Overview

Customer feedback has been collected via a comments box on the bottom of the Hospital Characteristics form for the last two years.

Comments from the 2015 and 2016 audits will be presented in this document with a view of using these comments to guide the future of the audit.
Overview

We will be looking at:

• Bedside Audit feedback
• Patient Experience feedback
• Hospital Characteristics feedback
• General audit feedback and comments
<table>
<thead>
<tr>
<th>Question 1</th>
<th>Question 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty of Ward and Primary Consultant providing care?</td>
<td>How long has the patient had diabetes?</td>
</tr>
</tbody>
</table>

“Should have a **critical care** option.”

“**Critical care** should be added.”

“Remove **duration** of diabetes as this is never documented on admission.”

“Still could be clearer - especially clear guidance on whether questions about **duration** of DM, complications etc are referring to if they are recorded in the current admission notes or if patients should be asked at time of audit.”
Question 19

For patients on subcutaneous insulin on how many of these 7 days was the frequency of monitoring appropriate?

This was **misleading** as it is asking about s/c insulin but then gives the option for oral medication, there should have been a N/A box to tick.

Question 19 **incorrect** information as only asks for subcut insulin but then guidelines for other types of diabetes controlled patients. We have decided to use guidelines for all patients on all medications and not only for subcut insulin users.

**Confusing** Q 19 requires only those on S/C insulin, but chart below refers to those on oral agents.

Question 19 asked about appropriate monitoring relating to s/c insulin however it then listed the oral meds and other injectables. We presumed monitoring according to the guidelines set out in the table **not just for s/c insulin**.

Why were we only asked to say if the frequency of monitoring was appropriate for patients on subcutaneous insulin? Surely the monitoring should be judged if appropriate on **all patients**?

This was **confusing**, as we assume those on oral therapies need to have appropriate monitoring also according to recommendations. Was the wording an **error**?
<table>
<thead>
<tr>
<th>Question 20</th>
<th>Question 27</th>
<th>Question 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of glucose readings between 3 - 3.9 mmol/L</td>
<td>If there has been hypoglycaemia (any glucose below 4mmol/l in a 4 hour period) during the last 7 days please indicate the number of episodes in each of the following time periods:</td>
<td>What level of control is appropriate for this patient? Good control (i.e. between 4 and 11 mmol/L)</td>
</tr>
</tbody>
</table>

If answer is "0" still required to complete all questions following on when **unnecessary**- could this be addressed for next year to make simpler.

Hypo analysis in question 27 is far **too in depth**.

If 'Symptomatic control' is ticked then the auditor should be referred to Q30.

If a zero answer we should have then have been directed to Q28.

Too **time consuming** to complete.
**Question 29**

Number of ‘good diabetes days’ in the last 7 days, defined as days in which the frequency of tests is appropriate (Q19) and there is no more than one reading more than 11 mmol/L and none less than 4 mmol/L.

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Frail Patients</th>
<th>Good Days Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not fall in line with the symptomatic control as a <strong>palliative care</strong> patient does not need to have good diabetes days and think the 2 questions need to be looked at and separated out.</td>
<td>This is open to a lot of interpretation about appropriate target range for more <strong>frail patients</strong></td>
<td>Number of good days in the last 7 days is <strong>not applicable</strong> if the patient has been in for less than this &amp; needs to be reworded.</td>
</tr>
<tr>
<td>Need a &quot;diabetes good days&quot; box for symptom control patients (i.e palliative). Noted some patients having hypos but not on any treatment as <strong>palliative care</strong> only. Need a separate box for recording hypos for these patients.</td>
<td>Didn't allow option for <strong>frail patient</strong> where a higher range of glucose was desirable to avoid hypo.</td>
<td>If a patient had only been in hospital for 4 days and had good control over 4 days - that could still be seen to be only 4 out of 7 days; when in fact it was 4 out of 4 days.</td>
</tr>
<tr>
<td>29 specially refers back to Q19 as the place to look for appropriate days for frequency of tests - however Q19 now only asks for SC insulin whereas Q29 refers to all therapies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Question 29 (Continued)

Number of ‘good diabetes days’ in the last 7 days, defined as days in which the frequency of tests is appropriate (Q19) and there is no more than one reading more than 11 mmol/L and none less than 4 mmol/L.

If Q28 had been answered as "symptomatic control", then it would not be expected to have "good days" during this timeframe. Perhaps in future, if Q28 is answered as symptomatic control, then proceed to Q30. Furthermore, if a patient has been on VRIII, those days when he/she is on this should be excluded from the calculation of "good diabetes days" but with a different denominator. Q32 could be improved upon - if answer is No, then proceed to Q35.

The question about good diabetes days is very confusing and is not clear whether or not you can take into account individualised targets. Although there is a question related to good control or symptomatic control, it is still seems like it is either or which isn't always applicable.

Limits good control days for those whose targets are 4-11 but precludes those on symptomatic control - for whom a day free of hypo or extreme hyperglycaemia is actually a day of 'good control'.
Section C – Whole Section
Prescribing and Drug Management Errors Over the Last 7 Days

The wording on the prescribing and drug management errors section is still a little confusing/unclear.

Some of the questions still a little confusing – e.g. drug error ones, feel they could be worded more clearly. The question that asks did the patient receive insulin should add s/c, as confusing with use of insulin infusion.

The wording for prescription and drug management errors needs to be changed to no rather than not at all as this is confusing.

Copyright © 2017 Health and Social Care Information Centre.
**Bedside Audit – Section C Feedback**

<table>
<thead>
<tr>
<th>Question 32</th>
<th>Questions 33,34,35,36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the patient receive insulin at any time during the last 7 days?</td>
<td>Please see BA Form</td>
</tr>
<tr>
<td>&quot;If you say no to question 32 it should tell you to <strong>move to number 35.</strong>&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;Q32 could be improved upon - if answer is No, then <strong>proceed to Q35.</strong>&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;Number 32 asks if the patient received insulin and if the answer was no then the form could have directed us to <strong>go to question 35.</strong>&quot;</td>
<td></td>
</tr>
</tbody>
</table>

"Should be **simplified** to either "Yes", "No" or "N/A". As even a single error would constitute "At least once", this is essentially a "Yes". Confusion can occur with the "Not at all" and "N/A" - there is the possibility that people filling in the form may tick "N/A" as the error did not happen as opposed to how it should be used (i.e. N/A as the patient was not prescribed insulin and/or an OHA)."

"Still don't like phraseology of **double negative** questions (33-36). creates some confusion for auditors." (2016)

"Qs 33-36. 'not at all' category was **clumsily worded.**"

"Q33/ 34/ 35 of audit **double negatives** please look at wording."

"Options for Q 34 + Q35 are **confusing.**"
“We had suggested correcting the term 'Oral Hypo Glycaemic Agents' to 'Oral Anti diabetic agents' for the past few years. The term Oral Hypo Glycaemic agents is no longer used as it has a negative connotations indicating it 'causes hypos'. The term has not been used for years and it would be great if the national audit form could correct this.”

“We thought that the answers we were able to give were not always appropriate and didn’t give a true picture because there isn’t always a black or white answer. For example we are asked if insulin or an OHA is not signed as given-sometimes there may be a valid reason that insulin or an OHA is not given but we cannot reflect this on the form. We thought therefore that there should be space for free text or the option to choose that there was a valid reason for an action taken.”

“This should be clarified for subsequent years. In the example Insulin not written up presumably at least once should be ticked if insulin was not prescribed and not at all should be ticked if the insulin was always prescribed and n/a should be ticked if the patient was not on insulin. However this required some thinking about and some discussion to ensure uniformed interpretation. Time we did not really have on the day!! Please could this be much clearer.”

“Need to separate out given and prescribed at incorrect time from the Insulin and OHA question as they are two different issues.”
“There are 10 questions about intravenous insulin infusion but we are only told if the infusion was appropriate or not. We are told numbers of patients admitted with a diabetic emergency but not what kind of emergency.”
Question 48
Should the patient have been referred to the diabetes team? (for example, see ‘Think Glucose’ referral criteria below).

Noticed some patients did not require a diabetes specialist referral for their diabetes control but did need foot MDT for active foot disease. Could the specialist foot MDT referral be separate from diabetes specialist team (confusing to call) as we hold the referrals as separate input from different teams.

Should this also include recurrent hyperglycaemia & End of Life Care?

ThinkGlucose Criteria should include recurrent hypoglycaemia, Recurrent hyperglycaemia, New to Insulin and End of Life. You could have a established T2 patient with recurrent hyperglycaemia who now requires insulin. Why would you be unsure when the criteria are below question? An ‘N/A’ OR ‘Other’ box would be better here and if ‘Other’ is ticked, ask why referred ie: recurrent hyperglycaemia, New to Insulin or end of life advice. Not all patients with diabetes need to be referred to the inpatient diabetes team so there should be a box to document this.

N/A would an appropriate option for questions for Q48 if Q47 is Yes.
Question 53
Was the patient seen by a member of the foot MDT within 24 hours?

Should have **N/A box**. If foot is low risk or even increased risk then feet should be reviewed daily you do not necessarily have to have input from the MDT and do we tick YES if the patient has been seen by the IPDSN?

Requires a **N/A option** as if patient does not have any foot problems why would review from an inpatient foot MDT member be necessary??

Q53 & 54 It would be helpful if there was a **NA option** for these 2 questions.

Add N/A - No Foot MDT box.
“Foot questionnaire misleading as if did not have foot problem would not require multidisciplinary foot review.”

“Foot examinations do not occur on every patient with diabetes unless they come in with a foot related problem or have an on going ulcer. There is literally no time to do this within a busy take.”

“Foot risk assessment criteria-full information is only on guidelines for completing hospital characteristics, not in the guidelines provided in box with questionnaires-criteria may be missed by ward auditors.”

“IS IT POSSIBLE IN FUTURE TO HAVE ‘NOT RELEVANT OPTION ON FOOTCARE SECTION IE PATIENTS WITHOUT LEGS!!!!”

The foot care section should not exclude all non-diabetic specific foot risk/pressure sore checks as this shows if the patient has had their feet checked. It is not always appropriate to do a touch test or similar when the patient is admitted as they are often acutely unwell and their current medical condition may mask any neuropathy present or give false readings. If the Waterlow or similar has been done this shows that the feet have been checked for overt diabetes related problems such as active ulcers. All patients should have care taken with pressure areas whilst in hospital.
In section G, there is no question asking if patient has had surgery and then ask if yes, answer the following questions.

It would be useful if there was a question asking if the patient had surgery during their stay, if No, end of questionnaire.

There was no option to say that patient did not come in for surgery or had no surgery in this admission.

Section G we should have been able to tick a box to omit this section if NO surgery.
National Diabetes Inpatient Audit 2016
Patient Experience Survey

Customer Feedback
2015 & 2016
The patient satisfaction audit is too long and complicated. Would be better to have 5 simple questions related to: meals, self admin of insulin, self blood glucose monitoring, staff knowledge and a general satisfaction question with a section for free text.

Keeping the questions to less than 10 probably makes more sense, and in that regard, 14 questions is an improvement.

The patient experience questionnaire does need to be shortened and simplified.

Questions where too wordy, too long and patient unable to see the tick boxes.
“Not all patients are well enough to complete, some decline/refuse and some are confused, dementia, Alzheimer's CVA. Should there be a box to tick to say why survey not completed?”

“A significant number of patients had cognitive impairment and unable to collect patient experience questionnaire. It would be worthwhile including a question on dementia diagnosis for future audit.”

“There was no box to tick on the patient form if they were unable to complete the form e.g. Dementia, ITU etc.”

“Should it be documented where the patient has dementia?”

“No option to document whether the patient refused/was unable to take part in completing the questionnaire.”

“A greater majority of patients were too ill to complete the patient audit.”

“Patient questionnaire was not appropriate for the majority of inpatients.”

“I also feel it is not always appropriate to be asking a lot of the patients these questions as they are often elderly and clinically unwell.”
“The patient questionnaire appeared geared to patients on insulin. Patients diet controlled or tablet controlled felt they didn’t understand questions.”

Patient questionnaire is difficult for patients to answer if they are patients with diabetes that is diet or tablet controlled. They cannot answer the questions, e.g. number 3, as their GP has arranged the care. Number 4 is a difficult question, even we didn’t understand it.

Patient experience survey is focusing more on insulin management.

Patient questionnaire was not appropriate for the majority of inpatients.
The expectation of staff staying with patients to fill in the patient questionnaire is completely unrealistic in the time frame and amount of patients to be audited.

Patient survey font size need to be bigger as most of the patients are elderly and had difficulty with this.

Patients felt they were all very similar/asking the same thing.

Some questions were closed, hence the patients did not have opportunity to give an explanation to their answer.

Some doubling up of questions on the patient questionnaire.

The patients experience questionnaire needs to be simplified. Patients staff found the questions difficult to understand when asking patients (some patients needed help to complete).
Customer Feedback
2015 & 2016
Section A of the Characteristics for can be easily misinterpreted. It should ask:

- Total number of occupied beds in the hospital (Our trust 1191)
- Of the occupied beds in the hospital, how many have been patients for 24 hours or more (995)
- Of the occupied beds how many have been identified as having diabetes (272)
- Of the occupied beds with diabetes, how many have been in hospital for 24 hours or more (230)
- How many patients have you managed to audit with diabetes who have been inpatient for over 24 hours (220)

Regarding this form Questions A, B and C should include a D, **total bed capacity** for hospital whether occupied or not so we get an idea of % of bed occupancy i.e.: on day of audit KCH only had 80% bed occupancy but from that 80% we had 20% patients with diabetes.
<table>
<thead>
<tr>
<th>Question 1</th>
<th>Question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each healthcare professional team please provide the total weekly hours spent on inpatient and outpatient care</td>
<td>Does your hospital have a policy for self-management of diabetes?</td>
</tr>
</tbody>
</table>

“The questions about staff hours are very poor - what do you class as "general admin/meetings?”

“Have found it very difficult indeed to populate the hours worked by the diabetes team as we are all pluripotential.”

“I have found it very difficult to complete questions 1, 2 and the foot section as it is complex to explain how things work here and so my manager helped and we have given the best answers we can.”

“Use of word policy misleading - we have guideline.”

“We have a standard operating procedure document, not a policy document as this is realistically impractical to implement as a policy.”

“Questions 6 and 7 need a partial box. There is a self administration policy but it is not diabetes specific so if people are assessed for self administration we would then assess them for diabetes management (if they are referred).”

“Difficult to answer as would say partial management. Can self administer insulin but no policy for self management of hypos and no written policy for Self management of glucose levels but we do some of this on an individual basis.”
Hospital Characteristics Feedback

Question 8
What percentage of wards in your hospital follow the self-administration of insulin policy?

% of wards using self-administration difficult to answer as not audited and all staff have access to this but unclear how many actually use.

It may be 10-50% of the wards but we are not sure.

In this form, there is some confusion about self management and self administration. Q6 asks about 'Self management' and then Q8 refers to it as 'self administration'. Two very different aspects of diabetes care for inpatients, when it comes to self administration policy and self management policy).

Unable to quantify as wards are inconsistent in what they do.

This is not audited and we would not know the answer.
**Question 9**
Does your hospital have a checklist to determine whether the patient is capable of self-managing their diabetes?

“We answered yes, but checklist is for medicine self-management rather than specifically diabetes.”

**Question 17**
Does your hospital have suitable Wi-Fi access available in all applicable wards which could be used to support the completion of NaDIA electronically in the future?

“I understand question 16 about wifi access and have ticked to say that that we do have access, however we would not have enough access to computers to complete the volume of forms required so would be unlikely to complete the audit if it was all computer based.”

“We ran a very successful local (Portsmouth and Southampton) electronic audit in 2014 (using the NaDIA question set as a base-line and the ele-survey software run either on tablets or laptops). This could easily be rolled out to all those with the interest to do similarly and allows for a MUCH quicker and simpler local review of the data collected - please contact me should you want details.”

“In the hospital Characteristic from, the answer to question 16 is 'I don't know', but there is no option for that. We have Wifi but I don’t know if it would be suitable for possible electronic version of NaDia Audit.”
**Question 19**
Have any of the following been introduced in your hospital? Please tick all which apply.

- In this form, question 18 is giving many options for the headings. Is it necessary?

- Some of the JBDS guidelines are being used by the DSN team but are not formally put into policies so I have had to write that no we not using them. Can there be a box for used by specialist only?

- First JBDS guideline should read: DKA and Hyperglycaemia, not Hypo
Question 20
Does your hospital hold Diabetes Mortality and Morbidity meetings which aim to identify the root causes of inpatient diabetes management issues such as severe inpatient hypoglycaemia, new DKA/HHS during the inpatient stay, new foot ulceration during the inpatient stay or unexpected inpatient death?

We hold monthly diabetes governance meetings where morbidity, mortality, case reviews can take place. We discuss audit and future audit projects at the governance meetings.

There is no dedicated diabetes M&M meeting but the Trust mortality matrix goes to the board for review and would include diabetes if applicable.

We have business meeting and clinical governance meetings which will aim to pick up the issues relating to q20.

We have Mortality and morbidity meetings which are for general medicine and not diabetes specific.

No specific M & M meeting for diabetes related deaths, but general medicine Mortality and morbidity meetings include all unexpected deaths including deaths in patients with diabetes.

We do not have active Mortality and Morbidity meetings however we do practice regular CST meetings whose agenda can sometimes include Mortality and Morbidity discussion.

The majority of issues relating to POCT, inpatient hypoglycaemia, hyperglycemic emergencies or death are all discussed in the monthly "Think Glucose" meeting.

We have weekly morbidity and mortality meetings where deaths are reviewed but not specific to diabetes.
General Audit Feedback
2015/2016

National Diabetes
Inpatient Audit 2015
“The way in which the forms were **stapled** together led to **omission** of some sections of the form by some auditors.”

“Please can you consider changing the way the forms are **laid out/folded** as it is easy to **miss sections.”**

“Could the forms not be **clipped together**?”

“This questionnaire needs to be a booklet or **stapled** in the middle not the side so that it flows chronologically as being stabled together as it is **causes confusion** over which question is next.”

“It is a **time consuming** process and taken us all day to do a small hospital with less than 300 beds.”

“It is a big **logistical effort** to carry the audit out”

“The audit is still too **cumbersome** and irritating to see more questions being added with questionable value.”

“This audit form is **too long** and too **time-consuming** to complete. Also we should reduce the NADIA to 2 yearly - yearly is now not needed.”

“Some of the questions where **open to interpretation** from the auditor.”

“Some of the audit questions **lacked clarity** and were **open to misinterpretation.”

“Too many questions **open to interpretation.”

“Some questions are **ambiguous.**”

“We have mental wards with diabetes we see them regularly **not on the audit.”
General Audit Feedback 2015 & 2016

“I believe this is a fantastic audit and we look forward to the results.”

“The annual NaDIA audit is a very well organised and well run programme. It is fairly easy to complete the audit proforma and questionnaire. The data generated from the process is helpful to inform local change.”

“The audit has been running for several years now and it clearly demonstrates the need for better care, more resources, more staff and more education.”

“The audit is very good.”

“The National diabetes inpatient audit has helped us understand the scale of the problem, and highlighted specific areas that needed improvement. We hope that this year’s audit will also help us in our endeavour to provide safe and high quality diabetes care to our patients.”

Copyright © 2017 Health and Social Care Information Centre.