Changing diabetes by improving control: Solutions

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changing diabetes

Call to action: Your response

The *Journal of Diabetes Nursing* would be delighted to receive details of any initiatives that have improved control in people with diabetes. For example, an initiative which helped to break down barriers to improving glycaemic control or improved education of people with diabetes.

Submissions could be short letters or articles of up to 2000 words. Contact the editorial team at the journal to discuss ideas on 0207 627 1510. *Or* send your submissions to: The Editor, *Journal of Diabetes Nursing*: editorial@sbcommunicationsgroup.com. Responses will be considered for publication in the *Journal of Diabetes Nursing.*

Working together

We now have a wide and growing range of treatments and technologies to improve blood glucose control. There are sufficient national guidelines and local protocols for healthcare professionals to follow and there is clear evidence that controlling blood glucose to as near normal levels as possible reduces the risks and delays the onset of long-term complications.[1] And yet, it is known that two-thirds of people treated for diabetes do not achieve their HbA_{1c} targets and this situation does not appear to be improving over time.[2] This would imply that there must be problems or barriers for people with diabetes regarding ordering, collecting or taking their prescribed medications.

Over the last 10 years, I have learned to come to terms and live with diabetes myself. Interestingly, the aims and priorities of the (retired) healthcare professional and person with diabetes that I now am, at times sit comfortably together and at other times, do not.

Working together

From the perspective of the healthcare professional, working in partnership with the person with diabetes begins from the point of diagnosis. At this stage, a key priority for the professional is to support the person concerned to come to terms with the potential loss of health; to watch for signs of depression; to provide essential information; to address concerns; and to answer questions. If the person has type 2 diabetes, it is also important that the progression of the condition is discussed at the outset – this may help in ensuring that the fear of needles does not become a subsequent barrier.

Partnership is also important when planning to improve glycaemic control. In my opinion, this should be a collaborative process whereby, once they understand the implications and issues for their daily life, people with diabetes can set their own goals in working towards achieving an HbA_{1c} level jointly agreed with the healthcare professional. When it comes to starting insulin and choosing a device for insulin injection and the most appropriate insulin regimen, the individual must be part of the decision making process. Healthcare professionals must also play their part, making an effort to learn more about individual people with diabetes, the quality of life they seek, and the daily pressures they face. It should be remembered that people with diabetes, and their carers, will need to acquire new practical skills if they are to improve or maintain good glycaemic control. Every day, at the very least, the individual must take all of their medications as prescribed, plan their meals, activities and exercise (while avoiding hypoglycaemia), and adjust all of these as circumstances dictate.

Sources of conflict?

In a target- and finance-driven health service, in general, healthcare professionals are required to reduce HbA_{1c} at the lowest cost with the aim to lessen the risks and delay the onset of costly long-term complications. Indeed, the Quality and Outcomes Framework indicators for HbA_{1c} will be lowered early next year (the lowest, for example, moves from 7.5% to 7.0%)[3]; to achieve these new targets, therapy will be further intensified, which could result in a greater risk of hypoglycaemia and an increasing burden of treatment for the person with diabetes. Given this potential conflict of priorities, it is therefore becoming even more important that the individuals with diabetes are fully consulted and are considered as partners in the decision-making process.

Furthermore, while there is a need for partnership between people with diabetes and their healthcare team, there are times when the professional may need to be more directive than at present, for example by initiating the next level of treatment in a timely fashion when it is required. Most people with type 2 diabetes need this prompt reassurance that the decision is appropriate for them, and it is therefore alarming that a recent study showed that 50% of healthcare professionals "prefer to delay initiation of insulin until it is absolutely necessary".[4] This delay, in the majority of cases, may not be in the best interests of the person with diabetes.

Conclusion

To reach even lower targets for control, it is clear that intensive therapy and financial incentives alone are not enough to improve HbA_{1c} (or other parameters). Perhaps such incentives should be offered to the people with diabetes – to whom the targets really belong! In my view, the key to improving control is to enable people to understand their own situation and for them to become competent and confident to set and achieve their own goals.

1. Diabetes Control and Complications Trial (1993) *New England Journal of Medicine* **329**: 977–86
2. International Diabetes Federation, Federation of European Nurses in Diabetes *Achieving Good Glycaemic Control* Available at: http://www.idf.org/home/index.cfm?node=1504 (accessed 18.11.08)
3. *QOF changes, GMS contract 2009/10.* Available at http://www.nhsemployers.org/pay-conditions/primary-886.cfm (accessed 18.11.08)
4. Peyrot M, Rubin RR, Lauritzen T et al (2005) *Diabetes Care* **28**: 2673–9

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