Leeds Children's Hospital

In-patient care for children with type 1 diabetes across hospitals in the Yorkshire and Humber region in the north of England

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Introduction

The first inpatient standards for management of children with diabetes were set and audited in the South of England in 2011[1]. Deficiencies highlighted were: lack of dietetic advice on wards, lack of education sessions for ED and ward staff and lack of contact with diabetes team especially for overnight admissions

Aims

Identification of variations in in-patient care provided to children with type 1 diabetes across the Yorkshire and Humber region, with a view to standardisation of care.

Methods

The audit was conducted against in-

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Results

Fifty six per cent of the units, consisting of 2 tertiary and 7 secondary care units, responded. Paediatric wards and EDs in all units had protocols for management of new diagnosis of diabetes, diabetic ketoacidosis (DKA), hypoglycaemia and surgery.

Centre	DKA protocol	Surgery protocol	New diagnosis protocol	Hypoglycaemia protocol	Protocols available on wards	Protocols available in ED	HDU/PICU protocols
DGH	Y	Y	Y	Y	Y	Y	Y
Tertiary centre	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	NA
DGH	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	NA
DGH	Y	Y	Y	Y	Y	Y	Y
Tertiary centre	Y	Y	Y	Y-not specific for diabetes	Y	sometimes	HDU-Y, PICU-n

All units had paediatric nurses in areas where children were

Results

Centre	Parents allowed to manage diabetes on ward	Link nurse on each ward	DSN have inpatient role	Dietetic support available on the ward	Children's nurse in all areas	Admissions to same ward whenever possible	24 hour access to diabetes specialist
DGH	Y	Y	Y	Y	Y	Y	N
Tertiary centre	Y	Y	Y	Y	Y	Y	Y
DGH	Y	N	Y	Y	Y	Y	N
DGH	Y	Y	Y	Y	Y	Y	7.00-20.00, OOH-escalation policy
DGH	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	N
DGH	Y	Y	Y	Y	Y	Y	Y
DGH	Y	Y	Y	Y	Y	Y	9.00-21.00, escalation policy OOH
Tertiary centre	Y	Y	Y	Y	Y	Y	Y

All units had regular education sessions for ward staff, although 22% expressed concerns regarding poor attendance and only 22% of units had education sessions for ED staff. Only 2 units had insulin prescription charts and only tertiary centres routinely audited insulin prescription and administration errors.

Centre	Insulin prescription charts	Audit of insulin prescription errors	Education-ED staff	Liaison with ED?	Regular education sessions for ward staff?
DGH	N	N	N	Y	Y
Tertiary centre	N	Y	Y	Y	Y
DGH	N	N	Y	Y	Y
DGH	N	N	N	Y	Y
DGH	N	N	N	Y	Y
DGH	N	N	Y	Y	Y
DGH	N	N	N	Y	Y
DGH	Y	N	Y	Y	Y
Tertiary centre	Y	Y	Y	Y	Y

Conclusions

There is a lack of 24 hour on-