Expediting discharge and preventing admissions

Jill Hill

Department of Health (2001) *National Service Framework for Diabetes: Standards*. DH, London

Department of Health (2008) *Five Years On: Delivering the Diabetes National Service Framework*. DH, London

National Diabetes Support Team (2008) *Improving Emergency and Inpatient Care for People with Diabetes*. NDST, Leicester

NHS Institute for Innovation and Improvement (2009) *Think Glucose*. Think Glucose, Preston. Available at: www.glasgows.co.uk/thinkglucose/ (accessed 05.10.09)

Sampson MJ, Crowle T, Dhatariya K et al (2006) Trends in bed occupancy for inpatients with diabetes before and after the introduction of a diabetes inpatient specialist nurse service. *Diabet Med* **23**: 1008–15

Jill Hill is a Diabetes Nurse Consultant, Birmingham East and North PCT.

In the current financial context of the NHS, with rumours of decreasing resources to tackle increasing workloads, it is appropriate that there has recently been an increased awareness of the cost of hospital bed use. Many nurses reading this journal will have been involved in collecting data for the National Diabetes Inpatient Audit held in September. This audit was organised by NHS Diabetes and aimed to discover how many people with diabetes were occupying a hospital bed, how the care of their diabetes was being managed, how long had they been in hospital, their perception of the experience of being in hospital, and so on.

Previous studies have shown that people with diabetes are twice as likely to be admitted to hospital than people without the condition, and that at any given time, 10% of inpatients will have diabetes (Sampson et al, 2006). Even if diabetes is not the reason for admission, it can have a significant impact on length of stay. For people under 60 years of age admitted for routine surgery, diabetes can result in 1.8 extra days on the ward, although other studies have suggested 4.0 extra days for some groups (Sampson et al, 2006). Prolonged stays in hospital among people with diabetes account for 80 000 bed days per year (National Diabetes Support Team [NDST], 2008).

The National Service Framework for diabetes (Department of Health [DH], 2001) recognised the importance of high-quality care for people with diabetes admitted to hospital, with guidance about good practice outlined in standard 8. Evidence suggests that hospital Trusts still have some way to go to achieve this. An audit in Brighton and Sussex University Trust, described in the document *Five Years On: Delivering the Diabetes National Service Framework*, found 15.9% of all beds were occupied by someone with diabetes, and more than 50% of them did not receive adequate care as judged by the five criteria listed below (DH, 2008). Patients must receive:

- Insulin or oral hypoglycaemic agents if needed.
- Adequate carbohydrates.
- Adequate management of their diabetes prior to, during and after procedures.
- Appropriate treatment of hypoglycaemia.
- Persistent hyperglycaemia reviewed.

Issues for people with diabetes in hospital include disempowerment and difficulty in being allowed to self-manage their diabetes, problems with control over food choices and timing of meals, lack of information and support, lack of communication with healthcare professionals and between staff, erratic blood glucose control, and perceived lack of staff expertise, particularly in regard to medicines management (NDST, 2008).

Commissioners looking for value for money will, therefore, be keen to reduce length of stay or, ideally, prevent admissions. The "Think Glucose" campaign has been launched this year, and covers many aspects of improving the care of people with diabetes during their hospital stay, including appropriate management of hypoglycaemia, safe use of medications and ward-staff training. Raising awareness of all staff caring for people with diabetes makes sense as there are increasing numbers of people with the condition who will be cared for in all departments and wards, not just diabetes specialist wards. The campaign has demonstrated an increase in appropriate referrals to DSNs, a reduction in insulin errors, and a reduction of length of stay by 2 days, which for an average sized Trust equates to £1 million per annum (NHS Institute for Innovation and Improvement, 2009).

Reducing length of stay can be facilitated by timely management of insulin and oral hypoglycaemic agents, education and liaising with community support. The role of the inpatient DSN involves these skills, and Sue Thompson describes how she uses these skills to achieve this on page 343. Sadly, despite the evidence to demonstrate the effectiveness of the inpatient DSN, many hospitals do not employ them (Sampson et al, 2006).

Given the poor experiences of people with diabetes during hospital stays, and the expense particularly with extended length of stays, the role of the Assertive Case Manager is important, particularly as these nurses work with patients with several long-term conditions who are most at risk of long stays in hospital once admitted. Lyndi Wiltshire is an Assertive Case Manager with a special interest in diabetes. On page 348, she describes how prompt action and working with other agencies can avoid admissions. ■