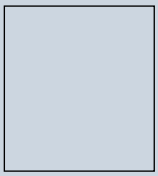
Letters

Delays in patients receiving insulin following discharge to the community



Urmila Griffiths

A problem has been identified in our area where community nurses served by several hospital trusts have been advised by their Director of Nursing Service not to use hospital discharge letter information to administer insulin at home. It must always be confirmed and written up on prescription chart and signed by a GP. This poses difficulties of initial administration of insulin, particularly on weekend or bank holiday discharge and often leads to the patient not receiving their medication at the appropriate time.

We would like to hear from other centres or trusts if they have encountered similar problems and how they may have resolved the issue. Has anybody developed a discharge protocol which covers such a dilemma?

Urmila Griffiths
Senior Diabetes Specialist Nurse,
Good Hope Hospital, Sutton Coldfield

In response to the above discharge problem

Eileen Padmore

The Crown 2 Report was commissioned because it had become apparent that the 1968 Medicines Act was significantly out of line with the way medical and nursing care had developed. There was recognition that it was no longer possible to meet the needs of patients by sticking to the letter of the law.

The dilemma Urmila Griffiths describes above is a classic example of a strictly legal approach, or what is perceived as strictly legal, being inadequate for patient care. It is entirely unacceptable for there to be delays in patients receiving insulin on discharge and this situation could even lead to the unnecessary trauma and cost of readmission.

Every acute trust will have its own pre-discharge documentation but it is usual for a doctor to sign a list of 'to-take-out' (TTO) medications immediately prior to discharge. In our hospital (part of Leeds Teaching Hospital Trust) the top copy is retained by the pharmacy and the three remaining copies sent to the ward with the TTO medications. One copy is mailed to the GP, one retained in the medical notes, while the third goes home with the patient.

I have taken advice from Mark Jones, RCN primary care policy adviser, who states: 'The discharge letter can technically form a prescription if the doctor has detailed the insulin regimen and signed it. There is no legal reason why the district nurse cannot give insulin as per these instructions. The trust is of course free to determine its own rules!'

The problem seems to be that since the Crown 2 Report the trusts are tending to scrutinise practice much more closely and are alarmed at what they uncover. Thus we find that systems which have worked well for years are being questioned or disrupted. We should not be afraid of Crown 2 — it was not intended as a stick to beat us with but as a crutch to support us in the current unhelpful legal situation.

Where acute and community trusts are separate there is a need for individual trusts to have clear and unambiguous protocols in place for the supply and administration of insulin. It would seem to me that if you have not got your own house in order then it is unlikely that trying to find solutions across two houses or more will work. Perhaps I am wrong. Maybe some of you have done this successfully — if so let's hear from you!

My feeling is that once in-house protocols are determined then we should be meeting together across acute and community trusts and collaborating across professional boundaries to produce joint protocols around discharge procedures and other issues — such as the communication of changed doses and regimen between DSNs and district nurses — that protect both patient and professional. It would be good to hear from any of you who have done this or are working on such schemes.

Eileen Padmore
DSN, Wharfedale General Hospital

Please send your letters and comments to The Editor, Journal of Diabetes Nursing, 15 Mandeville Courtyard, 142 Battersea Park Road, London SW11 4NB.