*). All adults on insulin therapy must receive an insulin passport and PIL. The insulin passport and leaflet are only one component of the alert but appear to be the aspect that is producing the most discussion and controversy.

NPSA has produced a double-sided A4 insulin passport, which folds into credit card size, and a supporting PIL (*Figure 1*). It is not mandatory to use this version, but if an alternative is adopted, key criteria must be included (NPSA, 2011b):

- Highlight error-prone situations.
- Facilitate patients receiving the correct insulin product.
- Allow for details of concurrent medications.

It is the responsibility of the healthcare professional who prescribes insulin to issue the PIL and passport, replace the passport when it is full or no longer fit for purpose and to assist the person with diabetes in its completion, particularly ensuring that there is no ambiguity in relation to the insulin product they use.

A number of national diabetes groups have questioned whether the scheme will succeed. There is no argument that improvements need to be made in relation to insulin safety (in particular, people with diabetes receiving

the correct insulin product), but it is unclear whether the passport will achieve this.

The general consensus of 10 diabetes healthcare professional groups who met the NPSA in August was that colour-coded cards that clearly illustrate the person's insulin type and mode of administration would be a preferable alternative. The card would be the size of a credit card, and show:

- Patient's name and date of birth.
- Name of insulin.
- Picture of insulin preparation, e.g. cartridge, disposable pen, vial.
- NHS number.
- Other insulins taken.
- Emergency contact.

Discussion is currently underway with insulin manufacturers to facilitate card production. An alternative PIL is being developed, which will be available nationally.

While it could be argued that, in many circumstances, the DSN is not the insulin prescriber and therefore not the healthcare professional responsible for issuing a passport



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Box 1. The National Patient Safety Agency requirements (NPSA, 2011a).

For action by all organisations in the NHS and independent sector where insulin is initiated, prescribed, dispensed, administered or monitored. An executive director working with relevant medical and nursing staff, the lead pharmacist and patient groups should ensure (through reviewing policies, procedures and staff training) that by 31 August 2012:

1. Adult patients on insulin therapy receive a patient information booklet and an insulin passport to help provide accurate identification of their current insulin products and provide essential information across healthcare sectors.
2. Healthcare professionals and patients are informed how the insulin passport and associated patient information can be used to improve safety.
3. When prescriptions of insulin are prescribed, dispensed or administered, healthcare professionals cross-reference available information to confirm the correct identity of insulin products.
4. Systems are in place to enable hospital inpatients to self-administer insulin where feasible and safe.

Insulin Passport **NHS**

Instructions

You should complete as much information for your passport as possible, then fold it back to credit-card size.

Keep it with you for emergencies and for reference when insulin products are prescribed or dispensed.

The area below is **not** for use as a daily diary record.

In the table below you should record information of your current insulin products. Provide as much detail so that all your insulin products are clearly identified. A healthcare professional can help you with this. If someone else has added information, ask them to sign it. You must keep this information up-to-date. Keep the passport with you and when you need to contact a healthcare professional, show it to them. They can use the information to help identify exactly what insulin products you use.

Date Started	Date Stopped	Insulin Brand name	Presentation (for example, vial, cartridge or pre-filled pen) and device for insulin administration	Signature

Other medicines (optional)
Use this space to record any other medicines you might be taking. Include any over-the-counter medicines.

Insulin Passport

EMERGENCY INFORMATION

I have Type _____ diabetes and inject insulin. If I am ill or fainting my usual 'type' treatment is _____

Please give it to me unless I am unable to cooperate or unconscious.

- If I have not recovered after 10 minutes please repeat the treatment.
- If I am unconscious/unable to cooperate do not give me anything by mouth.
- Call 999 for an ambulance immediately.

My Name: _____
Date of Birth: _____
NHS number: _____
Address: _____
Postcode: _____
Telephone number: _____

My GP Name: _____
Address: _____
Postcode: _____
Telephone number: _____

Emergency contact:
Name: _____
Telephone number: _____

Please unfold for important information on insulin use

Figure 1. Proposed National Patient Safety Agency insulin passport: front and rear.

and PIL, the reality is that in the majority of cases insulin is commenced by a nurse and the majority of education relating to insulin and insulin safety is provided by nurses. DSNs have a responsibility to embrace the principles of this alert and review their practice in relation to reducing the errors that it seeks to address.

Now is the time to familiarise yourself with the passport scheme. Ask your local risk management team what the plans are in your area. Remember that whatever decision is made will impact on your day-to-day clinical practice.

Patient safety is an essential component of any nurse's clinical practice. Any nurse involved in supporting people with diabetes in their day-to-day management of insulin therapy needs to ensure their clinical practice addresses the issues highlighted by the NPSA alert.

Reflection is an integral component of modern nursing practice, and now is the time to reflect on whether our clinical practice proactively tries to address the issues highlighted by this alert:

- What steps do we currently take to ensure patients understand exactly which insulin they are taking and the format in which it is administered?
- Do we highlight to them the potential risk of being given the wrong insulin?
- Are we utilising all the tools available to us to support the patient in correctly identifying that they have been given the correct insulin?
- Would the insulin passport or a local alternative help minimise the risk of patients being given the wrong insulin product?
- Would the patient education leaflet help patients to identify areas of potential insulin error and minimise these risks?

Whether the NPSA insulin passport and PIL meet the needs of your local diabetes population, or whether a local or national alternative would be preferable, needs to be agreed by your local team – but in 10 months' time, you and your team need to be issuing people with diabetes with a patient information leaflet and passport that fulfils the NPSA requirements. ■

NPSA (2011a) *The Adult Patient's Passport to Safer Use of Insulin*. Patient Safety Alert NPSA/2011/PSA003. NPSA, London. Available at: <http://bit.ly/rjfirm> (accessed 18.11.11)

NPSA (2011b) *The Adult Patient's Passport to Safer Use of Insulin: Supporting Information*. Patient Safety Alert NPSA/2011/PSA003. NPSA, London. Available at: <http://bit.ly/rjfirm> (accessed 18.11.11)