Subcutaneous Insulin Audit Tool

From the Victorian Medicines Advisory Committee

Name of organisation	Audit completed by	Designation	Date

Recommendations	Circle Appropriate (yes/no/not applicable)	If yes, include evidence. If no, indicate planned actions to mitigate risk.	Examples of evidence
1. Is there promotion of insulin as a high risk medicine in your organisation?	Y / N / NA		▪ Audit of promotional material. ▪ Staff Survey
2. Does your organisation promote use of the word 'units' in full instead of the dangerous abbreviation 'u' in prescriptions for insulin?	Y / N / NA		▪ Prescribing or abbreviations policy ▪ Audit of prescriptions
3. Do policies and culture exist to support staff who question potentially unsafe or ambiguous prescriptions?	Y / N / NA		▪ Relevant prescribing, bullying and harassment policies ▪ Reported incidents
4. Do guidelines exist for monitoring and responding to blood glucose levels at the bedside? ▪ Blood glucose monitoring has been reviewed and is documented in a standard way ▪ Guidelines for responding to hypoglycaemia are available and current	Y / N / NA Y / N / NA Y / N / NA		▪ Approved blood glucose monitoring guidelines ▪ Audit of BGL recording ▪ Guidelines for management of hypoglycaemia
5. Do guidelines for insulin use exist in your organisation? Do these include information on ▪ Formulations & delivery devices ▪ Pen cartridges are for single patient use only ▪ Storage for ward stock ▪ Storage for individual patient use ▪ Labelling ▪ Delivery devices ▪ Common insulin doses ▪ Insulin dosing during fasting and enteral feeding ▪ Dose validation for unusual doses ▪ Standardised sliding scale if this practice is used or ▪ Algorithm for supplemental insulin doses	Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA		▪ Approved insulin guidelines

The QUALITY USE OF MEDICINES PROGRAM provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this TOOL for the development of appropriate local responses for the safe use of high risk medications.

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Recommendations	Circle Appropriate (yes/no/not applicable)	If yes, include evidence. If no, indicate planned actions to mitigate risk.	Examples of evidence
▪ An organisational approach to self administration of insulin	Y / N / NA		
6. Are educational materials used to increase awareness of the range and names of insulin products available?	Y / N / NA		▪ Available educational materials ▪ Audit of clinical areas
7. Has the range of insulins stored in clinical areas been reviewed? ▪ All insulin products stored on wards are routinely used ▪ Different insulins stored in separate, clearly identified containers ▪ Insulins are removed from their outer packaging when stored in clinical areas ▪ TALLman lettering is used to differentiate products ▪ Photographs of products have been used on containers storing insulin	Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA		▪ Audit of insulin storage area
8. Have 100 unit syringes been removed from wards? ▪ Syringes for doses greater than 50 units are supplied on a named patient basis following dose verification	Y / N / NA Y / N / NA		▪ Insulin policy or guidelines ▪ Audit of insulin syringes

Recommendations	Circle Appropriate (yes/no/not applicable)	If yes, include evidence. If no, indicate planned actions to mitigate risk.	Examples of evidence
9. Do patients receive appropriate education, and insulin delivery devices for home administration? ▪ Competence is assessed prior to discharge ▪ Patients are involved in insulin administration and monitoring	Y / N / NA Y / N / NA Y / N / NA		▪ Insulin administration competency tool ▪ Patient survey

Action Plan

Insert recommendation for implementation (Identified from audit tool)	Actions required to implement recommendation	Person responsible	Date for completion

Insert further lines if necessary

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Governance			
Recommendation	**Circle Appropriate (yes/no/not applicable)**	**If no, indicate what actions (if any) are planned**	**Person Responsible**
1. Does a formal process exist for approving guidelines, prescription order forms and flow sheets before use in your organisation?	Y / N / NA		
2. Are insulin guidelines and procedures part of your organisation's training programmes? ▪ Are they included in orientation and continuing education sessions for relevant clinical staff?	Y / N / NA Y / N / NA		
3. Has the competency of medical, nursing and pharmacy staff been assessed in their roles and responsibilities for insulin therapy?	Y / N / NA		
4. Is effective communication provided to all relevant staff regarding changes to insulin formulations stocked or guidelines and processes for documenting orders and blood results?	Y / N / NA		
5. Is there a reporting process designed to capture insulin errors and near misses in your organisation? ▪ Are reported events used to develop error prevention strategies?	Y / N / NA Y / N / NA		

Overall comments and actions recommended by clinical governance

Person responsible: **Signature:** **Date:**

Next audit review date: