Medicines in Hospital driver diagram

Aim

Reduce inpatient episodes of diabetic ketoacidosis (DKA), hyperosmolar hyperglycaemic state (HHS) and severe hypoglycaemia, as a result of diabetes medicine management, by March 2028.

Outcome measures:

- **Rate of DKA**
- **Rate of HHS**
- **Rate of severe hypoglycaemia**

The outcome measures have been selected as indicators of diabetes-related harm that may be influenced by the safe use and management of diabetes medicines, particularly insulin, during an inpatient stay. The operational definitions are adapted from those in the NHS England National Diabetes Inpatient Safety Audit (NDISA); please refer to the SPSP Medicines in Hospital measurement plan for full details.

Primary drivers	Secondary drivers
A people-led approach to the planning and delivery of safe care	People and professionals are equal partners in shared decision making
	Care and support is shaped to meet the needs of people with diabetes
	People are supported to safely self-manage diabetes with insulin where appropriate
	People, families, carers and staff are systematically listened to, and concerns are acted upon
Effective and inclusive communication	Individuals and teams feel safe and able to speak up
	Multi-disciplinary team (MDT) communication and collaboration
	Safe communication at transitions of care
	Communication between MDT and people, families, carers
Leadership at all levels to support a culture of safety	Leadership is compassionate and inclusive
	Staff feel supported and valued to learn and develop
	Learning system for diabetes medicines-related events to support continuous improvement
	Education and support for staff competency in managing diabetes medicines
Safe clinical and care processes for safe diabetes medicines management	Identification of people with diabetes and those of higher risk of inpatient diabetes complications
	Reliable monitoring and timely response to out-of-range blood glucose levels
	Safe prescribing, administration and monitoring of diabetes medicines
	Timely access to equipment and resources
	Safe staffing levels and resources

A people-led approach to the planning and delivery of safe care

People and professionals are equal partners in shared decision making	Use ‘What Matters To You’ approach to document diabetes specific information in all processes to plan, deliver and review care	Provide accessible and quality information to support informed decision-making about diabetes medicines management	Embed a standardised process to support shared decision making about diabetes management throughout admission	Process to promote a culture that supports people as experts in their own care
Care and support is shaped to meet the needs of people with diabetes	Process at admission to discuss and document usual meal patterns, insulin administration and dosing	Locally agreed process for access to appropriate snacks within 15 minutes when needed, including overnight, for prevention of and recovery from hypoglycaemia	Implement a checklist to support clinical judgement in identifying people who may need specialist diabetes input	Standardised approach to managing diabetes technology in hospital as per Joint British Diabetes Societies (JBDS) guidelines
People are supported to safely self-manage diabetes with insulin where appropriate	Structured self management assessment as per Joint British Diabetes Societies (JBDS) guidelines	Locally agreed self-administration agreement form	Provide access to tools and resources to support safe self-management of diabetes for example, ‘My Diabetes My Way’ and ‘High-Risk Medication Card’	Test and implement a local policy supporting self-management of diabetes with insulin
People, families, carers, and staff are systematically listened to, and concerns are acted upon	People, family and carer views of illness and concerns are consistently sought and recorded	Provide a clear route for people, families and staff to request a diabetes review, with defined response times	People, family and carer perspectives are routinely included in handovers and transitions of care	

Effective and inclusive communication

Individuals and teams feel safe and able to speak up	In daily ward huddles, identify people with diabetes who may be at increased risk of deterioration or critical illness	Local induction processes for all staff include diabetes escalation pathways and access to specialist diabetes support	Processes to promote a culture which supports staff and students to raise concerns
Multi-disciplinary team (MDT) communication and collaboration	Structured MDT discussions routinely include diabetes medicines-related safety concerns for example, during existing MDT huddles	Clear and accessible escalation guidance to enable timely access to specialist diabetes expertise	Shared understanding of MDT roles and responsibilities in supporting safe diabetes care
Safe communication at transitions of care	Locally standardised diabetes medicines reconciliation and management plan on admission and updated throughout hospital stay, with input from diabetes team as necessary	Safe processes to communicate and transfer diabetes medicines plan between care settings for example, use of diabetes passports for elective surgical pathways	Safe processes for sharing information about diabetes medicines plan at time of discharge to relevant health care professionals and teams for example, GP, district nurses, care homes
Communication between MDT and people, families, carers	Process to discuss persons' normal diabetes daily routine, including medications and normal range of blood glucose levels, to inform plan of care	Provide opportunity for sharing information with people, families and carers when dosing of insulin has changed including the reason for the change	Local standardised process for sharing information about diabetes medicines with people, families and carers at time of discharge

Leadership at all levels to support a culture of safety

Leadership is compassionate and inclusive	Regular leadership safety walk rounds include diabetes medicines safety conversations with frontline teams	Local process to regularly review diabetes medicines safety events (including near misses) as part of medicines governance, with defined actions and feedback shared with frontline teams	Multi-disciplinary team (MDT) leadership at team, locality, and strategic levels demonstrating compassionate leadership behaviours	
Staff feel supported and valued to learn and develop	Teams regularly share and recognise improvements in diabetes medicines safety	Provide access to senior support and discussion for staff delivering diabetes care for example, regular 1:1 or supervision conversations	Teams routinely collect, review and act on staff feedback and contribute to local governance processes for example, through huddles, surveys, or debriefs	Opportunity for staff to lead and test diabetes medicine safety improvement projects
Learning system for diabetes medicines-related events to support continuous improvement	Provide opportunity for clinical staff to actively participate in local and / or national forums for safe diabetes medicines management	Local risk and improvement teams share, review and act on local diabetes medicines-related events to inform improvement priorities	Develop a reliable data collection process for inpatient episodes of DKA, HHS and severe hypoglycaemia	
Education and support for staff competency in managing diabetes medicines	Appropriate staff complete core diabetes medicines safety learning modules as part of online training for example, ‘Diabetes, Think, Check, Act tool’	Teams use regular scenario-based simulation or case review to support diabetes medicines management	Provide tailored diabetes education and training for clinical areas, informed and supported by the diabetes specialist team	Co-design and regularly update a Frequently Asked Questions resource, based on common questions, events and learning from diabetes medicines management

Safe clinical and care processes for safe diabetes medicines management

Identification of people with diabetes and those of higher risk of inpatient diabetes complications	Identify people with diabetes on admission and throughout their hospital stay for example, ward systems, handovers	Process to identify people at higher risk for example, people who are pregnant, older people living with frailty or people starting prescribed steroids	Use of clinical system prompts to highlight diabetes medications and any special instructions		
Reliable monitoring and timely response for out-of-range blood glucose levels	Individualised blood glucose range documented as per local policy	Individualised plan for blood glucose monitoring frequency for example, before meals, overnight if required	Local escalation pathway with defined thresholds for hyperglycaemia and ketones	Local protocol based on JBDS guidance for treatment of hypoglycaemia, DKA and HHS with defined timeframes for management and repeat blood glucose	Process to identify and act on missed or delayed blood glucose monitoring
Safe prescribing, administration and monitoring of diabetes medicines	Medicines reconciliation completed on admission as per local policy	Standardised prescribing of diabetes medicines aligned to national guidance	Standardised insulin administration safety check including blood glucose and meal timing for example, 6 Rs of insulin therapy	Process for SGLT2 inhibitors to be reviewed on admission and withheld when clinically indicated	Monitoring requirements clearly defined and linked to diabetes medicines, for example, blood glucose before insulin, ketones with SGLT2 use or acute illness
Timely access to equipment and resources	Local process for reliable availability of blood glucose monitoring equipment	Local process for reliable availability of ketone monitoring equipment	Local process on how to access, use and restock hypo boxes	Embed access to local diabetes guidance for example, on the 'Right Decision Service' within ward systems or desktops	Provision of a safe space to store insulin and related equipment for people competent with self-management
Safe staffing levels and resources	Processes to assess, mitigate and escalate staffing risks that may impact the provision of safe and high-quality care	Local escalation processes enable timely involvement of specialist diabetes team	Process to use staffing level tools alongside the professional judgement tool, as part of the common staffing method to inform workforce planning		