National Diabetes Inpatient Audit 2017

England and Wales

Published 14 March 2018

98 per cent of hospital sites known to be eligible for NaDIA participated in the 2017 audit.

The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit that took place between 25 and 29 September 2017. Hospitals in England and Wales answered questions on diabetes management, patient harms and the patient experience, to measure the quality of diabetes care provided to people with diabetes and support quality improvement.

This is the seventh annual report, and includes data on the care of 16,010 inpatients, admitted at 208 hospital sites.

Key findings –

Improvements in care

Teams have reduced patient harms for people with diabetes …

Fewer inpatients –

… had a **medication error** (from 40 to 31 per cent, 2011-17).

… had **any episodes of hypoglycaemia** (from 26 to 18 per cent, 2011-17).

… needed **injectable rescue treatment** (from 2.1 to 1.3 per cent, 2011-17).

… **developed foot ulcers** during their hospital stay (from 1.6 to 1.0 per cent, 2012-17).

.. **used IV insulin infusions** (from 11 to 8 per cent, 2011-17).

More inpatients –

… were **seen by the diabetes team** where appropriate (from 58 to 72 per cent, 2011-17).

… and delivered more care.

Recommendations

To build on the hard work of hospital teams using results from earlier audits to drive improvement in patient care, and to continue to further improve inpatient care for people with diabetes, the audit recommends:

Continue to contribute to this unique and valuable insight into the inpatient care of people with diabetes.

Contribute to the upcoming continuous harms collection.

Highlight hospital-acquired DKA, HHS and diabetic foot lesions at Mortality and Morbidity meetings.

Record all hospital-acquired DKA and HHS as Serious Incidents and undertake Root Cause Analysis.

Consider how to improve safe transfer to SC insulin, with processes for prompt intervention in emergencies.

Learn where Electronic Prescribing / Patient Records work well and encourage system adoption.

Innovate and improve systems of blood glucose monitoring.

Work with colleagues in surgical areas to ensure safety levels that are at least comparable to medical units.

Ensure diabetes teams are adequately staffed to support other healthcare professionals and patients in the delivery of safe diabetes care.

Every provider should have 7 day DISN provision.

Explore and address issues with hospital food through patient surveys.

Benchmark their outcomes against national reductions in hypoglycaemia.

Scope for further improvements in care

Staffing provision

28 per cent of hospital sites report no diabetes inpatient specialist nurses (**DISNs**).

Just **9 per cent** of hospital sites provide **7 day DISN** provision.

Medication errors

Medication errors occurred **more** frequently in **surgical** wards (33 per cent). Where Electronic Prescribing is used medication errors are **less likely** (33 vs. 29 per cent).

Foot disease management

One fifth of hospital sites do not have an **MDFT** (20 per cent). **36 per cent** of inpatients with active foot disease do not have a **foot risk exam** within 24 hours.

Use of insulin infusions

6 per cent of infusions were inappropriate and 7 per cent lasted for 7+ days. For **one in six** patients the transfer from infusion was not appropriate (**16 per cent**).

Hyperglycaemic emergencies

1 in 25 of patients with Type 1 diabetes developed DKA in hospital as a result of under-treatment with insulin (4 per cent), and **1 in 800** of patients with Type 2 diabetes developed HHS (0.1 per cent).

Patient experience

Inpatient perception of the suitability of meal choice (54 per cent) and timing (62 per cent) have **worsened** from 63 per cent (meal choice) and 70 per cent (meal timing) in 2013.

The full annual report and local level reports can be found at: http://content.digital.nhs.uk/pubs/nadia2017