DIABETES POLICY

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Policy applies to (area): Suffolk Community Healthcare Clinical Services

Guideline applies to (Staff Groups):
Community Nurses
Inpatient Units
Community Matrons
Specialist Nurses i.e. Cardiac, Neurological, COPD

Required compliance: This policy must be complied with fully at all times by the appropriate staff. Where it is found that this policy cannot be fully complied with, this must be notified immediately to the owner through the waiver process

Guideline owner:  
Director of Nursing, Therapies & Governance

Guideline authors:  
Head of Nursing & Professional Practice
Practice & Development Nurse

Other contact:  
Clinical Quality & Safety Assurance Group

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AGREED GUIDELINE REVIEW / RATIFICATION / ADOPTION PATH:

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STATEMENT OF OVERARCHING PRINCIPLES

All Policies, Procedures and Guidelines of SCH are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

1. Introduction

This policy seeks to establish the principles that must be followed to support people with diabetes in community settings within Suffolk Community Healthcare and to provide information for the staff around the care available for these patients in acute and community settings.

2. Purpose Of This Clinical Policy

The purpose of this policy is to provide a standardisation of the provision of diabetic care to patients accessing the services of Suffolk Community Healthcare. This will include monitoring, education, administration of insulin and diabetic annual review to maintain optimum independence of the patient and to promote quality of life, independence and reduce the possible complications of diabetes.

3. Policy Agreement Path

See policy document front page.

4. Definitions

Diabetes “A metabolic disorder of multiple aetiology characterised by chronic hyperglycaemia with disturbances of carbohydrate, fat and protein metabolism resulting from defects in insulin secretion, insulin action or both.”

Type 1 Diabetes Previously known as insulin-dependent, juvenile or childhood-onset; this is characterised by deficient insulin production and requires daily administration of insulin. Symptoms include excessive excretion of urine (polyuria), thirst (polydipsia), constant hunger, weight loss, vision changes and fatigue. These symptoms may occur suddenly.

Type 2 Diabetes Previously called non-insulin-dependent or adult-onset; this results from the body’s ineffective use of insulin. Type 2 diabetes comprises 90% of people with diabetes around the world, and is largely the result of excess body weight and physical inactivity. Symptoms may be similar to those of Type 1 diabetes, but are often less marked. As a result, the disease may be diagnosed several years after onset, once complications have already arisen. Until recently, this type of diabetes was seen only in adults but it is now also occurring in children.

Gestational Diabetes Hyperglycaemia with onset or first recognition during pregnancy. Symptoms of gestational diabetes are similar to Type 2 diabetes. Gestational diabetes is most often diagnosed through prenatal screening, rather than reported symptoms. These should be primarily cared for within the acute setting.

HbA1c Glucose in the blood binds irreversibly to a specific part of haemoglobin in red blood cells, forming HbA1c. The higher the glucose, the higher the formation of HbA1c. HbA1c circulates for the lifespan of the red blood cell, so reflects/indicates the prevailing blood glucose levels over the preceding 2–3 months. The HbA1c measures the amount of glucose that is being carried by the red blood cells in the body. The HbA1c target is 48 mmol/mol.
or 6.5%.

DCCT  The Diabetes Control and Complications Trial: Type 1 Diabetes

UKPDS  UK Prospective Diabetes Study: Type 2 diabetes

Hypoglycaemia  For the purpose of this policy this would be a blood sugar level of less than 4 mmols/per litre

Normal Blood Sugar  For the purpose of this policy, this would be a pre-meal (pre-prandial) blood sugar level of 4-7 mmols/per litre - 2 hours post meal (post-prandial) blood sugar level of 9 mmols/per litre or less.

Hyperglycaemia  Anything above the patient’s normal blood sugar range would be classified as hyperglycaemia

5. Diagnosis

5.1. A confirmed medical diagnosis of diabetes mellitus must be made, following the criteria set out by the World Health Organisation (1999) and cited in NICE Guidelines (2009)

5.2. Methods and Criteria for diagnosing diabetes mellitus:-

5.3. Diabetes symptoms evident – polyuria; polydipsia; and unexplained weight loss; PLUS
a) a fasting plasma glucose concentration 7.0 mmol/L (whole blood 6.1 mmol/L) or
b) a random venous plasma glucose concentration of 11.1 mmols/L or
c) two hour plasma glucose concentration 11.1 mmol/L two hours after 75g anhydrous glucose in an oral glucose tolerance test (OGTT)
d) an HbA1C above 48 mmols

5.4. Without any symptoms, diagnosis should not be based on a single glucose determination but requires confirmation by plasma venous determination. At least one additional glucose test result on another day is essential either fasting from a random sample, or from the two hour post glucose load. If the fasting or random values are not diagnostic the two hour values should be used. (WHO 1999; NICE 2009)

6. Blood Glucose Monitoring

6.1. Clinical Monitoring:
   a) SCH staff to use organisational agreed blood glucose monitor and corresponding test strips for on the spot monitoring.
   b) Monitors should be calibrated with every new box of test strips.
   c) Monitors should be tested in accordance with manufactory advice for Quality Control Testing.
   d) Regular blood glucose monitoring is an individual need which should be agreed in discussion with the patient and Diabetic Nurse Specialist, Consultant or GP.
   e) Random blood glucose testing on its own is not a reliable measure and should never be used in isolation

6.2. HbA1C Monitoring: Targets/ Composite measures
   • When setting a target HbA1c, involve the person in decisions about their individual HbA1c target level which may be above that of the 48 mmols target set for people with Type 2 diabetes in general.
• Those individuals with Type 1 diabetes blood glucose control should ideally be optimised towards attaining DCCT-harmonised HbA1c targets for prevention of micro vascular disease, less than 58 mmols and, in those at increased risk of arterial disease, less than or equal to 48 mmols. Adults with Type 1 diabetes should be assessed for arterial risk at annual intervals. These patients will be monitored by the Acute Unit
• Adults with Type 1 diabetes should be assessed for early markers and features of eye, kidney, nerve, foot and arterial damage at annual intervals. According to assessed need, they should be offered appropriate interventions and/or appropriate onward referral.

6.3. Frequency of Monitoring
• 2 to 6 monthly, according to individual needs, until stable on unchanging therapy
• 6 monthly once blood glucose level and blood glucose lowering therapy are stable

6.4. Self-Monitoring:
  a) This is essential to people with Type 1 diabetes.
  b) For people with Type 2 diabetes:
    • Only offer to a newly diagnosed person as an integral part of self-management education
    • Advice will vary depending on blood glucose control, treatment regime, personal preference in using results to achieve desired lifestyle
    • Teach self-monitoring skills close to time of diagnosis and initiation of treatment
    • Interpret results in light of clinically significant life events.
    • Reassess skills, use of results and equipment used, at least annually.
    • Discuss urine glucose monitoring if plasma monitoring is found to be unacceptable.

For full guidance please see WSCCG and IESCG guidelines (appendices 2 and 3)

6.5. Target
Pre-food blood glucose level 4.0 – 7.0 mmol/litre, post-food blood glucose level less than 9.0 mmol/litre. However, individual targets are needed to suit the individual’s circumstances.

7. Annual Review
7.1. The long term complications of diabetes involve many different systems in the body. These may be found at the time of diagnosis of diabetes, or many years after the onset of diabetes. Many of the long term complications of diabetes are thought to be due to persistently elevated levels of blood glucose

7.2. The annual review should consist of the following:
  a) Laboratory tests and investigations:
    • Blood glucose control: an HbA1c blood test will measure long-term blood glucose control. Individualised target levels tailored to the requirements of individual patients show a better reduction in associated risk factors (see above for target levels)
    • Kidney function: urine and blood tests to check for protein will show the kidneys are working correctly.
    • Blood fats (lipids, cholesterol and triglyceride levels): a blood test that measures blood fat levels. A total cholesterol level of below mmol/litre (4.0mmol/l for patients who have had a cardiovascular event) or less and a fasting triglyceride of 1.7mmol/l or below are accepted as national target ranges.
  b) Physical examinations
    • Weight calculated as a Body Mass Index (BMI) which expresses adult weight in relation to height.
• Legs and feet should be examined to check skin, circulation and nerve supply. If they meet the referral criteria the patient should be referred to a HPC registered chiropodist/podiatrist.
• Blood pressure should be taken. Blood pressure to be at or less than 140/80. If it is at higher levels discuss with patient’s doctor.
• If the patient is on insulin, the injection sites should be examined.
• Eye screening should be carried out all patients over 12 years old annually. This is to examine the eye regularly through a ‘fundoscopy’ review where the pupils are dilated to detect any early changes at the back of the eye (retinopathy).

c) Lifestyle issues
The review should also provide enough time to discuss:
• General wellbeing; how the patient is coping with their diabetes at home, work, school or college.
• Current treatment.
• Diabetes control, including home monitoring results and hypos.
• Any problems the patient may be having and should include discussion about smoking, alcohol consumption, stress, sexual problems, physical activity and healthy eating issues.
• Annual review should be carried out by the health professional most relevant to the service.
• As part of the holistic care of the patient community patients who have diabetes and are housebound and currently on the Community Nurses case load may, where appropriate have their review carried out by the Community Nursing team.
• Housebound patients not on the District Nurse case load must be reviewed by the patient’s GP or Practice nurse.

d) Reviews will be conducted by the Acute Unit or (in the East) within the community by the Integrated Diabetes Service Nurse Specialists (see appendix 3 for referral guidelines).

8. Desmond and Diabetes UK
8.1. DESMOND – Diabetes Education and Self Management for Ongoing and Newly Diagnosed
8.2. DESMOND is a structured group education programme developed by experienced healthcare professionals, in participation with people with diabetes. It meets Diabetes NSF Standard 3 for Self Management, Nice and DoH/DUK Quality Standards and Criteria for Structured Patient Education. All people newly diagnosed with Type 2 diabetes should be offered the opportunity to attend a DESMOND session by their Practice Nurse or GP.

8.3. All of the above references taken from the local diabetes website: http://www.diabetesuffolk.com

9. Sick Day Rules
9.1. In people with Type 1 diabetes this may lead to very high blood sugar levels and a condition known as diabetic ketoacidosis
9.2. The basic points to advise patients:
  a) Test blood glucose levels more often - at least four times a day and four times a night.
  b) With Type 1 diabetes, if blood glucose levels are over 15mmol/l or more, a blood or urine test for ketones may be requested by the local Specialist Service/ Acute Unit.
  c) Continue to take insulin or diabetes medication and adjust the dose in response to test results.
  d) Drink plenty of sugar free drinks.
e) If being sick, take carbohydrate containing drinks such as milk and other milky drinks, fruit juice or sugary drinks such as Lucozade, ordinary cola or lemonade

f) If able to eat but have no appetite, eat little and often, taking carbohydrate containing drinks, as above, and snacks such as toast, biscuits and cereal

g) Contact your doctor or healthcare team if any of the following apply: blood glucose levels are continuously high, ketones in blood or urine, vomiting, diarrhoea or if you are unsure what to do

10. Management of Hypoglycaemia Attack

10.1. Severe hypoglycaemia is defined as a blood glucose level of less than 2.2 mmol/l. Mild hypoglycaemia is defined as blood sugars of less than 4 mmol/l.

10.2. When a hypo happens, the person often experiences ‘warning signs’ which occur as the body tries to raise the blood glucose level. These ‘warning signs’ vary from person to person but often include feeling shaky, sweating, tingling in the lips, going pale, heart pounding, confusion and irritability.

10.3. Treatment is usually very simple and requires taking some fast acting carbohydrate, such as a sugary drink or some glucose tablets, following this up with some longer acting carbohydrate such as a cereal bar, sandwich, piece of fruit, biscuits and milk or the next meal if it is due. If left untreated the person might eventually become unconscious and would need to be treated with an injection of glucagon (a hormone that raises blood glucose levels).

11. Footcare

11.1. People with diabetes have an increased risk of foot ulceration (particularly in pressure areas on the plantar surface of the foot). The risk is increased where there is impaired arterial circulation (ischaemia) and/or loss of sensation (neuropathy).

11.2. Many foot ulcers can be prevented by treating the complications of diabetes and by preventing injury and breaks to the skin. High risk patients require regular podiatric review.

11.3. Where new ulceration has occurred, prompt referral to the acute unit foot clinic is essential for immediate intervention as the rate of healing is frequently compromised.

11.4. Regular foot inspections by the patient and the wearing of functional footwear will be of benefit. NHS Podiatrists are able to offer advice on footwear and foot care, and can refer to specialist foot clinics if required (following NICE Guidelines). The Podiatry service is able to provide insoles and orthotics to cushion and protect feet and to reduce the effects of stresses on the feet. NHS Podiatrists are also able to carry out assessments of patients’ feet using a systematic clinical approach.

12. Oral Medication

Patients with Type 2 diabetes take tablets to lower their blood glucose levels. Different tablets work in different ways to lower blood glucose levels

13. Insulin

13.1. There are three groups of insulin – animal, human (not from humans but produced synthetically to match human insulin) and analogues - if we think of the insulin molecule as being like a string of beads, scientists have managed to alter the position of some of these beads to create 'analogues' of insulin.

13.2. Nowadays, most people use human insulin and insulin analogues, although a small number of people still use animal insulin because they have some evidence that they otherwise lose their awareness of hypos or they find animal insulin works better for them.

13.3. There are six main types of insulin:
a) Rapid acting analogue – can be injected just before, with or after food and have a peak action at between 0 and 3 hours. They tend to last between 2 and 5 hours and only lasts long enough for the meal at which they are taken. They are clear in appearance.

b) Long acting analogue – tends to be injected once a day to provide background insulin lasting approximately 24 hours. They do not need to be taken with food because they do not have a peak action. They are clear in appearance.

c) Short acting insulin – should be injected 15–30 minutes before a meal to cover the rise in blood glucose levels that occurs after eating. It has a peak action of 2–6 hours and can last for up to 8 hours. It is clear in appearance.

d) Medium and long acting insulin – taken once or twice a day to provide background insulin or in combination with short acting insulins/rapid acting analogues. Their peak activity is between 4 and 12 hours and can last up to 30 hours. They are cloudy in appearance.

e) Mixed insulin – a combination of medium and short acting insulin.

f) Mixed analogue – a combination of medium acting insulin and rapid acting analogue.

14. Prescribing

14.1. A patient’s treatment must be initiated through a formal process, which must be the production of a prescription or PSD (a written instruction from a Prescriber to supply or administer a medicine to a specific patient) by an authorised prescriber

14.2. The PSD must be written as follows:

a) Medicines should be prescribed by approved names unless the brand name is clinically significant;

b) Prescriptions shall be legible and in black ink;

c) Prescriptions shall be signed with a full signature;

d) Instructions shall be in English only abbreviations listed in the BNF shall be used;

e) Prescriptions shall not be altered or amended by the prescriber;

f) Clear dose and time for administration on each sheet

14.3. A registrant may transcribe medication from one “direction to supply or administer” to another “form of direction to supply or administer”. This should only be undertaken in exceptional circumstances and should not be routine practice. BEWARE that in so doing you are accountable for your actions and omissions. Any medication that you transcribe must be signed off by a Registered Prescriber.

14.4. Where there are any ambiguities the prescriber must be contacted for clarification prior to insulin administration.

a) If insulin dose adjustment is necessary, the Registered Nurse will contact the appropriate prescriber to discuss changes in dose.

b) Prescriber will give verbal instruction i.e. telephone, and send written instruction by facsimile if cannot access medicine administration chart

15. Storage of insulin

a) All insulin needs to be kept at temperatures lower than 25°C, ideally between 2 and 6°C. Normal room temperatures are below 25°C but they can be warmer in the summer. Therefore, any insulin not currently used should be stored in the fridge throughout the year. Any insulin that has been out of the fridge for 28 days or more should be discarded.

b) Do keep the insulin currently in use in a cool, dry place (below 25°C).

c) Do not place insulin in, or close to, the freezer compartment. Insulin should not be used if it has been frozen.
d) Do not expose the vials or cartridges in the car during the hot weather.

e) Do not use the insulin if it has expired (check pack for the expiry date).

f) Within residential homes ensure all insulin is stored separately for each patient and clearly labelled.

16. Sharps from patients with diabetes

a) All used sharps from patients with diabetes should be disposed of in a regulation sharps container (this includes lancets and BD needle clippers).

b) Sharps containers are available for diabetics from all General Practice surgeries. General Practitioners should ensure that the patient is aware of the correct method of disposal of the filled sharps bin.

c) The Environment Agency (as the enforcing body) has agreed that, legally, sharps bins can be returned to the surgery for disposal under exemption 39(2) of the Waste Management Licensing Regulations 1994 (as amended). The Local Authority also has a duty to collect clinical waste including sharps from households. The householder may be charged by the local authority for this service.

d) Whichever route is used, the patient must be made aware that it must not be disposed of in the household waste system under any circumstances.


17. Administration

a) Ensure patient has an up to date care plan which includes the actions to be taken in the event of hypoglycaemia or hyperglycaemia.

b) The care plan must include who has clinical responsibility should any adverse clinical episode occur, as treatment may need to be adjusted.

c) Ensure accurate, contemporaneous recording on the appropriate drug chart of any drugs administered.

17.2. Inpatient Units

a) If the patient is able, they will be encouraged to continue drawing up and administering their own insulin, using the device/equipment that they are familiar with. If they are newly diagnosed, the staff would support them to do this with liaison with the Diabetic Nurse Specialist. Responsibility for future management will be decided upon discharge.

b) All insulin must be administered in accordance with SCH POLICY FOR SAFE AND SECURE HANDLING OF MEDICINES and be prescribed on the medication instruction chart used within each area.

18. Advanced Preparation of Insulin Syringes for Patients to Administer at Home

18.1. Many patients are unable to draw up their own insulin and need Community Nurse support, although they are able to inject independently using a syringe once or twice a day.

18.2. The preparation of insulin injections by Community Nurses for patients to administer in their own homes at a later time has been widespread practice for many years. In this way each patient can administer their insulin at the correct time in relation to their meal times, and when they have carers or family to prompt and support self administration. This practice preserves the individual’s independence and convenience.

a) Pre-drawing up of insulin should only be considered after all other options have been exhausted, such as a switching to commercially pre-mixed insulin, or the introduction of an insulin pen device. This practice must follow a thorough assessment of the patient’s comprehension and competence to administer pre-drawn insulin safely.
b) Pre-loading of insulin should only be recommended when alternative methods of delivery are not possible.

c) Pre-loading of insulin should only begin following a full risk assessment, and through assessment of the patient’s understanding and ability to administer their own insulin.

d) Arrangements must be made to ensure the monitoring of diabetes control is undertaken. Diabetic monitoring may be undertaken by the patient, a family member or friend or by an interim visit by Community Services.

e) Regular re-assessment of the patient and the plan of care must be undertaken every 3 months, or sooner if the patient’s circumstances change, and be clearly documented.

f) Obtain written consent from the patient or their carer.

g) Pre-loaded insulin syringes should be stored in the main part of the refrigerator at 2 to 8°C. They should not be placed in the freezer or at the back of the fridge.

h) The needle should point upwards in mixtures containing isophane insulin to prevent blockage by suspended substances in the insulin.

i) The NPSAS advice is not to leave insulin pre-drawn for any longer than 24 hours. Under certain circumstances it may be considered necessary to pre-load several days supply of insulin syringes.

j) No more than one week’s supply of insulin should be left pre-loaded.

k) Syringes should be stored in a sealable container, clearly labelled with the following information:
   • date
   • number of syringes
   • name of insulin preparation
   • pre-loaded dose
   • instructions for administration, e.g. just before or 30 minutes before food at times agreed with patient and documented in the nursing notes with the name of the nurse who has drawn up the syringes.
   • Separate containers should be used for insulin to be delivered at different times of day, particularly if the syringe contains a different dosage or type of insulin.

l) All new patients must undergo a risk assessment and use of the Flow chart for deciding if the pre-loading of insulin is suitable for the patient prior to commencing this procedure.

18.3. Potential Problems

a) If morning and evening doses are different, it is possible that the two may become confused, particularly if the patient has poor vision. This should be addressed by the Community Nurse in their assessment of the patient’s capabilities and circumstances. Ways of overcoming the risk include the use of different shaped boxes for storage, which should be clearly marked to differentiate each dose.

b) Accidental waste of insulin by spilling or dropping it. Community nurses should ensure that patients know who to contact if this happens.

c) It is possible that doses may be given at too close or too great an interval. Again, the patient’s understanding of the regimen and their routine must be regularly assessed by the Community Nurse.

18.4. Contra Indications

a) Insulin not suitable for preloading
   • Short acting (Soluble)
   • Long acting Analogues e.g. Glargine

b) Unstable diabetic condition
c) Lack of suitable storage conditions

d) Unpredictable mental state or declining cognitive ability

e) Patients in care homes without individual storage facilities

18.5. Pre-loading of Lantus (Glargine Insulin)

a) An increasingly small number of patients in the community are still using Lantus (manufactured by Sanofi-Aventis) via pre-loaded syringes and although this is generally contra-indicated, these patients may wish to continue with this type of insulin administration.

b) In this case the following guidelines should be adhered to:

- Conduct a medication review with the patient in consultation with the GP/ Diabetes Nurse to ascertain whether an alternative type of insulin which is not contra-indicated with pre-loading would give as good or better control and be equally acceptable to the patient.
- If however, the decision is made to continue with Lantus then it should be pre-drawn into seven disposable insulin pens (e.g. the Lantus SoloStar) for administration over seven days.
- In order to reduce the risk of accidental needle puncture a device such as the NovoFine Autocover (or similar) should be used. These devices have been designed especially to conceal the needle and reduce the risk of needle-stick injury. The automatic shield feature hides the needle from view during injection and locks into place immediately after use, shielding the needle and reducing accidental needle puncture.

c) A Flow Chart for deciding if the pre-loading of insulin is suitable for the patient can be found at Appendix 1

18.6. Assessing Risk – The Pre-Loading of Insulin

a) The pre-loading of insulin should be considered as a last resort and only following a risk assessment. Its aim is to promote patient independence not as a means of saving nursing time.

b) If there are no contra-indications then a positive response to all of the questions on the pre-loading checklist at Appendix 2 is required before the pre-loading of insulin can commence.

18.7. The Procedure Chart for pre-loading insulin at Appendix 3 must then be followed.

19. Local Acute Unit and CCG Formularies

19.1. For current up to date information please see the links below:

- East Suffolk and Ipswich CCG
  http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/CCGFormularies/Formularies.aspx

- West Suffolk CCG

- Ipswich Hospital

- West Suffolk Hospital
  www.wsh.nhs.uk/ServicesAtoZ/ClinicalServices/N-P/Pharmacy/Services/TheFormulary.aspx

20. Record Keeping

20.1. In March 2011 the National Patient Safety Agency (NPSA) issued a Patient Safety Alert, The adult patient’s passport to safer use of insulin, aimed at empowering patients with diabetes to take a more active role in their treatment to avoid being given the wrong insulin.

S/Internal/DiabetesPolicy/June14/V2.0
20.2. The NPSA is asking NHS organisations in England and Wales to give all adult patients on insulin therapy an Insulin Passport to help improve accurate identification of their current insulin products. This will provide essential information across healthcare sectors and act as a safety check for the correct prescribing, dispensing and administration of insulin. A patient information booklet is also provided, empowering patients and supporting safer insulin treatment. All documentation can be found at the link below.

20.3. Where an Insulin Administration Record Sheet is used it should be incorporated, in conjunction with the Insulin Passport (obtained via the patient’s GP), within the patient’s Care Plan.

20.4. Please see NICE Diabetes Guidelines (QS 6) for further current guidance and pathway.
http://guidance.nice.org.uk/QS6

21. Responsibility of Managers

It is the responsibility of Managers to ensure all staff at the point of appointment are made aware of this policy. Where staff are currently in post, the policy will be cascaded through the policy implementation process and awareness raised at staff meetings.

22. Incident Reporting

22.1. Any incident or near miss that occurs in the workplace or whilst at work must be reported. Suffolk Community Healthcare has a single reporting system that incorporates the reporting of both clinical and non-clinical events.

22.2. An Incident is an occurrence or event where there is loss of life; injury; or loss or damage, to persons or property. It can include any event that may give rise to physical, emotional or psychological harm.

22.3. A Clinical Incident is an incident but occurs as a result of a clinical intervention involving a patient.

22.4. A Near Miss – is where a serious incident could have occurred but did not, due to one or more factors, such as a member of staff detecting an error or unsafe condition and taking appropriate corrective action

The Risk Management Team will always give advice and guidance regarding incident reporting. The team’s contact details are available at:

23. Cross Reference to Other Related Polices/ Documents

- Disciplinary Policy - See SCH Intranet “Policies/ HR Policies”
- Incident Policy - See SCH Intranet “Policies/ General Policies”
- East of England Serious Untoward Incident Policy - See SCH Intranet “Policies/ General Policies”
- Record Keeping Policy - See SCH Intranet “Policies/ Clinical Policies”
- Clinical Waste Reduction Strategy - See SCH Intranet “Policies/ Clinical Policies”
- Consent Policy - See SCH Intranet “Policies/ Clinical Policies”
- Retinal Eye Screening Policy - See SCH Intranet “Policies/ Clinical Policies”
- Safe and Secure Handling of Medicines - See SCH Intranet “Policies/ Clinical Policies”
- Mental Capacity Act - See SCH Intranet “Policies/ Clinical Policies”
- Nursing Midwifery Council “Standards for Medicines Management” 2010
- Suffolk Podiatry Services - see SCH Intranet “Our Services/ Podiatry”
- “Screening & Management of the Diabetic Foot” Guidelines for Podiatry Service Staff April 2010 – see SCH Intranet “Our Services/ Podiatry / Forms, Documents and Product User Group”
- Royal College of Nursing “ An RCN guide to the National Service Framework for Diabetes
• Royal College of Nursing “Advance preparation of insulin syringes for patients to administer at home”
• The Patient Safety Alert, *The adult patient’s passport to safer use of insulin*, and supporting material is available from: www.nrls.npsa.nhs.uk/resources/type/alerts
Appendix 1: Self administration assessment flowchart

Has the patient, through education and support, shown that he/she is:-
- Able to administer insulin correctly and independently at the appropriate time and dispose of syringes safely.
- Is unable to draw up accurately and independently the prescribed insulin dose.
- Understands their insulin regime.

YES  

Consider alternative methods of insulin administration which facilitates accurate dialling/drawing up - refer to Diabetes Nurse Specialist. Are alternative methods of administration appropriate?

YES  

Provide support/education to patient until independent with insulin regime

NO  

Are there contraindications to the pre-loading of insulin?

YES  

NO  

Can patient:–
- Provide correct storage requirements
- Monitor diabetes’s control independently or arrangements in place for monitoring to be undertaken
- Distinguish between am and pm dose containers if on twice daily insulin

YES  

NO  

Would pre-loading of insulin promote patient independence and meet patient need?

YES  

Commence pre-loading of insulin.
Arrange with patient to undertake weekly blood glucose monitoring and draw up of insulin arrangements are on place, for regular re-assessment of the care plan and patients ability (re-assessment should take place 3 monthly or sooner if patients circumstances change).
Appendix 2: WSCCG Guideline on the frequency of blood glucose self-monitoring

Primary Care Guideline on the frequency of blood glucose self-monitoring in patients with type 2 diabetes mellitus not controlled by insulin

Type 2 diabetes mellitus treated with:

- Drug class: Examples
  - Alpha glucosidase inhibitors: Acarbose
  - Biguanides: Metformin
  - DPP-4 Inhibitors (Ogliptins): Linagliptin, Sitagliptin, Saxagliptin, Vildagliptin
  - GLP-1 Analogues (Incretin mimetics): Exenatide, Liraglutide, Linaglutide
  - Thiazolidinediones (Glitazones): Pioglitazone
  - SGLT2 Inhibitors: Dapagliflozin

If any of these treatments are given in combination with a sulphonylurea or a meglitinide then follow the guidance given for patients treated with a sulphonylurea or meglitinide

Diet and exercise alone

- Drug class: Examples
  - Meglitinides (Prandial glucose regulators/glinitides): Nateglinide, Repaglinide
  - Sulphonylureas: Glipizide, Glimepiride

These medicines can cause hypoglycaemia
Blood glucose monitoring may therefore be required in patients:
- who are not stabilised on treatment
- who are drivers (see DVLA guidance below)
- in other certain circumstances (see below)

Regular blood glucose monitoring not necessary
A supply of blood glucose test strips may be required (as an acute prescription) in certain circumstances (see below)

Blood glucose monitoring may be required in patients:
- with acute illness
- co-prescribed steroids (test at midday, before evening meal and two hours after evening meal)
- undergoing significant changes in pharmacotherapy or fasting, for example, during Ramadan
- at increased risk of hypoglycaemia/hypoglycaemia unawareness
- with unstable or poor glycaemic control (HbA1c >6.5% [84mmol/mol])
- with postprandial hyperglycaemia (due to the potential link with macrovascular disease)
- who are pregnant or planning pregnancy

DVLA guidance for diabetic patients managed by sulphonylurea or glinide tablets

<table>
<thead>
<tr>
<th>Driver Group</th>
<th>DVLA Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (cars, motorcycles)</td>
<td>It may be appropriate to monitor blood glucose regularly and at times relevant to driving</td>
</tr>
<tr>
<td>Group 2 (buses, lorries)</td>
<td>There is a requirement that the patient regularly monitors blood glucose at least twice daily and at times relevant to driving</td>
</tr>
</tbody>
</table>

Note: The DVLA do not define how frequently blood glucose should be tested when advising ‘regularly’ and ‘at times relevant to driving’ for diabetic patients managed by sulphonylurea or glinide tablets, and it is therefore not possible to clarify the DVLA guidance further.
Prescribing Tips

- NICE recommend that HbA1c is checked twice annually in all diabetic patients

- The frequency of blood glucose monitoring required will vary for individual patients according to a number of factors such as the treatment regime in use, the target level of glycaemic control, the patient’s stability on treatment, the advice given by the DVLA for drivers, and other acute circumstances such as illness or pregnancy; this variety of factors means it is not possible to define a specific quantity of test strips that patients should be issued.

- Clinical judgement should be used in assessing individual patient requirements for the frequency of blood glucose monitoring required and the number of blood glucose test strips that should be issued; advice should be sought from a diabetes specialist if necessary.

- Patients who require blood glucose test strips as part of their regular treatment for diabetes can be issued with a repeat prescription; for those patients who require to monitor their blood glucose only in certain acute circumstances, then test strips should preferably be issued as an acute prescription.

- Prescribers are encouraged to regularly review how frequently their patient monitors their blood glucose and subsequently review the appropriate issuing of blood glucose test strips – patients should only ever be issued sufficient quantities to meet their needs, and to prevent stockpiling and waste.

- The relevant directions for use should be added to the product dispensing label to enable better compliance.

- The expiry date of the test strips should be taken into account.

- A record of the patient’s driving status should be made in the patient notes — this can be read coded i.e. heavy goods driver, motor car driver, does not drive a vehicle.

- Only one brand of test strips, relevant to the meter the patient is using, should be prescribed.

References:
Appendix 4: IESCCG Guidelines for Blood Glucose Monitoring

Ipswich and East Suffolk Clinical Commissioning Group Guidelines for Self-Monitoring of Blood Glucose (SMBG) in Adult Patients with Type 2 Diabetes

Key Points

- All patients with type 2 diabetes requiring a blood glucose meter should be given one that is included in the formulary (appendix 1) unless they are exempt.

- The CCG will not support the prescribing of test strips for meters other than those listed in appendix 1 unless the patient is exempt or due to specific circumstances identified by a specialist require a non-formulary meter.

- At a time of financial pressures within the NHS, health care professionals have a responsibility to ensure resources are used wisely. Healthcare professionals should undertake regular reviews to identify and support those who find SMBG useful while identifying those who gain no benefit from testing.

1. Background

Ipswich and East Suffolk CCG spend in the region of £1 million annually on blood glucose testing strips. In light of current financial pressures within the NHS there is a need to look at current practice and ensure we are making the best use of resources.

With no national guidelines available on the frequency of self-testing there is currently national inconsistency in the advice being given to patients. This guideline aims to address local inconsistency and provide comprehensive recommendations on self-testing to ensure all our patients receive safe and appropriate advice, relevant to their personal circumstances.

2. Blood Glucose Meters

The choice of meters available has been increasing over the years and there is now significant variation in the cost of test strips for these meters. Prices now range from between £7 - £16 for 50 strips. It is important that both the CCG and Ipswich Hospital ensure that the most cost effective options are being used whilst still maintaining quality and providing patient choice.

There are differences between all the meters available, however accuracy, ease of patient use and acceptability are vital. To ensure patients still have choice, the CCG has identified four formulary meters (appendix 1). All patients with type 2 diabetes who need a blood glucose meter should be started on, or switched to, a formulary meter unless exempt. All formulary meters are available for practices to order free of charge from the manufacturer, details can be found in appendix 4.

The following patients are exempt from having their meter switched:

- Those using insulin
- Pregnant
- Already using a cost effective meter (test strips <£10 per box of 50 strips)

Please note the CCG will not support the prescribing of non-formulary strips for patients where there is no justifiable reason, e.g. a specialist request based on the specific circumstances of a patient, or an exemption (see above).

The formulary choice of pen needles are GlucoRX Finepoint needles (see appendix 2).
3. **Who to Test and Frequency of Testing**

There is good evidence to support SMBG in patients with type 1 diabetes and type 2 diabetes on insulin. There is no robust evidence to support regular SMBG in patients with type 2 diabetes not using insulin or a sulfonylurea. Self-testing should be integrated with a care package, accompanied by education and should enable the individual to interpret results and adjust treatment accordingly or inform their healthcare team. Structured assessment of self-monitoring skills, the quality and use made of the results obtained should be performed annually or more frequently according to need, and reinforced as appropriate.

There is a lack of national guidance on the frequency of testing therefore local consensus has been reached. It is important that patients are provided with adequate quantities of strips to enable them to self-test as clinically appropriate.

Appendix 3 below gives clinicians a guide on frequency of testing. It is important to note that in certain situations patients will need to increase the frequency of self-testing. Examples of these situations are listed at the bottom of appendix 3.

4. **Driver and Vehicle Licensing Authority (DVLA) Requirements**

The DVLA has specific requirements that diabetic patients need to be aware of and adhere to in order to maintain their license. Where specific self-testing requirements are stipulated by the DVLA these are included in appendix 3 below. Useful links to further information are included at the end of the document.

**References**

3. Self-monitoring of blood glucose in patients with Type 2 diabetes mellitus that are not using insulin (review). The Cochrane Collaboration 2005
5. At a glance guide to the current medical standards of fitness to drive. DVLA 2013.

**Useful links**

- Information on the DVLA requirements for diabetics (https://www.gov.uk/diabetes-driving)
- Diabetes UK: http://www.diabetes.org.uk
- NICE CG15. Type 1 diabetes, 2004 (http://www.nice.org.uk/cg15)
- International diabetes federation: www.idf.org
Appendix 1: Formulary Blood Glucose Meters for adult patients with type 2 diabetes ONLY

The following patients are exempt from having their meter switched:
- Those using insulin
- Pregnant
- Already using a meter listed below (as these are already cost effective choices)

<table>
<thead>
<tr>
<th>Meter</th>
<th>Testing strips</th>
<th>Cost/50 strips (Dmg Tariff 03/14)</th>
<th>Memory</th>
<th>In-use test strip expiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; choice formulary option</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accu-Chek Active</td>
<td>Active</td>
<td>£0.95</td>
<td>500 tests</td>
<td>18 months</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; choice formulary option</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MylifePura</td>
<td>MylifePura</td>
<td>£9.50</td>
<td>500 tests</td>
<td>3 months</td>
</tr>
<tr>
<td>MicrolifeDv+</td>
<td>MicrolifeDv+</td>
<td>£9.95</td>
<td>500 tests</td>
<td>6 months</td>
</tr>
<tr>
<td>TrueYou Mini</td>
<td>TrueYou Mini</td>
<td>£9.92</td>
<td>500 tests</td>
<td>4 months</td>
</tr>
</tbody>
</table>

Non-formulary but patients already on these do not need switching as they are all cost effective options.

- GlucoLab
- GlucoRx
- GlucoRx Nexus
- iCARE Advanced
- Supercheck 2
- GlucoMen GM
- Omnitest 3
- WaveSense JAZZ
- SD Codefree

All other meters are non-formulary
Appendix 2: Formulary choice pen needles are GlucoRX Finepoint

Key features:

- A universal fit – screw on fit for all leading insulin pen delivery devices including Eli Lilly, Novo Nordisk AS, Becton Dickinson, Owen Mumford and Sanofi.
- Complete range of sizes
- Triple bevel needles, allowing for a smooth and comfortable delivery system.
- Product uses Maxflow™ technology (extra thin walls allows maximum flow rate and reduced injection time).

For further information please see their website;


Latest advice recommends that no needles larger than 8mm needles should be used.

<table>
<thead>
<tr>
<th>Needle Length</th>
<th>Needle Gauge</th>
<th>Colour</th>
<th>Price for 100 (04/14 Drug Tariff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4mm</td>
<td>31g</td>
<td>Yellow</td>
<td>£5.95</td>
</tr>
<tr>
<td>5mm</td>
<td>31g</td>
<td>Green</td>
<td>£5.95</td>
</tr>
<tr>
<td>6mm</td>
<td>31g</td>
<td>Purple</td>
<td>£5.95</td>
</tr>
<tr>
<td>8mm</td>
<td>31g</td>
<td>Blue</td>
<td>£5.95</td>
</tr>
</tbody>
</table>
### Appendix 3: Frequency of testing for patients with Type 2 diabetes

<table>
<thead>
<tr>
<th>Diabetes Type</th>
<th>Treatment Group</th>
<th>Self-Blood Glucose Monitoring Regime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>All adults</td>
<td>Patients may need to test 2-4 times a day or more.</td>
</tr>
<tr>
<td>On insulin</td>
<td>All adults</td>
<td>Driving:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients may need to test 2-4 times a day or more.</td>
</tr>
<tr>
<td></td>
<td>Type 2</td>
<td>- Group 1 license (car/motorcycle): must test in the 2 hour window prior to the start of the first journey (ideally 30mins to 1 hour prior to starting the journey) and every 2 hours while driving. More frequent testing may be required if for any reason there is a greater risk of hypoglycaemia for example after physical activity or altered meal routine.</td>
</tr>
<tr>
<td></td>
<td>Type 2</td>
<td>- Group 2 license (buses/lorries): must self-test at least twice a day and at times relevant to driving (no more the 2 hours before the start of the first journey and every 2 hours while driving). More frequent testing may be required if for any reason there is a greater risk of hypoglycaemia for example after physical activity or altered meal routine. A meter with a memory must be used for patients with a group 2 license.</td>
</tr>
<tr>
<td></td>
<td>Patient on sulfonylureas or rapid acting insulin secretagogues (glinides)</td>
<td>Approximately 100 - 250 strips a month</td>
</tr>
<tr>
<td>Not on insulin</td>
<td>Controlled with metformin alone or with glitazone glipidins or GLP-1 analogues</td>
<td>Patients may need to self-test 2-3 times a week.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Driving:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients do not need to routinely self-test.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group 1 license: may be appropriate to monitor blood glucose regularly and at times relevant to driving to enable the detection of hypoglycaemia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group 2 license: must test twice a day and at times relevant to driving.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approximately 50 strips every 2-3 months</td>
</tr>
<tr>
<td>Type 2</td>
<td>Controlled with diet and exercise</td>
<td>Patients do not need to self-test.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If test strips are required they should <strong>not</strong> be put onto a repeat prescription.</td>
</tr>
<tr>
<td>Diabetes in pregnancy</td>
<td>Existing</td>
<td>Most patients with type 2 diabetes need to test before and after each meal, before bed and at symptoms of hypoglycaemia. Minimum of 7 tests a day is usually required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Driving:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- For already existing diabetic patients DVLA requirements will be the same as previously i.e. if using insulin the requirements above will continue.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approximately 250 - 350 strips a month (or more if required)</td>
</tr>
<tr>
<td>Gestational</td>
<td>Patients need to test 4 times a day or more.</td>
<td>Driving:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group 1 license: In gestational diabetes where insulin is needed there are no requirements from the DVLA for holders of a group 1 license.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group 2 license: In gestational diabetes where insulin is needed the requirements listed above under insulin apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approximately 150 – 250 strips a month (or more if required)</td>
</tr>
</tbody>
</table>

**Additional monitoring may be needed in these circumstances:**
- If steroids are prescribed
- When therapy is changed or being titrated
- Anaemia/haemoglobinopathies/undergoing venesection/receiving regular transfusions
- Intercurrent illness
- Lifestyle changes
- Frequent hypoglycaemia
## Appendix 4: How to order free formulary meters

<table>
<thead>
<tr>
<th>Meter</th>
<th>How to order free meters and any further information on these meters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accu-Chek Active (Roche)</td>
<td>Sharon Ferrer on 07912 970 997</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:sharon.ferrer@roche.com">sharon.ferrer@roche.com</a></td>
</tr>
<tr>
<td>MylifePura (Ypsomed)</td>
<td>Customer services: 0800 092 6787</td>
</tr>
<tr>
<td></td>
<td>Sales rep: 0758 423 7644</td>
</tr>
<tr>
<td></td>
<td>E mail: <a href="mailto:info@ypsomed.co.uk">info@ypsomed.co.uk</a></td>
</tr>
<tr>
<td></td>
<td>Order online: <a href="http://www.mylifepura.vb7.co.uk">www.mylifepura.vb7.co.uk</a></td>
</tr>
<tr>
<td>Microdot+ (Microdot)</td>
<td>Helpline at 01450 462620</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:help@microdot.biz">help@microdot.biz</a></td>
</tr>
<tr>
<td>TrueYou Mini (Nipro Diagnostics)</td>
<td>Tasha Chiew (Territory Sales Executive): 07769 882643</td>
</tr>
<tr>
<td></td>
<td>Dedicated Sales Support Representative: 01459 854826</td>
</tr>
</tbody>
</table>
Appendix 5: Pre-loading of Insulin Checklist

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has the patient shown that he/she understands their insulin regime?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Has the patient been provided with education and support regarding the drawing up of insulin but remains unable to do this accurately and independently?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Has the patient shown that he/she is able to administer insulin correctly and independently at the appropriate time?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Does the patient know how to dispose of the used syringes safely?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Has advice been sought from the Diabetes Specialist Nurse Team?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6</td>
<td>Have alternative methods of insulin administration been considered/tried without success?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>Can the patient monitor diabetes control independently or are arrangements in place for monitoring to be undertaken?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>Is the patient aware of the nursing team’s contact details and available support between nurse’s visits?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9</td>
<td>If on twice daily insulin dose, will the patient be able to distinguish between am and pm dose?</td>
<td>☐</td>
<td>☐</td>
<td>☐  or N/A</td>
</tr>
<tr>
<td>10</td>
<td>Does clinical judgment support the use of pre-loading of insulin for the patient?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11</td>
<td>Would pre-loading of insulin promote patient independence and meet patient need?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12</td>
<td>Will arrangements be put in place (and documented) for the regular re-assessment of the plan of care (3 monthly or sooner if patient’s circumstances change)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Assessment carried out by:........................................................................................................

Date:......................................................Reassessment Date Due:..............................

S/Internal/DiabetesPolicy/June14/V2.0
Appendix 6: Procedure for Preloading Insulin

Equipment:

- Plan of care
- Gloves
- Sharps Box
- Insulin Syringes 30, 50 or 100 unit syringes (depending which is most appropriate for the dose), needle length should be no more than 8 millimetre (mm).
- Relevant prescribed Insulin Vial
- Labelled Container(s) provided by patient for storage of pre filled syringes
- Mediswab

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Read and check plan of care and drug administration prescription sheet. Check for allergies/contra-indications.</td>
<td>To ensure correct doses drawn up</td>
</tr>
<tr>
<td>2 Check all previous pre loaded syringes have been administered and safely disposed of.</td>
<td>To ensure patient correctly utilising syringes</td>
</tr>
<tr>
<td>3 Explain procedure to patient, ensuring consent obtained</td>
<td>To confirm patient understands procedure and is willing to participate in self care</td>
</tr>
<tr>
<td>4 Prepare clean working surface and collect equipment required; check insulin for expiry date and against instructions of care plan.</td>
<td>To ensure all required equipment is at hand prior to commencing and prevent delay</td>
</tr>
<tr>
<td>5 Wash Hands.</td>
<td>To prevent contamination of insulin and syringes</td>
</tr>
<tr>
<td>6 Prepare equipment and shake insulin vial</td>
<td>To re-suspend insulin at least 10 times if using cloudy insulin</td>
</tr>
<tr>
<td>7 For each syringe follow 8-16</td>
<td></td>
</tr>
<tr>
<td>8 Swab insulin vial with a mediswab and allow to dry.</td>
<td>To prevent contamination of insulin</td>
</tr>
<tr>
<td>9 Remove needle cover and pull back plunger to measure an amount of air equivalent to the amount of insulin prescribed.</td>
<td>To prevent pressure differentials within the vial</td>
</tr>
<tr>
<td>10 Invert the insulin vial</td>
<td>To prevent air being drawn up in syringe</td>
</tr>
<tr>
<td>11 With insulin vial standing upright, insert the needle through the centre of the rubber cap and push down plunger</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Instructions</td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
</tr>
<tr>
<td>13</td>
<td>Pull back plunger until slightly more than correct dose is drawn up.</td>
</tr>
<tr>
<td>14</td>
<td>Expel any air bubbles back into vial.</td>
</tr>
<tr>
<td>15</td>
<td>Recheck correct prescribed dose has been drawn up and remove needle from vial</td>
</tr>
<tr>
<td>16</td>
<td>Carefully re-sheath needle There is no risk of contaminated needle stick injury as needle is sterile – in the event of a needle stick injury the syringe must be safely discarded</td>
</tr>
<tr>
<td>17</td>
<td>Store pre-filled syringes with needle end slightly elevated, within a labelled protective container in main body of the fridge (away from freezer section or the back of the fridge). For twice-daily injections, with different doses, a method of identification for the containers must be negotiated with the patient and recorded in the care plan, taking into account the patient’s preferences and capabilities.</td>
</tr>
<tr>
<td>18</td>
<td>Dispose of clinical waste and wash hands.</td>
</tr>
<tr>
<td>19</td>
<td>Complete nursing notes ensuring date, time, insulin type/dose and number of insulin syringes drawn up are recorded</td>
</tr>
<tr>
<td>20</td>
<td>Advise patient re:- Timing of their injections. Re-suspending all pre-loaded insulin at least 10 times prior to injection, if using cloudy insulin. Correct disposal of sharps.</td>
</tr>
<tr>
<td>21</td>
<td>Ensure arrangements are in place, based on the risk assessment, for patient support and monitoring. Ensure patient is aware of Community Nursing Team contact number</td>
</tr>
<tr>
<td>22</td>
<td>Ensure plan of care meets patient’s needs, and ability, by regular review and reassessment (3 monthly or sooner if patient’s circumstances change). Liaise with Diabetes Specialist Nurse as required.</td>
</tr>
</tbody>
</table>
Title of Policy/Guideline: Diabetes Policy

| Description: The purpose of this policy is to provide a standardisation of the provision of diabetic care to patients accessing the services of Suffolk Community Healthcare and provide information for staff |

**Part 1: Assessment of Impact**

**a) How will the policy meet the needs of different communities and groups?**

<table>
<thead>
<tr>
<th>Age</th>
<th>Religion or Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is not considered that the age will have any impact on the application of this policy</td>
<td>This organisation is aware of different religions and belief systems but this policy is considered to apply equally to all groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is anticipated that this policy will impact on all adult patients in equal measure</td>
<td>It is considered that this policy should apply equally to all patients whatever their sexual orientation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Socio-economic disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>This organisation is aware of different practices and different ethnic groups but this policy is considered to meet the needs all such groups</td>
<td>This policy should not impact to cause any socio-economic disadvantage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender (including transgender)</th>
<th>People living in rural areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>This policy is intended to meet the needs of all such groups regardless of gender.</td>
<td>This policy should be applied equally regardless of place of residence and should not impact on people living in rural areas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers. However, this policy should be applied equally to all SCH service-users.</td>
<td></td>
</tr>
</tbody>
</table>

**b) Positive Impact:** Reducing Inequalities: How is the Policy likely to have a significant positive impact on equality by reducing inequalities that already exist? Explain how it will meet our duty to:

| Promote equal opportunities: this policy will ensure that all staff are equally aware of the correct procedure so that adherence to the policy is standardised through all patient groups. | Promote good community relations – As with other policies and guidelines within the organisation, this one aims to ensure that SCH provides quality services to the community of Suffolk ensuring that the whole community has access to a safe healthcare environment. Fostering good relations with partner organisations will be enhance by the application of this policy. |

| Get rid of discrimination: staff working within this policy and within professional guidelines should avoid discrimination at any level. | Promote positive attitudes towards, encourage participation in and enable more favourable treatment of, disabled people: This policy applies to all patients equally irrespective of any disability and staff will make all reasonable adjustments to accommodate any disability. |

| Get rid of harassment: There are policies in place which prevent harassment both within the organisation and between the staff and patients (e.g. Whistle Blowing Policy, Disciplinary Policy, Adverse Incidents, Code of Conduct, Confidentiality Code of | Promote and protect human rights: SCH recognises that patients to whom this policy applies are potentially vulnerable but this policy is designed to ensure their human rights are not affected in any way |

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c) Negative Impact – Potential Discrimination: Could the Policy have a significant impact on equality in relation to each of the following groups or characteristics?

<table>
<thead>
<tr>
<th>Group</th>
<th>Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>It is anticipated that age will not have a negative impact on this policy.</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>Staff are expected to be aware of the possibility of differing views by religious groups but this should not impact on the application of the policy.</td>
</tr>
<tr>
<td>Disability</td>
<td>This policy should be applied equally regardless of any disability.</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>This policy will apply equally regardless of sexual orientation.</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>It is not considered that ethnicity will have a negative impact on this policy although the attitudes towards it may vary according to ethnic group.</td>
</tr>
<tr>
<td>Socio-economic groups</td>
<td>It is not anticipated that this policy will have a negative impact in relation to this.</td>
</tr>
<tr>
<td>Gender (including transgender)</td>
<td>This policy will be applied equally regardless of gender.</td>
</tr>
<tr>
<td>People living in rural areas</td>
<td>It is not anticipated that this will have a negative impact.</td>
</tr>
<tr>
<td>Other</td>
<td>This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers. However, this policy relates to all individuals who are service-users and as such will be applied equally and should not have a negative impact.</td>
</tr>
</tbody>
</table>

Part 2: Evidence

What is the evidence for your answers above?

<table>
<thead>
<tr>
<th>Group</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>It is the intention and aims of this policy that in consultation with statutory and non-statutory bodies that the policy reflects current best evidence and practice and will be applied equally regardless of the age of the recipient within the defined age-group.</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on religion or belief.</td>
</tr>
<tr>
<td>Disability</td>
<td>It is the intention and aim of this policy that it will reflect best evidence based practice and not discriminate based on a physical or mental disability</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on sexual orientation.</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on ethnicity.</td>
</tr>
<tr>
<td>Socio-economic groups</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on socio-economic status</td>
</tr>
<tr>
<td>Gender (including transgender)</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on gender.</td>
</tr>
<tr>
<td>People living in rural areas</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on ethnicity.</td>
</tr>
<tr>
<td>Other</td>
<td>This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers. However, this policy applies to individuals who are service-users and therefore will be applied equally and reviewed regularly to ensure it adheres to current best evidence based practice.</td>
</tr>
</tbody>
</table>

Part 3: Conclusion

B – A negative impact is unlikely. The guideline has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist.
Part 4: Next Steps

Action Plan: To review the operation of the policy as per SCH protocol to ensure there are no changes in its impact.

Part 5: For the Record

| Name and Title of people who carried out the EIA: Sarah Miller, Clinical Effectiveness Manager | Name of Director who signed EIA: Pamela Chappell |
| Date EIA completed: 2/7/14 | Signature of Director: Pamela Chappell |