Name of project: Diabetes care in Thanet residential care homes

Project lead: Lisa Ralf, specialist community nurse in diabetes

Kent Community Health NHS Foundation Trust

What was our aim?

To improve knowledge and understanding in diabetes for new Kent Community Health Foundation Trust (KCHFT) community nurses and residential home care colleagues.

To reduce avoidable harm to residents by improving diabetes education for community nurses and residential care home colleagues in regards to blood glucose monitoring, insulin administration, hypoglycaemia and sick day rules.

Increasing competence of care home colleagues will reduce the number of community nursing visits requested by these care homes for insulin administration.

Why is it important to service users and carers?

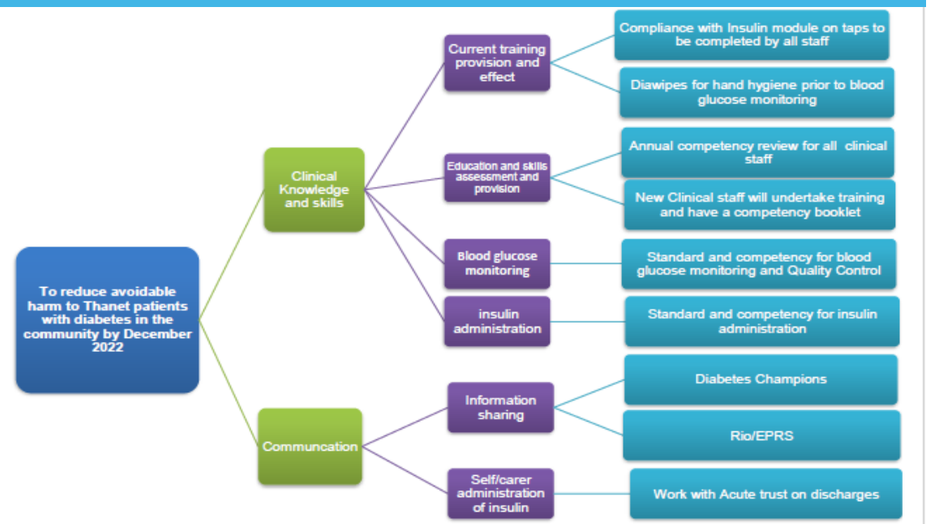
Within the community nursing team there are a number of demands which are impacting on the capacity and workload of existing colleagues and, in turn, decreasing patient facing time in regards to diabetes management and insulin administration. There are additional requirements to support our bank colleagues, who are often less familiar with diabetes management and insulin administration.

Residential care homes do have colleagues with insulin competencies but, at times, do not have enough competent colleagues to cover seven days a week. Therefore, residents can be referred onto the community nurse case load at very short notice for support with diabetes management.

The complexity and volume of patients with diabetes on insulin therapy being referred to the community nurse case load from both primary and secondary care is indeterminate. The unpredictability of the patient's length of stay on the community nurse case load is down to their individual need and requirement and can add pressure to nursing team capacity.

An improved diabetes competency training package both for new community nurses and residential home care colleagues will help to reduce any potential harm to residents by ensuring insulin is given correctly and at the most appropriate time. This will also help to reduce pressures on the existing community nurse team by freeing up capacity for other face-to-face visits.

Ideas and tests of change



The tools we used

Plan, do, study, act (PDSA) cycles were run to test out the change ideas, including training for residential care home colleagues:

Cycle	Plan	Measures	Do	Results	Study	Act
Accumulating information, Data and Knowledge						
1.1	Diabetes specialist nurse to offer training to increase knowledge of care home colleagues within a residential care home. The goal is for the trained colleagues to be competent with blood glucose monitoring and administration of insulin. It will be a 4-hour session with content planned in advance.	Feedback to be requested via paper evaluation form- this will be collected when completing competency sign-off with colleagues. Number of visits for insulin requested by the home pre and post training.	Session was run by the diabetes nurse specialist with 4 care home colleagues attending. Had expected to do a 4-hour session but only 2 hours had been allocated.	'I found the training especially the practical extremely interesting' 'Everything was very good and easy to understand' 'Very useful'	The session went well and all those that attended were positive and felt they had learnt something about diabetes and the management of insulin that they did not know previously.	Adapt- The session will be changed to 3-hours and offered to more of the care home colleagues. Blood monitoring and insulin administration to be signed- off at later date
1.2	The previous training would be offered to more colleagues within a residential care home. The goal is for the trained colleagues to be competent with blood glucose monitoring and administration of insulin. It will be a 3-hour session with content planned in advance.	Feedback to be requested via paper evaluation form- this will be collected when completing competency sign-off with colleagues. Number of visits for insulin requested by the home pre and post training.	A 3-hour session was run by the diabetes nurse specialist with 4 care home colleagues attending.	'Content of slides very easy to follow and very informative. Everything explained in a way that made the carers understand what was being taught.' 'Plenty of opportunity for the carers to interact.' 'The whole experience was very positive' 'Lovely Trainer'	The 3-hour session was adequate to deliver the course and keep the attendees engaged.	Adopt- To implement the 3-hour training sessions with other care home colleagues. Share findings with KCHT colleagues.
Goal						

Improvement

Results/How did we do/Anticipated outcome

Residential homes trained in diabetes competencies and insulin/GLP1 administration	
Residential care home one	
Training and competency sign off	four colleagues
Visits saved weekly for community nurses	10 visits per week
Residential care home two	
Training and competency sign off	three colleagues
Visits saved weekly for community nurses	six visits per week
Reduced community nurse visits for insulin administration by **64 visits every 4 weeks**	

Feedback from KCHFT and residential care home colleagues during the Quality Improvement (QI) project:

- I found the training, especially the practical, extremely interesting
- All very informative and educational
- Good informative session
- Very interesting course
- Content of slides easy to follow and very informative. Everything was explained in a way that made the carers understand what was being taught
- The whole experience was very positive.

What we learned and what's next

We have learned:

- We can reduce demand for insulin administration from residential homes
- We can reduce risk of harm to patients by improving diabetes knowledge of KCHFT new starters and residential care home colleagues
- We can improve patient safety with insulin being administered at correct timings by care home colleagues
- We can improve patient safety through educating colleagues on how to treat hypoglycaemia and hyperglycaemia correctly
- Standard Operating Procedures for quality control of glucometers were in place but not always being followed. This has been addressed within the project,I through training, cascade of information and spot checks.
- Annual reviews of insulin competence would be beneficial for KCHFT and residential home colleagues
- Diabetes training for residential care homes is patchy and there is no consistent model of delivery.

What's next?

- Create Diabetes Champions for community nursing teams
- KCHFT and community partners strategically reviewing diabetes training across Kent
- To continue with current support offered to community nursing teams and residential homes and capture the benefits.

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