Providing a specialist diabetes service in residential care settings

Beryl Murphy

Over the course of a year from October 2004 until October 2005 a residential care assessment programme was performed for people with diabetes who currently reside in residential or nursing homes (residential care settings) in the Tameside and Glossop area. The programme was jointly implemented by a team of DSNs and podiatrists, and set out to determine the need for specialist diabetes interventions in residential care settings. This article will focus on the nursing aspect of the programme.

Article points

1. DSNs in Tameside and Glossop have started running annual reviews for people with diabetes in residential care homes.
2. Education for care home staff on caring for people with diabetes is run alongside the patient review.
3. As a result of this service development, funding has been provided for a DSN to work alongside residential care staff.

Key words

- Residential care
- Audit
- Staff education
- Diabetes management

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The Tameside and Glossop Primary Care Diabetes Team consists of a team of DSNs, specialist podiatrists, specialist dietitians, and Asian diabetes support workers. Traditionally, the nursing caseloads have been created as a result of referrals received from healthcare professionals within and outside of the trust, including those from private sector residential care settings. Referral reasons vary considerably, but the main requests are for assessment of poor control, insulin initiation and education of patients and carers.

All referred patients are assessed by an experienced DSN, and care programmes are based on that assessment. A typical care programme would include education of the patient, carer, or both, intervention by the DSN and referral to other appropriate agencies.

In most cases, the DSN assessment identifies the clinical symptoms of sub-optimal diabetes control which were evident at the time of referral. People with diabetes often present with symptomatic hyperglycaemia, frequent unexplained hypoglycaemia and poor understanding of their own condition. There are many reasons for delays in referral, although often there is not one specific factor.

The development of clinical symptoms prior to referral suggests a lack of ability by the referrer in managing the specific needs of the individual. It may also be indicative of poor recognition of the need to refer early for interventions. However, if the person with diabetes is not attending regular appointments and full information is not being given to the healthcare professional responsible, then the need for referral is not necessarily apparent.

People with diabetes living in residential care are often not in a position to recognise and request interventions for themselves. For these people, it is the carers who are best placed to identify problems and initiate referral because of their close contact with the patient. In these instances it is imperative that the care staff concerned have a basic level of knowledge in order to support people with

Page points

1. Appointments for the annual review were made with care home managers.
2. A total of 231 patients were assessed as part of the audit.
3. Letters were sent to patients' GPs informing them of the results of the annual review.

diabetes and to enable them to recognise the need for intervention and seek assistance from the most appropriate source.

Since 2003, the team has run a series of training programmes for staff in residential settings based on a model set by the Northern and Yorkshire Regional Working Group (2002). While evaluation of this programme has shown that the audience found it to be a very informative and useful course, we believe that it has largely been poorly attended and appears to be ineffective. High turnover of staff in the homes is a reported problem, as is lack of authority when feeding information back to the home. This reduces the effectiveness of the training as those attending are often not in a position to be able to enforce changes.

The problems related to providing ongoing training and the evident delays in referral were major contributing factors in determining that a full assessment of needs was required in order to be able to provide an appropriate service in these settings.

Following consultation with the team, it was decided that a nursing and podiatry assessment would be performed on all people in residential care settings within the locality who were known to have diabetes. While the podiatrists assessed the required level of input from their section of the service, the nursing team focused on four main areas: glycaemic control, nutritional needs, medication and blood pressure management.

The audit

Using a predetermined audit tool all residents were assessed in order to identify their:

- current peripheral blood glucose status
- blood pressure
- current medication
- dietary intake.

Appointments for the audit were arranged with the manager of the individual establishment and were agreed to be undertaken within the care setting, with the team having full access to residents' care notes, treatment sheets and any available test results. A regular member of the care staff was in attendance at each assessment.

The information gained during this process determined which outcome was required. The options available were:

- no further action required
- referral for more detailed assessment by DSN
- referral to another member of the healthcare team
- immediate action required with supporting follow up.

Results

In 51 residential care settings 231 individuals were assessed, all of whom were previously diagnosed with diabetes. Any resident who was not accessible at the time of the audit has not been included in the overall figures.

All of the 231 patients were assessed but there was refusal by some patients to have foot checks, blood pressure or blood glucose tests performed.

- Sixty-seven (29 %) of the residents were treated by diet alone
- One hundred and eighteen (51 %) were taking oral hypoglycaemic agents
- Forty-six (20 %) were on insulin therapy.

In all cases, letters were sent to the individual's GP reporting the findings for that specific patient and informing of any interventions that had been performed or were required in the future.

A total of:

- Eighty-five patients (37 %) required changes to their current diabetes treatments
- Ninety-nine (43 %) were found to have a blood pressure reading above the guideline recommendation of 140/80 mm/Hg
- Fifty-one (22 %) required further detailed assessment by a DSN with subsequent follow up
- Twenty-five (11 %) required district nursing services, which were not currently being provided.

Impact on the resident

At the time of assessment 222 participants (96%) were found to have a need for further assessment or intervention.

For many of these people, that intervention focused around further monitoring of blood pressure levels or minor adjustments to established treatment regimens and would not necessitate the intervention of a specialist diabetes team. For others there were more in-depth assessments and interventions required.

It became evident when analysing the data that there was no consistency in the numbers of people requiring interventions from each home. In some residences none of the participants required any further follow up, while in others all required follow up for a number of reasons. This clearly demonstrates that there were significant variations in the level and standard of intervention offered to these residents with diabetes. The cause of these variations may be attributed to:

- lack of information available to the staff employed within the care settings
- variation in operating systems employed by the clients' GP practices
- existing variations in service provision from GP practices
- reactive service delivery by the specialist diabetes team.

Next steps

Following the collation of the audit data it was determined that further action was required in order to ensure that residents received the level of care that they required, in line with the National Service Framework for diabetes standards 3 and 4 (Department of Health [DOH], 2001a). As the audit demonstrated, in 22% of cases further assessment or intervention was required by a DSN. The main concern for the diabetes team was that many of these residents had never been referred to the service despite a need for intervention, and this demonstrated a need for active assessment in order to ensure that timely interventions could be delivered.

As the past provision of education for care staff had received a mixed response it was felt that the content of the course was appropriate and well evaluated, but that the delivery required some amendment. One of the main concerns was poor attendance at training sessions. It was acknowledged by all involved that low staffing levels within the care setting and reluctance by managers to release staff for extended periods of time caused the poor attendance rate. It was further determined that the venue for the training had a significant impact on the attendance level.

When training was provided on site for the staff a minimum of 10 staff attended each session. However, when training was provided at a central location and offered to staff from all residential care settings, the attendance level was between 10 and 30% of that expected.

It was felt that both the delivery of education and the care and treatment of residents were something that could potentially be achieved in one programme. In line with this opinion a plan has been developed by the team in order to incorporate both education and care into an ongoing programme.

The future

As a result of the audit performed, the team have now secured funding for a dedicated DSN to take responsibility for actively assessing all residents on an annual basis. This role will also incorporate the provision of support and education for staff within those settings. A dedicated residential care DSN has now been recruited and will work 10½ hours per week (0.3 whole time equivalents) specifically alongside residential care staff.

The aim of this post is to develop a programme whereby each residence will be targeted on an annual basis. All residents diagnosed with diabetes will be assessed within the care home and the relevant treatments, amendments and referrals would be initiated as would apply with any DSN assessment. Staff from that home will then be invited to attend an in-house afternoon training session where a condensed version of the original training programme will be delivered to staff from the home. This training will be focused on those individuals currently residing within the premises, taking

Page points

1. Significant differences were found in the diabetes related care that residents received in residential homes.
2. Attendance levels at staff training sessions were good when conducted on-site, and poor when conducted off-site.

Page points

1. The introduction of a combined assessment and tailored education programme for residential care settings should support and empower care home staff.
2. Allocating a named DSN to a residential home will give staff a specific point of contact for enquiries and referrals related to diabetes.

into account their specific requirements, medication regimen and dietary access, thus making the content of the training applicable and pertinent to the target audience. This training will be open to all staff and could include management, qualified nursing staff, care staff and catering staff.

The content of the programme will focus on identification of symptoms, day-to-day management and identification of problems with guidance on appropriate referral. While the main focus is on improving the care of residents diagnosed with diabetes, there will be some emphasis based on the prevention of onset of type 2 diabetes. Additionally, the programme will develop strategies to identify those residents who may have diabetes but are not currently diagnosed, as required by National Service Framework standards 1 and 2 (DOH, 2001b).

As this programme is currently in the planning stage it has not been possible to include an evaluation of its success.

Impact on other healthcare professionals

It is anticipated that a proactive programme such as this is likely to generate referral to other services, and will, as a consequence, increase workload for those services in the short term. The primary aim of the programme is to support and enable care staff to maintain optimal control for people with diabetes, thus reducing the risk of both short- and long-term complications, promoting well-being for the residents and reducing the need for interventions in the future.

Impact on emergency service interventions, such as paramedic intervention during hypoglycaemic episodes, will be monitored throughout the course of the programme.

Conclusion

The residential care home assessment programme identified that while most people are receiving services within the residential care setting, there is an apparent lack of consistency regarding the frequency and quality of that service, and for some the level of intervention required is higher than the current service provision allows. The introduction of a combined assessment and tailored education programme for the residential care setting should both support and empower care home staff to provide an improved quality of basic care and timely referral for more in-depth care as and when it is needed.

The allocation of a named DSN will give care staff a specific point of contact for enquiries and referrals. Changing working practice to develop a proactive service will allow the specialist team to identify the need for intervention earlier, and take the necessary steps to improve patient care. ■

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