Royal College of Physicians

Diabetes Care Accreditation Programme (DCAP)

Accreditation standards

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GIG CYMRU NHS WALES
Grŵp Gweithredu Diabetes
Diabetes Implementation Group

NHS
East of England Diabetes Network

Contents

Introduction

This document has been designed to assist inpatient diabetes services participating in the Diabetes Care Accreditation Programme (DCAP). It defines the standards and evidence required.

Getting started checklist

- [ ] **1** Log into the website and set up logins for all relevant staff (max 10 people)
- [ ] **2** Set up an accreditation programme working group or add as an item on the team meeting agenda
- [ ] **3** Go through standards framework
- [ ] **4** Complete self-assessment and begin an improvement plan
- [ ] **5** Share out tasks with the team
- [ ] **6** Involve people with diabetes in your accreditation journey
- [ ] **7** Keep in touch with the DCAP team and ask for any guidance
- [ ] **8** Start uploading evidence onto the website
- [ ] **9** Arrange your half day remote assessment

Leadership and operational delivery

Standard 1.1: The service has a comprehensive service description and operational plan.

Documented service description, which should include:

- organisational chart for the service
- scope of the service provided, including number of inpatient beds in the organisation (for all specialties) and approach to working across wards
- roles and responsibilities for staff members involved in the service, including any sub-specialty roles and the foot care team
- summary of staffing cover, including at weekends and overnight – meeting minimum national recommendations for diabetes inpatient specialist nurse (DISN) staffing numbers
- referral pathways from other clinical services / external organisations
- links with key users of the service, for example link nurses on each ward
- description of support provided from a managerial, administrative, and technical (IT) perspective
- plans for service transformation and innovation
- Operational plan – reviewed annually
- Minutes of service management meetings where operational plan is discussed.

Standard 1.2: The service meets nationally advised staffing levels.

- Meets nationally advised staffing levels

  JBDS_19_Optimal_Staffing_Calculator_19042023.xls (live.com)

Standard 1.3: The service has procedures for admissions/referrals.

Documented admission procedure that should include:

- how and where emergency admissions are managed (for those with diabetes as the primary condition for their admission)
- process for managing newly suspected diagnosis of diabetes
- process for identifying people with diabetes on admission
- how referrals to diabetes specialist team are made and what input is provided when under other teams
- provision of foot assessment process within 24 hours of admission
- documentation of response times to assess inpatients
- process of ensuring that people with diabetes-related emergencies are reviewed by the diabetes team within 24 hours of admission.

Standard 1.4: The service has procedures for admissions/referrals 7 days a week.

- Process of ensuring that people with diabetes-related emergencies are reviewed by the diabetes team at the weekend

Standard 1.5: The service works to avoid admissions for people with diabetes.

- Documentation of admission avoidance procedures – this could include admission avoidance clinics; discharge clinics or phone calls and telephone advice services
- Examples include recurrent diabetic ketoacidosis (DKA), hypo and type 1 diabetes without admitting

Standard 1.6: The service benchmarks admissions avoidance.

- Evidence of review of admission avoidance rate compared with other organisations (if interventions are provided by the organisation, eg not a community provider)

Standard 1.7: The service has a discharge process.

- Document outlining discharge procedure, including how those with glucose monitoring and injection equipment are managed
- Evidence of people with diabetes and care providers being provided with discharge correspondence
- Evidence of people with diabetes being provided with information about ongoing management
- Document of services available post discharge
- Examples of post discharge care plans
- Evidence of discharge management plans to meet the needs of specific patients and complex needs, for example, frailty, learning disabilities, mental capacity and people with recurrent admission

Standard 1.8: The service has a comprehensive discharge process.

- Examples of post-care discharge plans for patients admitted under other teams

Standard 1.9: IT systems are used to support safe and effective care.

- Evidence of electronic access to clinical guidelines and informing staff how to access (eg induction guide/teaching presentations/ bulletins)

Standard 1.10: Advanced IT systems are used to support safe and effective care.

Evidence of:

- electronic pathways to refer patients to the diabetes inpatient team
- effective electronic prescribing systems to detect, record and avoid hypoglycaemic agent prescribing errors
- web linked glucose and ketone meters, which alert diabetes inpatient team to out-of-range glucose values
- evidence of staff training packages for EPMA and glucometer use, monitoring glucometrics across the organisation and at ward level and electronic safe discharge checklist usage.

Clinical effectiveness

Standard 2.1: The service supports nutritional needs.

- Evidence of dietetic involvement with catering contracts, specific to the needs of people with diabetes
- Process for supporting people with diabetes and nutritional needs with snacks and drinks
- Documentation of rapid access to carbohydrates at any time to prevent or treat hypoglycaemia

Standard 2.2: There are enhanced services supporting nutritional needs.

- Documented mealtime planning with information on adjusting meal times if necessary for medication, and procedures for preventing missed meals or supplying them after the fact
- Evidence of hypoglycaemia rescue packages available as PRN prescriptions
- Examples of hospital menus providing nutritional and carbohydrate specific content

Standard 2.3: The service supports the complex needs of people with renal disease.

Documented procedure that should include:

- process of admission including foot inspection
- process for regular medication review and the assessment of secondary risk of hypoglycaemia
- description of working arrangements with the renal team.

Standard 2.4: The service can evidence work with the renal team, to support the complex needs of people with renal disease.

- Minutes of meetings between renal and diabetes specialties

Standard 2.5: The service has foot care support available for people with diabetes.

- Care pathway outlining the support available in relation to footcare and access to a multidisciplinary team (MDT) with input from podiatry, diabetes specialists, vascular surgery and orthopaedics
- Pathway for the initial assessment and continuing care of individuals at risk of developing diabetic foot disease

Standard 2.6: The service measures impact of foot care support available for people with diabetes.

- How patient foot care outcomes are reviewed
- How data collected are used to improve foot care
- Evidence of completing foot assessment on admission

Standard 2.7: The service has a perioperative diabetes pathway.

- Evidence of alignment with Centre for Perioperative Care (CPOC) guidelines and for services in England, Getting it Right First Time (GIRFT) recommendations
- Guideline on appropriate medication adjustment prior to surgery or elective procedures
- Note: perioperative management can cross between community to hospital. This standard is focused on the hospital aspect.

Standard 2.8: The service documents outcomes of the perioperative diabetes pathway.

- Documentation outlining the members of the team and time allocated to providing elective care support
- Minutes of meetings of perioperative diabetes team demonstrating monitoring the perioperative pathway and review of complaints and audit data
- Note: perioperative management can cross between community to hospital. This standard is focused on the hospital aspect

Clinical effectiveness – clinical processes

Standard 3.1: The service has processes for the use of variable rate intravenous insulin infusions (VRIII).

Documented process for VRIII, which should include:

- reason for commencement
- frequency of capillary glucose testing
- glucose control during VRIII use.

Standard 3.2: The service measures the quality of variable rate intravenous insulin infusions (VRIII) use.

- How data relating to VRIII use are being reviewed is collected and acted upon

Standard 3.3: The service has procedures for managing diabetic ketoacidosis (DKA) and hyperosmolar hyperglycaemic syndrome (HHS).

Documented procedure that should include:

- the guideline for the management of the DKA and HHS being used across the hospital site(s)
- extent of involvement of diabetes team in management of these patients
- how patients are managed overnight and at weekends
- how 16–18-year-olds are managed.

Standard 3.4: The service reviews the outcomes of diabetic ketoacidosis (DKA) and hyperosmolar hyperglycaemic syndrome (HHS) management.

- How patient outcomes are reviewed
- How data collected are used to improve care

Standard 3.5: The service has procedures for managing glucocorticoid therapy.

Documented procedure that should include:

- management of glucose control during glucocorticoid use.

Standard 3.6: The service reviews the outcomes when managing glucocorticoid therapy.

- How patient outcomes are reviewed
- How data collected are used to improve care

Standard 3.7: The service has procedures for the management of enteral feeding.

Documented procedure that should include:

- guideline for managing enteral feeding for people with diabetes (with specific reference to VRIII)
- process for referral to the diabetes team once a feeding regimen has been established
- process for recording glucose measurements in all people treated.

Standard 3.8: The service has enhanced processes for the management of enteral feeding.

- Pharmacy support and medication review
- How dieticians are upskilled to learn about specialist diabetes care
- How data collected are used to improve care
- How patient outcomes are reviewed

Standard 3.9: The service has procedures for avoiding and managing hypoglycaemia.

- Guideline for avoidance of hypoglycaemia
- Guideline for management of hypoglycaemia

Standard 3.10: The service reviews outcomes of the management of hypoglycaemia.

- Care pathway outlining follow-up plans for severe hypoglycaemia
- How patient outcomes are reviewed
- How data collected are used to improve care

Standard 3.11: There are procedures for safe and accurate prescribing.

- Procedure outlining how insulin (including intravenous insulin and insulin pumps) is prescribed, provision for variable doses of fast-acting insulin, provision for large doses of insulin check
- PRN hypo treatment prescription protocol
- Document outlining how medication errors are recorded and strategies to reduce errors

Standard 3.12: The service works to improve the quality of insulin prescribing.

- How patient outcomes are reviewed
- How data collected are used to improve care

Person-centred care

Standard 4.1: There are person-centred care plans based on the needs of the individual.

- Policy for end-of-life care
- Evidence that people with diabetes/family are involved in decision making in their care

Standard 4.2: There are enhanced person-centred care plans for specific groups.

- Evidence outlining how frailty and functional status of people with diabetes are assessed, including access to dietetic provision
- Evidence of how health inequality is addressed

Standard 4.3: Individuals are supported with self-management and education.

- Self-management policy with sign off from pharmacy, organisation management and diabetes team, which should include:
  - assessment criteria for self-management
  - process to review and adapt self-management responsibilities in relation to changing clinical condition
  - supporting suitable individuals with using technology such as pumps, flash glucose monitoring etc
  - process for the safe disposal of sharps and storage of insulin on the ward
  - escalation procedure for inpatients self-managing with significant glycemic excursions
  - information for inpatients on self-management procedures and carbohydrate contents of meals
  - documentation for insulin dosing so staff are aware how much insulin/medication taken
  - self-management consent document
  - assessment of competency document.
- Evidence that a self-management checklist and consent forms are available and used at ward level.

Note: self-management refers to the definition outlined by the Joint British Diabetes Societies (JBDS).

Standard 4.4: There are enhanced processes to support self-management.

- Examples of written/online material to support patient education and self-management (eg information leaflets and feedback on the self-management process)

Note: self-management refers to the definition outlined by JBDS

Standard 4.5: There are regular opportunities for people with diabetes / carers to provide feedback.

Patient/carer survey results in the past 12 months specific to diabetes care. Examples of what may be included:

- views on the quality of care provided
- involvement of the diabetes team when individuals are admitted under other teams or transferred from another site
- shared decision making and involvement in care
- availability of patient information and education, and signposting to local/national support groups.

Standard 4.6: The service acts on feedback from people with diabetes / carers.

- Evidence of discussion of survey results with team members involved in diabetes care
- Action plan to continue to improve the service, with objectives, named leads and timescales

Standard 4.7: The service records and investigates concerns and complaints.

- Evidence of review of patient complaints relating to aspect of diabetes care in the hospital (regardless of which specialty the individual was admitted under)
- Evidence of sharing learning from themes arising from complaints with diabetes team and others if applicable

Safety and risk

Standard 5.1: The service has a local risk register.

- An up-to-date risk register that identifies risk, mitigation plans and risk reduction activities. Note: typically the following areas are high risk and may warrant an entry in the local risk register:
  - use of insulin
  - perioperative pathway
  - use of variable rate intravenous insulin infusion
  - use of enteral/parenteral feeds
  - use of steroids
  - management of diabetes ketoacidosis (DKA)
  - management of hyperosmolar hyperglycaemic state (HHS)
  - management of severe hypoglycaemia.

Standard 5.2: There are effective meetings for discussing and learning from incidents and near misses.

- Minutes from diabetes and insulin safety meetings (at least quarterly, with representation from a member of the hospital safety committee and executive board, or equivalent, and IT/analytics)
- Minutes from governance meetings where harm data are presented
- Minutes from mortality and morbidity meetings where diabetes inpatient teams have hosted
- Evidence of participation in local and national harms audits where applicable (such as NaDIA Harms in England)
- Examples of how learning from incidents has helped to improve care
- Provision of input from people with diabetes where appropriate.

Standard 5.3: The service acts on and shares learning from incidents and near misses.

- Minutes from diabetes and insulin safety meetings (at least quarterly, with representation from a member of the hospital safety committee and executive board, or equivalent, and IT/analytics)
- Examples of how learning from incidents has helped to improve care

Improvement

Standard 6.1: The clinical service participates in local and national audit programmes.

- Evidence of involvement in national data collection
- Audit of guideline compliance with action plans for improvement if necessary
- Audit plan (eg 5-year plan) outlining timetable for carrying out audits, which may include (but are not limited to) the following areas:
  - hypoglycaemia
  - diabetic ketoacidosis
  - management of perioperative diabetes
  - self-management of diabetes
  - enteral feeding and diabetes
  - hyperosmolar hyperglycaemic state
  - admission avoidance
  - readmission rate
  - foot ulceration
  - management of hyperglycaemia during glucocorticoid use
  - use of variable rate intravenous insulin infusion
  - discharge checklist
  - management of frailty and diabetes
  - medication prescribing and administration at mealtimes
  - mortality.
- Examples of at least two completed audits within the past 12 months

Standard 6.2: The service uses audit to improve locally and benchmark nationally.

- Evidence of data and analytic support to review audit data against comparable organisations with regards to length of stay, readmission rates and mortality

Standard 6.3: The service develops a quality improvement (QI) plan based on clinical metrics.

- Minutes of service management / clinical governance meetings where performance is discussed
- Evidence of encouraging staff involvement in improvement

Standard 6.4: The service has a quality improvement plan and can demonstrate how this has been used to improve care.

- Improvement plan that documents performance against key clinical metrics and outlines ways to continue to enhance the service.

The metrics may include:

- frequency of hypoglycaemia
- hospital acquired foot ulceration
- amputation rates
- DKA/hypoglycaemia rates
- foot check within 24 hours of admission and inspection daily thereafter
- insulin errors
- admission avoidance
- readmission
- mortality
- frequent attenders
- examples of improvement resources developed.

Workforce

Standard 7.1: A review of the workforce is undertaken a minimum of once a year and a strategy is developed in anticipation of future demands on the service.

- Documented workforce review and strategy to meet demand
- Evidence of DISNs meeting competencies as outlined by TREND/Diabetes UK.

Standard 7.2: The service has a comprehensive multidisciplinary team workforce.

- Evidence that the inpatient team includes a diabetes consultant, specialist nurses/ practitioners to run a 7-day service and meets national standards

  JBDS_19_Optimal_Staffing_Calculator_19042023.xls (live.com)
- Access to a diabetes specialist podiatrist, pharmacist and dietitian, and psychological support

Standard 7.3: There are training and development opportunities for staff members.

- Evidence that all staff involved in the care of people with diabetes receive basic training on diabetes management, including the safe use of insulin and hypoglycaemia prevention and management

Standard 7.4: There are leadership training opportunities for the diabetes team.

- Evidence of appropriate members of the team being supported with leadership training
- Evidence of support for staff to undertake CPD in quality improvement training and other developmental opportunities for learning

Standard 7.5: The service aims to reduce harm by sharing knowledge and upskilling teams responsible for looking after people with diabetes.

- Examples of ad hoc teaching for organisation staff (eg grand round presentations, ward-based teaching on topics of interest)
- Examples of basic diabetes care in junior doctors' induction packs/training.
- Evidence of training for colleagues across the organisation in:
  - who to refer to inpatient diabetes team
  - safe use of insulin
  - managing insulin infusions
  - managing and preventing hypoglycaemia
  - managing DKAs and HHS.

Further information

For further information on DCAP visit **www.dcap.org.uk**

If you have any queries about the work of DCAP, please email us at **askDCAP@rcp.ac.uk**

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