Improving the inpatient experience

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Supplement Editor

It is widely acknowledged that 10% of an acute unit trusts' bed occupancy will be by people with diabetes; very often the admission is not diabetes related, and the length of stay is longer. Frequently, patients report inappropriate diabetes management, or diabetes specialist nurses (DSNs) unearth episodes of care that, in today's climate, amount to clinical incidents. What strategies can be put in place to improve the patients' experience when admitted to hospital? My views tend to fluctuate.

Should we abandon all hope of skilling ward nurses and put in place DSNs with an inpatient responsibility? Interestingly, this group of nurses is growing, with an inpatient nurse forum set up addressing the issues of inpatient care. Should we continue to plug away and aim to skill the ward staff? I suspect it has to be a combination of both. Alongside this should we really hone in on skilling and empowering patients to manage their own care whilst in the acute unit?

Developing ward staff

Unfortunately, the organisation of nursing care would still appear to be environment-driven; the ritualistic practice of early rising ward and medicine rounds are still very much in evidence. It is possible that nurses assume these tasks as it is perceived to be time saving. In order to achieve self-management and more appropriate management in the acute unit, there needs to be a change in the organisation of care and an increase in the knowledge of diabetes amongst ward staff.

The concept of link nurses is not new, and many secondary care services have strived to develop the role of the link nurse, reporting various successes or the difficulties in maintaining an active interest. Unfortunately, the evidence to suggest link nurses improve the patients' care or experience in hospital appears to be lacking. How do link nurses end up in the role? Are they self-selecting? That is, do they volunteer for the role, or are they nominated by their ward manager? The 'appointment' process may well influence the impact these nurses have on patient care. As a result of being a link nurse how are their responsibilities and roles defined? There appears to be no national guidance: it appears to be locally driven, possibly based on the nurse's need rather than the patient's. Una McErlean, in her article, describes the development of a link nurse programme in her hospital. This included defining the role of the link nurse and a 5-day placement programme in the diabetes centre, which set out to ensure the nurses were competent to be active in the role. There have been a number of successful spin-offs as a result of this programme, whilst an improvement in patient care has yet to be proven. Bridging the theory–practice gap has to be a very positive step in the right direction.

Self-management in the acute unit

The practice of self-management is widely accepted by healthcare professionals; utilising an empowerment approach, patients are increasingly encouraged to play an active role in the decision-making regarding their treatment and management. Whilst education concerning the principles of management will enable the patient to develop the knowledge and skills necessary to manage their diabetes, the application and the decisions patients make on a daily basis rely largely on the experiential learning and the knowledge acquired by the individuals when managing their diabetes. However, this principle seems to be mainly evidenced in the individuals' own home or as outpatients. Upon admission to hospital, the management of diabetes is frequently taken over by the healthcare professionals, leading to frustration and often an iatrogenic deterioration in diabetes control, leading to potentially compromised and delayed recovery. People with diabetes and their relatives are often aware that their knowledge of diabetes is far greater than the healthcare professionals'.

The hospital ward is an environment over which patients often feel they have no control. This can create a feeling of powerlessness as patients feel they have no control of events during hospitalisation, which can, in turn, lead to learned helplessness as events occur without any personal choice or are unpredictable. Relating this to diabetes in the acute clinical setting, many aspects of diabetes occur without any choice for the patient, for example the frequency of blood glucose monitoring and the unpredictability of timing and doses of hypoglycaemic agents (tablets and insulin). As a result of this the patient either takes on a passive recipient role or kicks up a fuss! Whilst articles and Diabetes UK have encouraged patients to continue self-care, this requires the patient to feel confident to do so. There is only a limited amount of literature that looks specifically at advocating patients continuing the self-management of their diabetes in the acute clinical setting. Niki Robinson, in her article, explores the concept of self-administration of diabetes medication in the acute clinical setting, the advantages to patients and the ward team, and the strategies that would need to be put in place to achieve this successfully. Empowering patients and enabling them to be in control of their diabetes management in the acute clinical setting requires the ward nursing team to be empowered to facilitate this. ■

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