

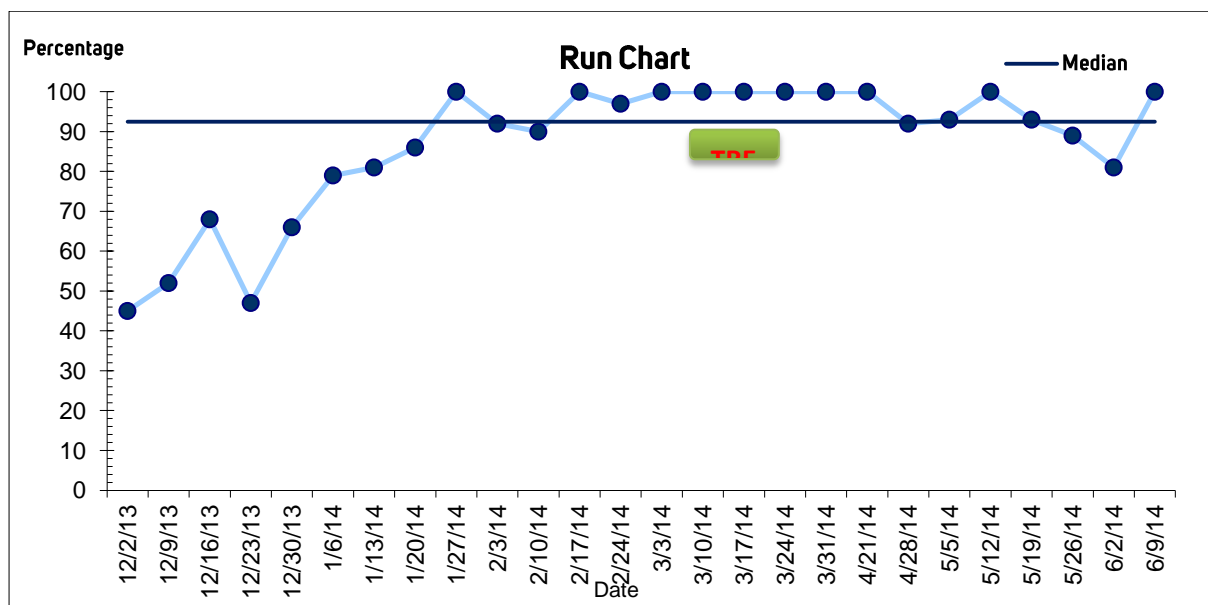
# Patient identification using fridge magnets



As a test of change pilot ward ideas (100 beds) in the Western General Hospital Edinburgh, were asked to identify those patients with pre-existing diagnosis of diabetes using a fridge magnet. This was placed on the ward whiteboard (at the nurses' station) when the patient was admitted to the ward. The percentage of patients correctly identified was recorded by a weekly ward visit, and comparison was made to the electronically generated list of in patients with diabetes (generated through a SCI-Diabetes and TRAK link).

The results of the work are shown in figure 1. It quickly became apparent from the data results (and ward feedback) that this was a very helpful and successful process in patient management, as diabetes care became part of the safety briefing consideration and ward rapid rundowns. Ward staff felt this small but significant change was really beneficial. Changes in clinical condition (eg fasting for surgery) were considered alongside diabetes care (particularly medication) at safety huddles, and consideration made to whether specialist diabetes team input was required.

It was also apparent on ward visits that the fridge magnets were also being used for patients who were at risk of developing hyperglycaemia during their admission, eg those on parenteral nutrition or corticosteroid use.



**Figure 1.** Runchart showing the percentage of patients with a preadmission diagnosis of diabetes, identified with a white board fridge magnet



### Insulin error identification in the Western General Hospital, Edinburgh

A consultant diabetologist visited the pilot ward areas once weekly and selected up to 5 charts of patients with insulin treated diabetes, at random. Using the scoring template (figure 2) the drug and insulin prescription charts were assessed for insulin errors.

Errors were collected for insulin type, dose, timing and administration. The results of insulin dosage are presented in figure 3.

Our pilot ward areas included 2 general medical wards, 2 infectious diseases wards and a colorectal surgery ward. Visiting the ward allowed identification of challenges with insulin management specific to that specialty area. It also facilitated timely feedback to both medical and nursing staff on errors and education on how they could be avoided in the future. This was well received by the wards as it was based on recent clinical scenarios, and was 'fresh in the mind'. In our experience the highest proportion of errors were seen with insulin dosage and administration.

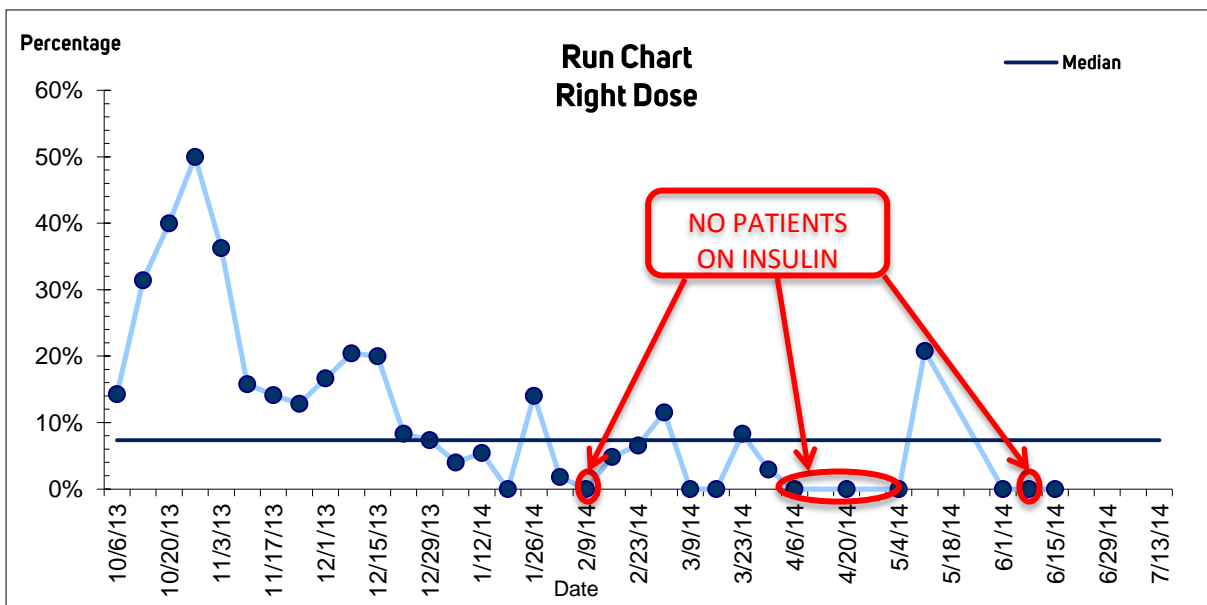


Figure 3. Run chart demonstrating the percentage of insulin prescriptions with a dose error (y-axis) over time (x-axis)

## **Figure 2.**

### **Insulin prescribing audit – data collection guidance**

Insulin errors will be expressed per dose prescribed

Aim to audit five patients per week

Each insulin dose should be prescribed and administered

1. The right insulin
2. The right dose
3. The right time
4. The right way

For there to be no errors, all four of these need to be correct; otherwise there is an error

#### **The right insulin**

The Kardex and administration chart should both state the correct insulin

#### **The right dose**

The dose of insulin on the administration chart should be clear

The dose of insulin on the administration chart should be correct

#### **The right time**

Any short acting or mixed insulin should be prescribed and given with the appropriate meal (within 30mins prior to the time of the meal)

#### **The right way**

The Kardex and administration chart should be signed by the prescriber

The Kardex and administration chart should be signed when the insulin is administered

The abbreviations U or IU should not be used

Insulin dose should be prescribed "as charted" on the Kardex

The completed audit forms should be returned to the project manager each week