Collaborating to improve diabetes and palliative care

Sara Da Costa

Nursing has been appearing in the national news over the past few months, and has often been associated with negative headlines. Examples have been given of nurses not caring for their patients or of neglecting their basic needs, and in some cases this has been blamed on there being too few nurses on the wards. Those of us who work in diabetes specialist nursing in both primary and secondary care acknowledge and appreciate the many stresses that nurses are exposed to on a daily basis. District and practice nurses are faced with increasing demands on their time, but without any additional resources. The same is true in the hospital; emergency and admission units receive more and more patients, yet nursing resources remain the same, prompting some calls for an agreement regarding minimum staffing.

My clinical input is within a medical admissions unit, which I, or one of the specialist nurses, visit daily, to review all patients with diabetes, regardless of whether this is the reason for admission. While working in this unit, I appreciate the extreme pressure on the nursing and other medical staff dealing with incredible numbers of admissions of very sick people every day; yet these patients are treated professionally, with respect and good clinical care.

Our role as DSNs is to use our specialist knowledge to improve patient care and outcomes, behaving professionally to influence the patient as well as our nursing and medical colleagues. Diabetes is rarely the reason for admission in my experience, and without our input, people with diabetes may be disregarded, consequently allowing poor diabetes control to affect individuals' recovery and delay their discharge. Many of our patients are older, which further complicates existing comorbidities. These patients require our specialist nursing input to assess their current medication in terms of safety, as impaired liver or renal function will require reduction or stopping of treatments.

According to current Quality and Outcomes Framework indicators (British Medical Association and NHS Employers, 2011), GPs are only alerted if a patient's HbA_{1c} level is too high, not if it is too low. Low HbA_{1c} levels may be due to hypoglycaemia, which may have caused falls, confusion or accidents that may have prompted the admission. Older people often have reduced cognition and so are not aware of hypoglycaemic episodes, and they may have no warning to enable them to act. All treatments that can cause hypoglycaemia should be used with caution in this group, and when used, individuals should have the ability to monitor blood glucose levels.

Among older people with diabetes who are admitted to acute hospitals, if one of their comorbidities is terminal illness, this complicates the situation even further. In our hospital, owing to a need to improve our collaboration with our palliative care team, our primary care DSNs visit the local hospice as required to review treatments and ensure that the patient is kept symptom-free and comfortable by appropriate use of diabetes treatments. Previous experience without our input resulted in an older person with type 1 diabetes having insulin withdrawn and suffering diabetic ketoacidosis. By chance, we were asked to review this patient – we restarted her insulin and some blood glucose monitoring, and enabled a more comfortable death. This experience taught us, as a team, the need to collaborate.

The accompanying article by Debbie Hindson et al discusses problems that we can recognise and highlights the need for advocacy for the older person with diabetes who cannot choose care for themselves. Importantly, it shows how rechecking of abnormal blood glucose results is often not carried out, which suggests collaborative decision-making should be agreed and documented for all carers to know and work with. This could avoid confusion and instead bring more clarity and confidence to end-of-life care. ■

British Medical Association and NHS Employers (2011) *Quality and Outcomes Framework Guidance for GMS Contract 2011/12. Delivering Investment in General Practice.* BMA, London. Available at: http://bit.ly/rACyyU (accessed 13.04.12)

Sara Da Costa is Nurse Consultant in Diabetes, Western Sussex Hospitals, and Visiting Fellow, University of Brighton, Brighton.