

# Can diabetes care be “bundled”?



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**D**o you know what a care bundle is? I didn't. The accompanying article describes care bundles as “groups of high-impact, evidence-based healthcare interventions that are well-known in secondary but not primary care”. So that will be why I've not heard of it – I am firmly entrenched in primary care. The author outlines findings from a care bundle pilot in primary care for managing chronic kidney disease (CKD).

Surely all of us in primary care recognise the importance of detection and management of kidney disease in diabetes? There is NICE guidance to follow, appropriate investigations to perform and QOF points to be gained. But, as this article points out, systematic care is patchy. Blood pressure, even if measured accurately (and that is a different story), is not always optimally treated and adherence with medication remains poor. Information prescriptions ([www.informationprescription.info](http://www.informationprescription.info)) have not been universally adopted and we need to consider how we engage people with diabetes in understanding and managing their condition. Could care bundles be one answer?

In this pilot study, involving people with and without diabetes, four practical activities had to be performed at the same clinic attendance: recording people with CKD stages 3–5 on a register, measuring proteinuria, prescribing blood pressure medication where necessary, and assessing cardiovascular risk.

## Register

Simply entering CKD stages 3–5 in the register of people with type 2 diabetes has no effect on their health – action needs to be taken. The Renal Association is a good source of additional information on CKD ([www.renal.org](http://www.renal.org)).

Recording the estimated glomerular filtration rate (eGFR) often raises the question: what do we do about the metformin dose? NICE (2008) advises that the dose should be reviewed if eGFR is <45 mL/min/1.73 m<sup>2</sup> and to avoid if eGFR is <30 mL/min/1.73 m<sup>2</sup>. Oral blood glucose-lowering agent options for people with impaired

renal function are limited if metformin has to be discontinued, providing little choice for the individual or the healthcare professional.

## Measuring proteinuria

Measuring microalbuminuria and proteinuria should be routine and standardised, but it appears not to be so. NICE (2008) states that an abnormal albumin:creatinine ratio (ACR) in people with diabetes is >2.5 mg/mmol in men and >3.5 mg/mmol in women. CKD has the potential to damage people's lives; perhaps if we were consistent in our method of detecting, preventing and treating it – as piloted in this study – much suffering could be averted.

## Blood pressure medication

Hypertension can be controlled, although it may involve the person with diabetes taking multiple daily medications. In QOF 2008/2009 the indicator  $\leq 145/85$  mmHg was achieved by 79.9% out of a total available 99.7% (NHS Information Centre, 2010). This makes it the second most difficult diabetes indicator to reach after HbA<sub>1c</sub>, despite it attracting the highest number of points (18) and despite setting a blood pressure target that was higher than that advocated for most people with type 2 diabetes. We can do better.

## Assessing cardiovascular risk

Nowadays, we recognise that almost everyone with type 2 diabetes has a raised cardiovascular risk. We can use the UK Prospective Diabetes Study risk engine to prove it ([www.dtu.ox.ac.uk/riskengine](http://www.dtu.ox.ac.uk/riskengine)). Lifestyle interventions – not advice, which may be little heeded – involving the person with diabetes, must form part of our care plan but we must take a critical look at the care we provide and make sure it is “bundled” appropriately. ■

NHS Information Centre (2010) *QOF Data for April 2008 – March 2009, England*. NHS Information Centre, London. Available at: <http://bit.ly/9ia73V> (accessed 28.09.10)

NICE (2008) *Chronic Kidney Disease: Early Identification and Management of Chronic Kidney Disease in Adults in Primary and Secondary Care*. NICE, London

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