Evaluation of diabetes courses: could do better

Maggie Watkinson
Editor

One role of the diabetes specialist nurse (DSN) is to educate other health care professionals — nurses in particular. Many educational initiatives have been set up by DSNs for ward-based nurses, link nurses and practice nurses and their purpose is usually to increase the knowledge base of attendees, in the hope of improving diabetes care.

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Many of these courses are evaluated; however, most evaluations consist of 'happy sheets' which attempt to elicit whether participants were *pleased* with the course. Comments on the venue, timing and delivery of sessions are often asked for, accompanied perhaps by a request for information about the usefulness of the event. Happy sheets tend to ask for feedback on the effectiveness of the *teaching* rather than the *learning*, and there is little indication that the courses succeed in changing practice.

Evidence suggests that simply providing knowledge to people with diabetes does not always result in improved diabetes control. Perhaps then, the mere provision of knowledge to non-specialist health care professionals will not necessarily ensure improved practice. Turner Parker et al (1995), for example, found that an educational programme which increased the knowledge of nurses working in a long-term care facility did not result in improved patient care.

It is time that DSNs improved the evaluation of the education they deliver. We need more studies to evaluate changes in practice following diabetes courses, particularly in the British and European contexts. Assessing practice before courses commence and evaluating it immediately afterwards — as well as several months later — might be an appropriate strategy.

In addition to evaluating the effectiveness of courses in relation to fitness for purpose, DSNs must think about who is being educated. Drass et al (1989) suggest that to remain knowledgeable, nurses need to be updated every six months. I once calculated that if we ran diabetes study days in my area, for this purpose, and every nurse attended, we would need to conduct them every working day of the year! This, of course, is not practicable and probably explains the advent of the link nurse. Most link nurses exist in the hospital setting but there is no reason why they may not be used in community units or, now that primary care groups are here, within groups of practices.

DSNs should also consider how education is carried out. For example, the use of open learning packages and practice-based manuals which have been devised for local use may be effective ways of providing information.

Following their study of ward nurse education, Davis et al (1992) believe that the only effective way to consistently maintain and improve the care of people with diabetes in hospital wards is to have link nurses who have been educated by DSNs, maintain contact with them on a regular basis and provide written reference material which is kept up to date. These principles could obviously also be applied to link nurses in other areas.

Huge research agenda

The recipients of education by DSNs surely have the right to expect that those who educate them are knowledgeable about educational theory and are aware of (and act upon) the results of studies which explore the most effective ways of delivering health professional education. To ensure that the education provided by DSNs is used to improve patient care, there appears to be another huge research agenda! There are few studies which deal specifically with diabetes but many that explore 'general' post-basic education, and perhaps diabetes nurses could start by applying the results of these to our own work. ■

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