National Diabetes Inpatient Audit 2016
England and Wales
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The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit of the quality of diabetes care provided to people with diabetes during their hospital admission. The audit took place between 26 and 30 September 2016, at hospitals in England and Wales, and answers questions on diabetes management, patient harms and the patient experience.

This is the sixth annual report, and includes data on the care of 15,774 inpatients, admitted at 209 hospital sites.

Key findings – Improvements in care

With an increasing workload ...
Teams have delivered more care ...
Improved patient care ...
Reduced patient harm ...

- The proportion of people with diabetes in hospital increased from 15 to 17 per cent (2011 to 2016).
- 69 per cent of people were seen by the Diabetes Team where appropriate (58 per cent in 2011).
- Intravenous insulin infusion use was reduced to 8 per cent (11 per cent in 2011).
- The incidence of all hypoglycaemia episodes was reduced to 20 per cent (26 per cent in 2011).
- Patient development of foot ulcers during their hospital stay was reduced to 1.3 per cent in England (2.2 per cent in 2010).

Recommendations

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

- Continue to contribute to this unique and valuable insight into the inpatient care of people with diabetes.
- Continue to educate and support junior doctors and nursing staff, while also developing and testing new systems to reduce prescribing and medication management errors.
- Learn where Electronic Prescribing / Patient Records work well, and encourage system adoption.
- Encourage Diabetes Teams to involve patients in their care planning.
- Take measures to prevent nocturnal hypoglycaemia, including the introduction of bed time snacks.
- Ensure that Diabetes Teams are adequately staffed to support other healthcare professionals and patients in the delivery of safe diabetes care.
- Ward referral systems should ensure all appropriate patients are promptly referred and promptly seen by the Diabetes Team.
- Record all hospital-acquired DKA and HHS as Serious Incidents and undertake Root Cause Analysis.
- Continue to focus on surveillance of inappropriate use and duration of use of insulin infusions.
- Initiatives to improve foot examination on admissions and NICE guidance should be implemented to improve processes.

Scope for further improvements in care

<table>
<thead>
<tr>
<th>Medication errors</th>
<th>Insulin errors</th>
<th>Medication management errors</th>
<th>Diabetic Ketoacidosis</th>
<th>Staffing levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>The drug charts of almost two in five inpatients (38 per cent) showed a medication error. Medication errors occurred more frequently in surgical wards (41 per cent).</td>
<td>Almost half of patients treated with insulin had a medication error related to their insulin (46 per cent).</td>
<td>Almost one-third of patients treated with insulin had a medication management error recorded on their drug chart. (Type 1 – 29 per cent, Type 2 – 33 per cent).</td>
<td>1 in 25 of patients with Type 1 diabetes developed DKA in hospital (4 per cent) after under-treatment with insulin.</td>
<td>More than a quarter of hospital sites have no diabetes inpatient nurses (DISN) (28 per cent). Almost one quarter of hospital sites do not have a Multi-disciplinary Foot Care Team (MDFT) (24 per cent).</td>
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Patient experience

Inpatient perception of the suitability of both meal choice (54 per cent) and timing (63 per cent) has declined. (from 64 per cent (meal choice) and 70 per cent (meal timing) in 2011).