

# Community matrons: Supporting people with long-term conditions

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Community matrons (CMs) have an invaluable role in working with housebound people with long-term conditions. The CM role is to case manage a group of predominantly older people with conditions such as chronic obstructive pulmonary disease, diabetes, arthritis and heart failure. The role aims to reduce ill health and optimise treatment, care and support, where possible. CMs also aim to reduce avoidable and unnecessarily, lengthy hospital admissions (Fraser et al, 2005). This article outlines how the CM role has developed locally and nationally, explains what the role entails, and focuses on the CM role in supporting people with diabetes.

Although there have been many changes in the delivery of diabetes care, not everyone is benefiting. A report by the Audit Commission (2000) suggests that older people, those who are housebound and those living in residential care do not receive the appropriate level of care. Community matrons (CM) help this group to access care in their own homes.

## Background

In the UK, 2.5 million people have been diagnosed with diabetes and an estimated 500 000 are undiagnosed (Diabetes UK, 2008). Massó González et al (2009) suggest that rates of diabetes are increasing at a faster rate in the UK than in North America, where prevalence of the condition is one of the highest in the world.

According to Diabetes UK (2008) diabetes costs the NHS £1 million an hour and £9 billion a year, which equates to 10% of the entire NHS budget. People with diabetes are

twice as likely to be admitted to hospital and one in ten inpatients has diabetes. On average, inpatients with diabetes stay in hospital twice as long as other people (National Diabetes Support Team, 2008). The CM works with people to manage their long-term condition (LTC) and to reduce unnecessary admissions to hospital. These statistics clearly indicate that people with diabetes are a group that should be targeted for a case management approach (a named professional coordinating an individual's care).

The new NICE guidance for type 2 diabetes (2008) supports intensive management of blood glucose, blood pressure and blood lipids to minimise the risk of developing long-term complications. Structured education underpins people achieving these individual targets.

In the UK, there has been a move towards managing people with diabetes in primary care, with referral to specialist services, where needed, to address the projected healthcare needs described above.

## Article points

1. Community matrons are in a key position to teach, monitor and support housebound patients with long-term conditions, such as diabetes.
2. A proactive approach to case management for people with diabetes can have a positive effect on appropriate access to care, support, and improve quality of life.
3. A governmental drive to prioritise the needs of people with long-term conditions has improved the care and support that people with chronic conditions receive.

## Key words

- Community matron
- Long-term condition
- Self-management

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### Page points

1. Community matron (CM) intervention aims to increase individual and carer knowledge of the condition, increase people's confidence in their ability to self-manage their condition.
2. CMs coordinate all of the services and healthcare professionals involved in the individual's care to ensure a consistent approach with unified goals.
3. CMs are experienced registered nurses trained in the management of long-term conditions. CMs assess, diagnose and treat people, including the prescribing of medications for a range of clinical situations that often affect people with long-term conditions.

Management of LTCs requires input from a number of healthcare professionals, and nurses have a leading role in the care of people with diabetes. Diabetes specialist nurses (DSNs) have traditionally undertaken the role of insulin initiation, but a shift in practice has meant that practice nurses have developed their education and skills to undertake diabetes education and initiation of insulin in people with type 2 diabetes.

### Case management and the CM role

In autumn 2002, the Department of Health (DH) invited American United Health to assist PCTs in developing a case management approach (Evercare) to the care of older people. In 2003, the role of the advanced primary nurse emerged from Evercare and has since evolved into the CM role (DH, 2005a; 2005b).

In NHS Bristol and South Gloucestershire there are now 35 CMs based in GP practices managing caseloads of people with complex needs at risk of emergency hospitalisation. The role of the CM is to apply an individualised, person-centred approach to care, with all interventions focused on promoting maximal function, independence, comfort and quality of life (Asprey, 2004; Gravelle et al, 2006).

CM intervention aims to increase individual and carer knowledge of the condition and increase people's confidence in their ability to self-manage their condition. CMs also aim to work with people with diabetes and their carers to ensure that they have an emergency plan that identifies deterioration in their condition and initiates a planned course of action or treatment to prevent a health crisis.

### Five core components of the CM role (Fraser et al, 2005)

#### *Clinical*

CMs are experienced registered nurses trained in the management of long-term conditions. CMs assess, diagnose and treat people, including the prescribing of medications for a range of clinical situations that often affect people with LTCs.

The CM clinical role includes undertaking an expanded holistic nursing assessment by taking a complete medical history and physical assessment. This allows the CM to establish measurable baselines for the person with diabetes and supports chronic disease monitoring and management.

#### *Care coordination*

CMs coordinate all of the services and healthcare professionals involved in the individual's care to ensure a consistent approach with unified goals.

When people on CMs caseloads are admitted to hospital, CMs embrace advanced practice working across organisational boundaries. Continuity of care for the individual is maintained by CMs providing inter-professional teams with baseline information and supporting proactive discharge planning.

#### *Champion*

The CM strives to ensure quality of care for older people. Issues affecting older people on an individual and organisational level are identified and addressed, for example fragmented services or issues of inequality.

#### *Coach*

The CM teaches individuals and those close to them about the management of their condition and its associated complications, and how to identify early and subtle changes from baseline health as an adjunct to early intervention.

#### *Communication*

The communication aspect of the role runs through all components. The CM acts as an individual's first point of contact and shares information with the multidisciplinary team and those close to them.

#### *Case finding*

Dr Foster's (2009) Intelligence tool, and primary care and hospital data are used to identify people at high risk of hospital admission. Patients are also referred to CMs by other healthcare professionals (*Box 1*) using specific referral criteria. Typically, people in

the care of a CM have one or more chronic conditions, take multiple medications and may have difficulties with the activities of daily living (DH, 2005c; 2005d).

### CM intervention

Following assessment, the CM intervention with the patient may be time limited, based on individual needs. A care plan is developed in partnership, with agreed outcomes. When these outcomes are met the individual may then be supported by existing services within a plan of care, or independently, if possible. The decision to discharge an individual from the CMs caseload rests with the CM if they feel that intervention is not benefiting the individual and would not reduce admissions to hospital.

### Case study

Mr A is a 79-year-old man referred to a CM by his GP. He developed type 2 diabetes 10 years ago and was initially treated with oral medication. Four years ago he was initiated with mixed insulin 30/70, at a dose of 22 units in the morning and a further 18 units with his evening meal, to improve his glycaemic control. In addition to his diabetes Mr A also has coronary obstructive pulmonary disease (COPD); he has smoked since the age of 14 and had given up during the early years of his retirement. He is on long-term oxygen therapy. Mr A is on a considerable amount of medication to treat his numerous LTCs.

Mr A lives with his wife who is his carer, and their son lives some distance away. Mr A is able to manage most of his personal care and is mobile out of his house with the aid of a motorised scooter. Mrs A carries out all other aspects of care and on numerous occasions they have declined the intervention of community care.

The authors have worked with Mr A and his wife for 3 years. Initially, Mr A's health history and the CM role was discussed, including ways of working together to promote wellbeing and reduce the number of hospital admissions, of which he had four in the past 2 years related to COPD.

#### Box 1. Criteria for referral to the community matron (CM) service.

##### *How do I refer to a CM?*

- Via the GP practice at which the patient is registered.
- By contacting the CM directly using a contact sheet for CMs.

If you are unsure if a patient is appropriate for the service, please do contact us to discuss potential referrals. The final decision about the suitability of a patient rests with the CM. Where necessary, the referral will be discussed with GP mentor or CM lead team.

##### *Which people need a CM?*

The service is predominantly for older people (over 60 years); however, any adult that meets the criteria below can be referred.

For referral, people need to meet one or more of the following criteria:

- At high risk of an admission that could be prevented in the next 3 months. This may be related to a recent exacerbation or decompensation of chronic illness.
- Recent unplanned hospital admission.
- Complex health and social care needs.
- Frequent use of intermediate care services (e.g. rapid response, safe haven).
- Frequent use of accident and emergency and out-of-hours services.

People are also identified through Patient At Risk of Re-hospitalisation data and the Dr Foster (2009) Intelligence tool.

Other factors that may influence your decision to refer include: falls, polypharmacy, cognitive impairment, carer strain, bereavement and people who would benefit from a case management approach to meet their complex needs to prevent avoidable hospital admissions.

If the individual is not appropriate for the CM service, the CM may be able to signpost to other community services, where appropriate.

Over the next few weeks Mr A and the CM worked together to produce an individualised self-management plan. Quality of life was the main focus of the plan rather than strict HbA<sub>1c</sub> control. The key aim was to reduce hypoglycaemic episodes. The management plan also focused on what Mr A should do if he felt his COPD was worsening and specific criteria for when steroids and antibiotics would be used.

It became clear during discussions that every time Mr A was treated with steroids he found his diabetes very difficult to control, experiencing regular hyperglycaemic episodes, especially in the early afternoon. Steroids affect blood glucose levels as they induce a state of relative insulin resistance – most people will not have significantly different fasting blood glucose but postprandial hyperglycaemia is exaggerated (Hillson, 2002). In Mr A's

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situation it was very important to control the episodes of hyperglycaemia, as they impacted on his quality of life in terms of polyuria, tiredness and blurred vision.

Mr A's plan initially consisted of a regimen of monitoring his blood glucose levels – he usually tests twice per week. To allow a detailed assessment during steroid usage, Mr A was asked to check fasting and post-meal glucose levels for 2 days. Review of these results demonstrated a rise in lunch postprandial levels of between 18 and 22 mmols/L. Controlling blood glucose levels will improve osmotic symptoms and reduce the risk of infection and hyperglycaemic emergencies. At this point the need to increase his morning dose to 26 units was discussed, and a review planned for 2 days time.

Two days later, the increase had made little impact on Mr A's lunchtime blood glucose levels; therefore, the advice of the local DSNs was sought. A small dose (4 units) of short-acting insulin was introduced at lunchtime, during the time Mr A was taking steroids (rather than further increasing the morning insulin). If given at lunchtime, the peak action of the insulin will be when postprandial glucose levels are a problem. The lunchtime dose of insulin required Mr A to learn how to use a different injection device. Mr and Mrs A were educated about the new device, which enabled Mr A to differentiate between his two insulins. This item was prescribed and commenced the same day.

Mr A continued to monitor his blood glucose levels more closely for the remaining few days of his steroid treatment and for a few days thereafter as glucose levels generally remain elevated up to 48 hours after discontinuing steroid therapy (Hillson, 2002). The addition of the lunchtime short-acting insulin was useful in reducing hyperglycemia, during this treatment his blood glucose levels returned to 11 mmol/L.

This treatment was added to his self-management plan, discussed with his GP and an updated care plan sent to the out-of-hours GP service to ensure the continuity of care. In the past 3 years, the author had supported Mr and Mrs A through several serious episodes, and during this time, Mr A was

admitted once, (appropriately) to hospital. In this case, the intervention of a CM resulted in a reduction in emergency admissions and improved Mr A's quality of life and self-management of his LTCs.

### Discussion

The CM caring for Mr A demonstrates the advanced clinical role of the CM, their teaching of patients about their long-term conditions and the interplay between the disease processes. Communication and care coordination are evident in aspects and especially in the liaison with specialist services.

CMs are highly trained generalists. As such, it is not possible for them to be experts in all of the chronic diseases. It is important to emphasise that part of the clinical and care coordination element of the CM role is to refer people for specialist opinion. CMs ensure that individuals get the necessary specialist assessments and appropriate management of their chronic conditions.

Following work to identify the training needs of CMs, the aim in Bristol is for all CMs to undertake appropriate chronic disease diplomas alongside their master's modules in clinical examination skills and prescribing. The authors recommend that all CMs undertake appropriate diabetes courses, most commonly the diabetes diploma.

### Conclusion

CMs enjoy the opportunities, challenges and job satisfaction of working in this role. People really value the service and comment on its personalisation. In a recent local patient satisfaction survey, one patient of a CM commented, "the link with other services is good, everything runs smoothly. Liaison between my CM, GP, district nurse and the hospital are good".

What is truly unique about the CM role is the intensive and trusted relationship that develops between the nurse, the individual and those close to them. They are able to work in partnership with people to manage and teach them to manage their long-term conditions holistically. ■