Developing guidelines for diabetes care

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Article points

1. A consistent approach to the delivery of patient care is of great importance.
2. Policy dictates that all clinical guidelines must go through a meticulous process of research, critical appraisal, consultation and evaluation to ensure that the best possible care is provided for people with diabetes.
3. There must be evidence to support all recommendations.
4. The guideline process is time consuming and involves large numbers of professionals. Thus, it is associated with high costs.

Key words

- Clinical guidelines
- Guideline development

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In recent years the authors' hospital and primary care trusts have responded to recommendations from the Healthcare Commission by introducing a central process for the development and distribution of clinical guidelines. A policy has been written to direct the management of all documents that guide clinical practice, which has to be adhered to by every member of staff. This article explores the guideline process used within the authors' hospital and primary care environment and, in addition, demonstrates the first diabetes-related guideline to be put into practice following this process.

Clinical guidelines are systematically developed statements that assist clinician decision making. Long gone are the days when senior staff in a department could put together a few notes about how to provide care and adapt them day-to-day. In the past, guidelines were based largely on local expert knowledge and clinical experience. The layout of the documents was in accordance with whatever was agreed within a department or ward and there were no demands for proof of evidence and no official standards for written communication. In contrast, today an important part of the clinical governance agenda is a consistent approach to the delivery of patient care.

Local policy now dictates that all clinical guidelines must go through a meticulous process of research, critical appraisal, consultation and evaluation to ensure that the best possible care is provided for people with diabetes. There must be evidence to support all recommendations included in the guidelines. Where research evidence is lacking, the alternative is to identify people with specialist knowledge who are prepared to validate the guidance.

Furthermore, the introduction, development and implementation of a guideline to assist health professionals requires the skills of a multidisciplinary team. It is important that all stakeholders are involved in the development of a new document that guides staff. In the authors' local area, in order to represent both primary and secondary diabetes care, the guideline group consists of the following people: one consultant diabetologist, two GPs, five DSNs (one lead DSN, three community-based and one hospital-based), one dietitian, one primary care pharmacist one podiatrist and one hospital-based clinical educator.

Additionally, there is one person responsible for the auditing and effectiveness of the hospital's clinical approach and one person from the community acting as a quality assurance person assisting in putting the guideline into a standard format that is made accessible to staff.

The process

A shortened version of the flow chart used

in hospital policy development is shown in *Figure 1*. A flow chart demonstrating the community policy and guideline development process is shown in *Figure 2*. The guideline used as a case study for this article was produced to prevent the occurrence of inconsistent practice of clinical staff treating people with diabetes, as all clinical areas throughout the trust will receive people with diabetes at some stage and there is a possibility that an episode of hypoglycaemia may arise. In this eventuality it is important that clinical staff are confident in their management of the patient's condition. *Box 1* shows an example of the rationale successfully submitted by the authors in support of new guidelines on hypoglycaemia.

Audit trail

Once the decision has been made to produce a particular guideline, it is important to consider a number of factors:

- the target audience
- selection reasoning for the guideline development team
- the nomination of a lead person to take responsibility of directing the process
- the input of service users
- the involvement of other people who have knowledge and expertise.

Equalities impact assessments (primary care)

When a new guideline is being developed, an equalities impact assessment must be carried out to ensure that the policy does not disadvantage a particular group.

Consultation team

It is vital that appropriate healthcare professionals are given the opportunity to be involved and consulted in order for them to offer their contributions. Their comments are returned and the guideline processed with the development team, together with the clinical audit department. A procedure to standardise the format for producing guidance documents is followed in order to avoid any confusion for staff using them.

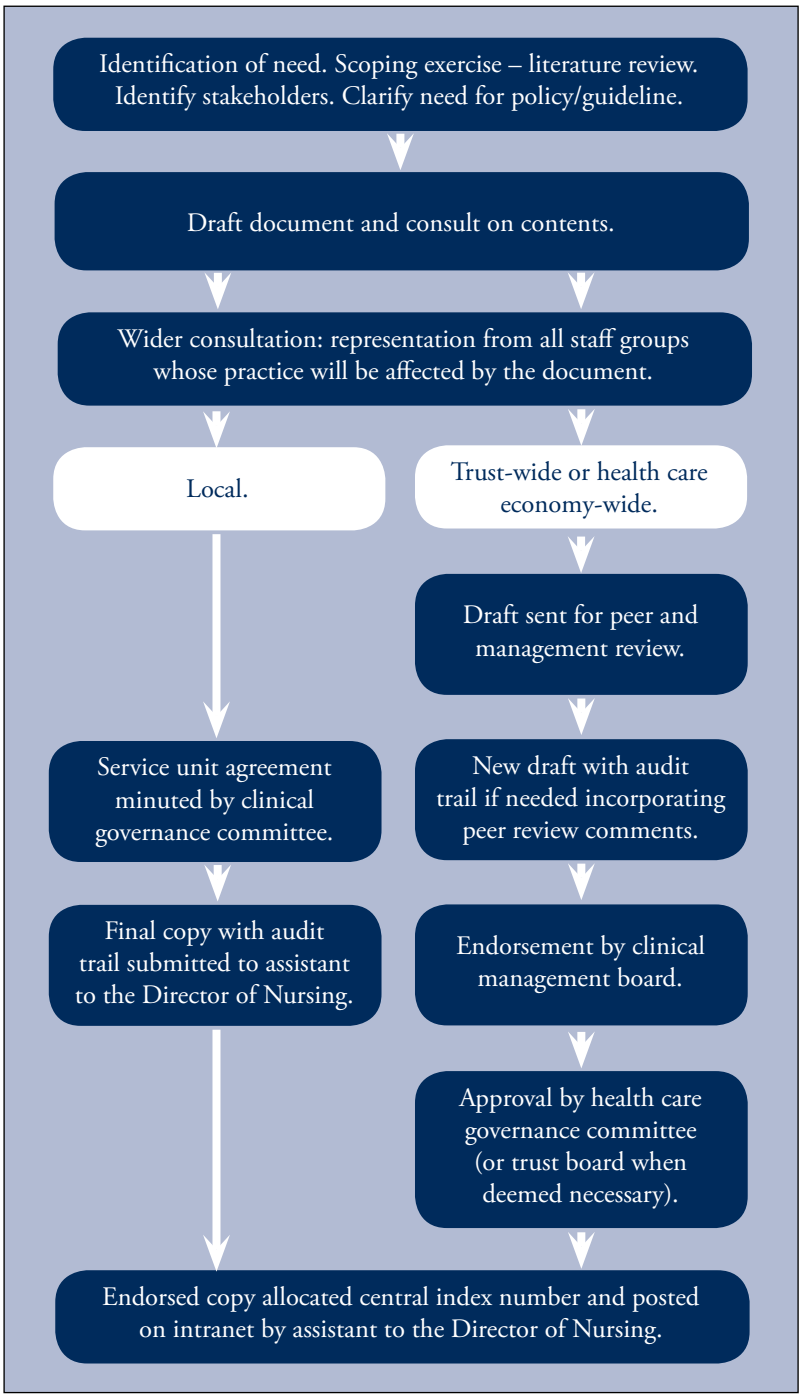

Figure 1. A shortened version of the flow chart used in hospital policy development.

The intention is that all clinical staff are able to recognise documents to guide clinical practice no matter which trust, department or speciality they are working in.

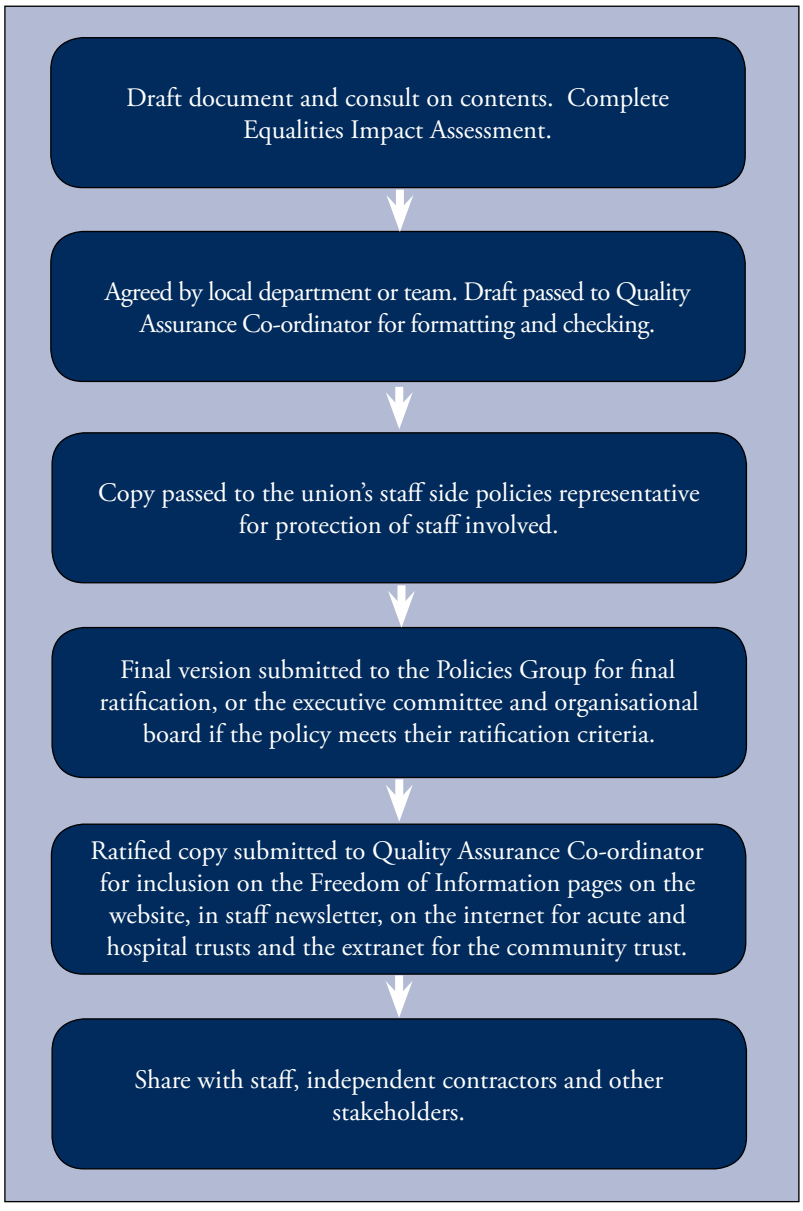

Figure 2. Clinical policy development flow chart (community).

Page points

1. Hospital guidelines often take longer to be endorsed than local guidelines.
2. Once the guideline is passed, it becomes available on the intra- or extranet.
3. Training provisions must be taken into account.

Endorsement or ratification process

In each locality all guidelines must follow an endorsement or ratification process. Guidelines and audit trails have to be presented to the appropriate selection of groups, committees and boards before it can be given final approval. However, the guideline process in hospital trusts often takes longer. One possible reason may be because the target audience is much wider and may involve stakeholders from all departments and specialist areas.

It is at this stage that the guideline will be passed, amended or rejected. Rejected guidelines are submitted back to the guidelines team for necessary amendments before resubmission.

Distribution and implementation

The ward guidelines created as part of this case study are shown in *Figure 3*. The administrator of the central database will enter the details on the central index. The administrator will be responsible for:

- amending the index
- archiving redundant documents
- adding or replacing the new document to the centrally stored collection.

This central index is available as a read-only document on the trust intranet. Each ward or department will have an identified person who will receive details of newly endorsed documents who are then responsible for putting a copy of the new document into the clinical policies and guidelines file, updating the index and removing the old document where appropriate. Newly endorsed documents will be listed and published bi-monthly following the clinical management board meeting.

In primary care, the quality assurance co-ordinator will place the new policy online and it will also be listed in the clinical governance newsletter. It is the responsibility of each line manger to seek guidance on the potential implications of such documents and the responsibility of the policy or guidelines lead to ensure that any new or amended policy or guideline includes consideration for the provision of training or guidance for managers and staff. Managers are responsible for ensuring staff are trained or retrained where appropriate.

Compliance with policies and guidelines is one strategy used by trusts to reduce clinical risk and enhance clinical governance activities. It is a requirement of both organisations and employees that guidelines are followed. Where clinicians judge that

the application of an established national or local guideline is inappropriate for a specific individual, a record should be entered in that person's notes of the action taken and the reason for non-compliance with the written recommendations.

In addition, where a clinician decides it is not in the best interest of the patient to comply with a National Institute for Health and Clinical Excellence technology appraisal this should be entered on the service unit risk register and the trust risk lead must be informed. Audits will be carried out periodically to monitor compliance with guidelines. Where a critical adverse event occurs, an assessment of the degree of compliance with any relevant policies, procedures or guidelines will form part of the investigation process.

Costs

The guideline process is very time consuming and involves large numbers of professionals. Although this is an expensive process it is necessary to ensure that high standards of care are maintained.

Conclusion

There is no doubt that the guideline process did improve quality (Peterborough and Stamford Hospitals NHS Foundation Trusts, 2004a). What is less clear is whether anyone other than those critiquing the guidelines ever reads them or whether it is simply the easier-to-read flow charts that are consulted when guidance is required. Audits on new guidelines may answer this question. Given the enormous amounts of resources that go into their production there must be a question of value for money.

From this first encounter several guidelines have been developed for diabetes care within secondary and primary care. In addition, several changes have been made to writing the guidelines and the processes in place to assist staff. Large numbers of professionals are still heavily involved and committed to this project despite the time and costs this incurs in order to improve diabetes care. ■

Box 1. Rationale submitted by the authors in support of new guidelines on hypoglycaemia.

It is estimated that as many as one in ten people in hospital have diabetes (Tattersall, 2002) and that nurses are the first point of contact for people seeking information on diabetes care (Dunning, 1995). Findlow and McDowell (2002) suggest that while nurses are the key providers of diabetes care their knowledge of diabetes is often variable. They maintain that most nurses have a limited understanding of diabetes management, however they may oversee or manage inpatient care for a person with diabetes (Cavan et al, 2001).

Following a questionnaire distributed to qualified community and hospital staff the outcomes confirmed that 79% of nurses were unable treat a mild hypoglycaemic attack. In view of this information it was necessary to act upon the data by developing and implementing a guideline to assist staff in dealing with this situation. Standard 8 of the National Service Framework (NSF) for diabetes addresses the need for guidelines for the care of the person with diabetes during a hospital stay (Department of Health [DoH], 2003). The ward area was the first place to target to improve inpatient care (Standard 8 NSF).

Cavan D, Hamilton P, Everett J, Kerr D (2001) Reducing hospital inpatient stay for patients in hospital. *Diabetic Medicine* **18**: 162–4

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Page points

1. Records must be kept of any individual circumstances where the clinical guidelines are not adhered to.
2. The process of policy development and approval is time consuming and expensive.
3. Diabetes guidelines appear to improve the quality of care in hypoglycaemic episodes.

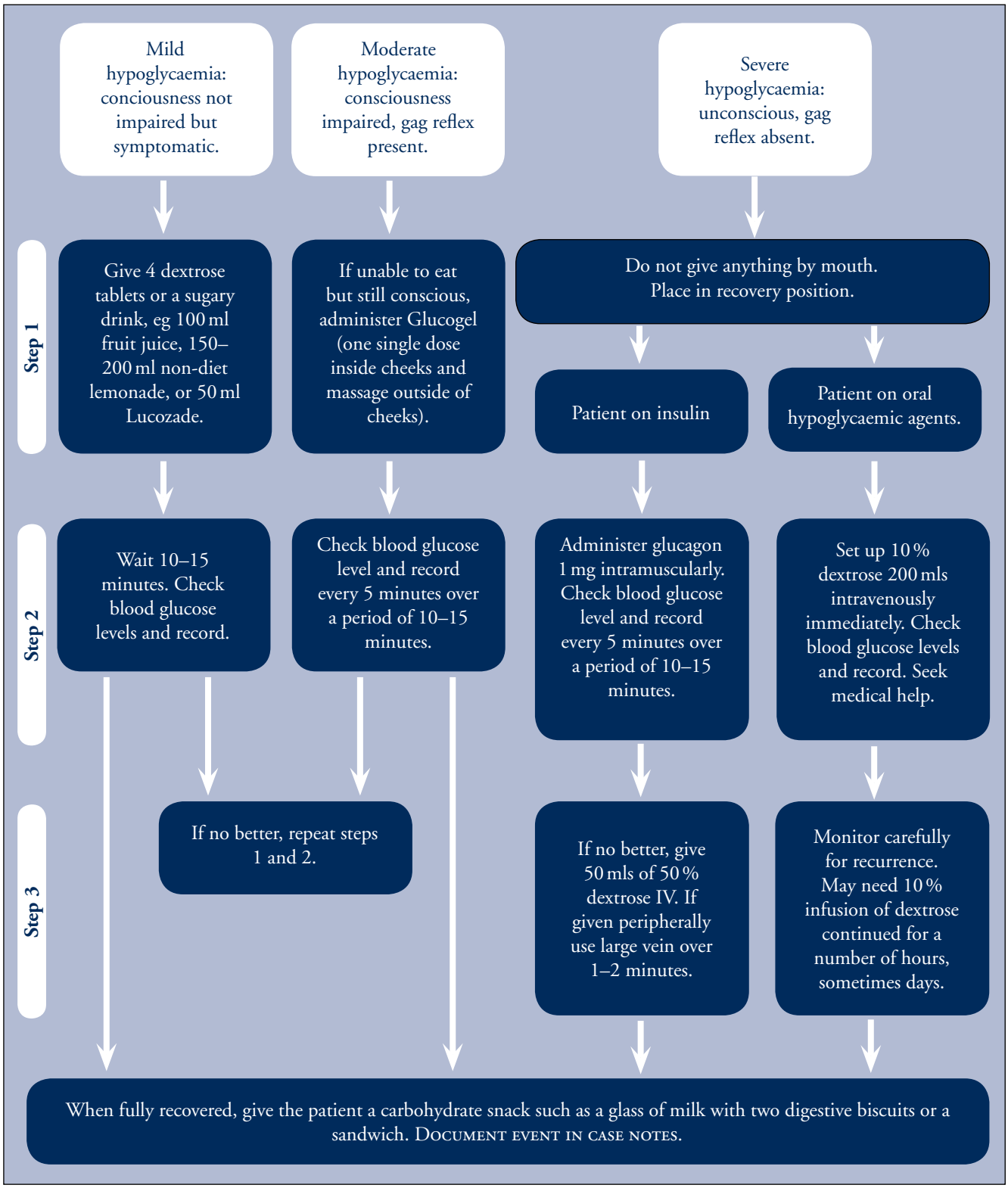

Figure 3. Ward guidelines for the treatment of hypoglycaemia (blood glucose levels below 4 mmol/l) in adults with known diabetes. Adapted from Peterborough and Stamford PCT ward guidelines (Peterborough and Stamford Hospitals NHS Foundation Trusts, 2004b).