Background

Management of patients with diabetes mellitus who undergo regular haemodialysis (HD) is complex and co-ordination of care across services and specialities is key. In April 2016 the Joint British Diabetes Society (JBDS) released their first national guidelines to support healthcare professionals and improve care for these vulnerable patients, who are at greatly increased risk of cardiovascular disease as well as diabetic complications such as hypoglycaemia and diabetic foot disease.

Aim

To assess diabetes care of haemodialysis patients against the JBDS Guidelines, which were amalgamated with criteria for satisfactory diabetic control derived from the National Diabetes Inpatient Audit (NADIA).

Method

Diabetic patients receiving regular HD at the Freeman Hospital were identified and data on the organisation of care, glycaemic control (from the seven preceding HD sessions), diabetes therapies, foot care and complications were obtained from electronic records, medical and nursing notes and structured patient interviews.

Results

Data was collected from 37 patients (28 male, 9 female) with a mean age of 68.7 years. In terms of organisation of care, 14% had an annual review of their diabetes by both their GP and Specialist Diabetes Clinic, 54% by one of these services and 32% by neither.With regards to glycaemic control, 100% of patients received an annual HbA1c and 100% had monitoring of blood glucose (BM) performed at least once during each HD session. According to a definition of satisfactory diabetic control during each HD session as no more than one blood glucose value greater than 12.0 mmol/L and none below 4.0 mmol/L, 38% of patients had seven satisfactory diabetes sessions while 22% had no satisfactory sessions. Of the patients with no satisfactory sessions, all of whom were treated with basal insulin, none had all of the recommended number of four blood glucose checks performed during HD. Another 24% of patients had a hypoglycaemic event on dialysis and for five of these patients (13%) treatment was not clearly documented. In terms of diabetic therapy 27% reported taking sulfonylureas however this form of treatment is not recommended as it increases the risk of hypoglycaemia. Foot surveillance was also suboptimal with 19% of patients reporting no foot check in the past year either by podiatry or a specialist foot clinic.

Conclusion

This pilot audit of diabetes care in HD patients has highlighted areas where improved care may be required as well as greater communication between specialities to ensure patients receive the best possible care.