Ensuring continuity of care for diabetic patients attending hospital

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ARTICLE POINTS

1 Diabetic patients attending hospital for investigations require efficient management to maintain their diabetic control.

2 Successful management requires clear instructions that are understood by all staff.

3 A reference document of management guidelines on the preparation of diabetic patients attending hospital for investigations was implemented.

4 Annual review of the document ensures up-to-date guidelines.

KEY WORDS

- Reference document
- Diabetes care
- Hospital investigations

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Introduction

The role of the hospital-based diabetes specialist nurse (DSN) can be made difficult by the constant requests for help from medical and nursing staff about the management of patients' diabetes during investigations or procedures. This article describes the production and implementation of a reference document of management guidelines for medical and nursing staff on the preparation required for patients with diabetes attending hospital for investigations. The role of the DSN was focal in the ultimate success of the document.

People with diabetes mellitus may be admitted to hospital for a number of reasons, which may or may not be related to their diabetes. Hospital health care teams have a responsibility to ensure that their care is managed appropriately in order to avoid distress, and destabilisation of their diabetes. Efficient management is therefore essential to attain this standard of medical practice.

The belief that successful management requires clear instructions that are fully understood by all staff led to the production and implementation of a reference document of management guidelines. This focused on the preparation required for diabetic patients attending hospital for investigations.

Hospital care

People with diabetes are at risk of medical or surgical intervention due to the nature of the condition and its associated complications, which may lead to hospital admission. Hospital-based DSNs are accessible to provide help and advice to ward staff. Sometimes their advice is not sought, with doctors' orders often causing problems for diabetic patients, delaying their discharge or resulting in home visits by the DSN to restabilise their diabetic control.

An important feature of the role of any DSN is to collate, filter and transmit ideas and information (Alderton et al, 1997). The DSN acts as a bridge between other health professionals to develop practice and this involves working with the clinical nurse specialist for medicine. Our rationale for producing the reference document is shown in *Table 1*.

Hospital admission and management of any patient requires assessing, planning, implementing and evaluating care. The reference document provides a framework to help with this process when medical and nursing staff are caring for a person with diabetes.

In a leaflet published in 1994, the British Diabetic Association (BDA) defined the level of care people with diabetes should expect in hospital (BDA, 1994). This includes the right to a full explanation regarding what

Table 1. Rationale for the production of the reference document

- Ensures continuity of care for people with diabetes requiring hospital investigations
- Avoids distress and destabilisation of diabetes
- Avoids prolonged hospital stay

is happening from a health professional, and access to the diabetes care team, who should be pre-informed of the patient's admission. However, in a review of diabetes services in Sefton Health Authority, Liverpool, Wilson (1994) found that health professionals were concerned about the management of diabetes in hospital. These insecurities reinforced the need for clear management guidelines for those medical and nursing staff who provide diabetes care in hospital.

Literature review

In preparation of the guidelines, a thorough review of the literature drew many references regarding preparation and management of diabetic patients for surgical interventions, but little regarding procedures or investigations of diabetic patients.

MacFarlane (1986) wrote about the preparation of diabetic patients attending the X-ray department as outpatients, and the possible implications that might occur if the patients were not prepared properly.

Document formulation

The first task was to collect guidelines and protocols relating to diabetes management in use on the wards and departments of Arrowe Park Hospital. Reviewing the material provided valuable insight to the preferences and approach to management of diabetes by the various consultant physicians.

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1 Reviewing existing protocols relating to diabetes management gave valuable insight to consultants' preferences.

2 Writing a set of guidelines for each procedure was difficult, as consultants' preferences were taken into account.

3 Copies of the reference document in each ward and department enable convenient access to the guidelines.

GASTROSCOPY

Preparation of an insulin-dependent diabetic patient before gastroscopy

1. Inform endoscopy unit that patient is diabetic (24-hour notice if possible)
2. Ensure the patient is listed as the first to be seen to commence preparation for an afternoon gastroscopy
3. Omit subcutaneous insulin
4. Give early morning breakfast
5. Record blood measurements (BM)
6. 8.00 am commence glucose, potassium, insulin (GKI) infusion, as prescribed by doctor (GKI see page 7)
7. Record BM every two hours
8. On return to ward, after gastroscopy, ensure the patient remains nil by mouth until fully conscious and swallowing reflex has returned
9. Maintain GKI infusion until patient is able to eat and drink normally
10. Resume subcutaneous insulin, as prescribed by doctor
11. Resume diet and fluids as per diabetic patient's requirements
12. Record BM pre-meals for 24 hours

Note: If an oesophageal biopsy is taken or therapeutic procedure performed, the consultant will give specific management instructions

Figure 1. An example of the Preparation Prior to Procedures for Non-insulin Dependent Diabetic Patients and Insulin Dependent Diabetic Patients reference document.

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1 The reference document has resulted in a reduced number of telephone enquiries for help with diabetic management.

2 The guidelines are reviewed annually and are updated for newly available procedures.

3 The reference document ensures an efficient, collaborative, management of patients with diabetes.

An 'A to Z' of investigations and procedures was compiled. Writing a set of guidelines for each procedure was probably the hardest task, as this involved consideration of consultants' preferences. However, by discussing the document with consultant diabetologists, consultant physicians, the ward manager, the X-ray department, dietitians and the endoscopy unit, the guidelines were refined and finally agreed.

Presentation

The guidelines form a reference document: the investigations or procedures are classified by department, for example X-ray or endoscopy and the treatment of diabetes. Having taken into account consultant colleague preferences, there may be two or three versions of a particular procedure. An example of the procedure for preparing a diabetic patient for gastroscopy is shown in *Figure 1*.

Each ward and department has two copies of the reference document, which is in the form of a booklet. The cost of producing the document was met by the medical directorate, following a presentation of the idea to the directorate managers.

Evaluation

Most of the evaluation looked at what went wrong when diabetic patients were inadequately prepared for investigation in the X-ray and endoscopy departments. When this happened, a member of the diabetes care team would visit the ward to determine what went wrong and make improvements to the guidelines to prevent this from recurring.

The number of telephone enquiries for help from the wards and departments of our hospital regarding the management of diabetic patients for investigations has declined, proving how effective the document has been. Diabetes link nurses have been an invaluable source of feedback regarding the document.

Each year we review the contents of the reference document and make changes as required. Guidelines for new services that are available, such as endoscopic retrograde cholangio pancreatography and angiography, have been added in liaison with consultants and staff involved. It is hoped that the guidelines will be transferred onto the hospital computer system in the near future.

Conclusion

The reference document is used daily with confidence by medical and nursing staff at Arrowe Park Hospital. Our belief that successful management of a complex condition such as diabetes requiring clear instructions can be achieved by working in collaboration with each other, regardless of specialty.

The role of the DSN in using communication and liaison skills, and clinical expertise, has been shown by the success of the reference document.

Promoting better practice by providing a framework for intervention has been fundamental in achieving continuity of care for people with diabetes attending hospital for investigations. ■

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Correction

The authors of *A nurse-led clinic for women with IGT following gestational diabetes* (**2**(4): 115-8) would like to make the following correction to their article:

The volume of Lucozade given in *Table 2* for the 75g glucose tolerance test should have read 354ml not 254ml. This volume is recommended by the manufacturers of Lucozade as giving the equivalent load as 75g of monohydrate glucose using a Lucozade concentration of 76kcal/100ml.

Source: SmithKline Beecham Consumer Healthcare Research and Development. Updated April 1998.