GAIN

GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

Diabetes in Care Homes – Are we getting it Right Now?

March 2013

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Foreword

Diabetes is a complex and chronic disease with no cure, which if not effectively managed has a significant impact on a person's quality of life and life expectancy. It is also a progressive disease and one which is not stable; no matter how well managed or controlled the condition does not stay still for anyone. A person's diabetes will change and progress throughout their life time, as they age and respond to the challenges of modern life.

As a result good diabetes management needs to respond to this constant change in order to match the evolving needs of the individual. This is achieved by good self-management skills; access to the full range of healthcare services such GPs, specialist hospital clinics and other members of a multidisciplinary diabetes healthcare team.

There is clear evidence that people living in care homes often have very limited access to the full range of healthcare services which is taken for granted by other people living with diabetes.

This is why establishing clear and robust standards of diabetes in Care Homes and monitoring their delivery is so vitally important for this growing section of our community.

It has been two years since GAIN published its Care Standards for diabetes in Care Homes so this current audit is essential in helping us answer the question 'Are we getting it Right Now?'

The results paint a very mixed picture of how different Care Homes are delivering the standards of care to their residents with diabetes. It is clear that two of the standards are not being met, Standard 1 which requires every resident to be screened for diabetes annually and Standard 4 which requires a resident with diabetes to have access to a named member of staff who is appropriately trained in providing diabetes care. This is a worrying state of affairs given that Care Home staff are likely to be the main providers of diabetes care to people living in Care Homes.

The delivery of Standards 2 and 3 are more positive;

Standard 2 requires evidence of a person's diabetes care being documented in their care plan. This indicates the existence of a record keeping process however does not demonstrate the quality of that care.

Standard 3, which requires every resident to have an annual review of their diabetes in the most appropriate setting, is a record keeping process which does quantify the quality of the review or what action is taken as a result of the review.

These concerns go to the heart of questions about the individuals own experience of living with diabetes in a Care Home and whether they receive the same quality of care which people living in the community would expect to receive. Only when we are confident that this situation has been reached can we be sure that vulnerable people living with diabetes

in Care Homes are being supported to achieve optimal health outcomes which enhance their quality of life and dignity.

As someone who witnessed their own grandmother live with diabetes and spend some time in a Care Home setting, I can say from first-hand experience, we still have a lot more work to do. But there is no doubt that the GAIN Standards and Guidance is a major step forward which if supported and monitored will help deliver the kind of quality care which everyone wants to see implemented in Care Homes.

The honesty and bravery of this first audit is very encouraging and I look forward to seeing the evidence it contains being acted upon. If this happens I am sure the second audit report will show further progress with this difficult and challenging area of work.

Iain Foster

National Director

Diabetes UK (NI)

Introduction

More than a quarter (27 per cent) of all care home residents in the United Kingdom [1] are estimated to have either type 1 or type 2 diabetes mellitus with many of these being undetected. The first-ever care home diabetes audit in Northern Ireland aims to examine current diabetes procedures and practices being delivered in care home settings. It is know that diabetes is likely to double the risk of admission to a care home [2]. Residents with diabetes have an increased risk of hospital re-admission [3], developing a disability [4] and also of developing pressure sores [5]. A study in 2005 of diabetes prevalence found the highest rates of undiagnosed diabetes in EMI residential care homes [6].

When you consider that more people are living in care homes and estimates for the UK and that the current population of 450,000 will increase to 1,130,000 in the next 50 years; the associated health and social cost of providing care escalating from £13 billion to £55 billion by the year 2051 [7].

The "ground-breaking" initiative is being led by GAIN, and comes after a recent pilot training scheme revealed variations in access to diabetes education and training for care home staff. It also found evidence of inconsistent documentation, including specific policies for management of the disease.

The primary purposes of this audit are firstly, to ascertain what areas of diabetes care within care home settings can be further supported and secondly, to gain better insight into the difficulties of providing enhanced care.

It has the potential to improve the standard of care received by residents with diabetes, and provide insight on how to provide staff with the training and support that they need, as well as assisting managers and policymakers to allocate resources.

This audit has the capacity to improve care for older people with diabetes living in care homes in Northern Ireland, and give insight on how to provide staff with the training and support that they need, as well as assisting managers and policymakers to allocate resources.

Background

Diabetes UK Northern Ireland has warned of the continuing increase of diabetes here as figures revealed the number of people living with Type 1 and Type 2 diabetes has increased by 33% in Northern Ireland during the last five years. The total number of adults with diabetes aged 17 and over registered with GPs here is 75,837. There are also an estimated 10,000 people who may also have diabetes but have not yet been diagnosed.[8]

The Guidelines and Clinical Standards of Care for People with Diabetes in Care Homes have been in place since 2009 (GAIN, 2010). GAIN guidelines had been developed to ensure that this group of people had access to screening for diabetes and received high quality care and education, in line with the national recommendations and standards of care for diabetes (GAIN, 2010). The aim was to reduce the risks of them developing complications and to optimise their quality of their lives. It is felt two years has allowed sufficient time for care homes to put all relevant processes in place to comply with the standards as set.

The latest review on long-term funding for older people [9] reported that although healthy life expectancy is increasing, there will be an even faster growth of older people with chronic conditions requiring health care support. Unless the health and social care system changes, it will not only fail to cope with the current needs of older people but it will also be overwhelmed by increased morbidity and associated costs. It has been stressed that older people, are more at risk of receiving inadequate care because of the presence of organisational schisms [10]. The risk of developing diabetes increases with age. Less than 1% of 16-24 year olds have been diagnosed with diabetes in comparison with 8% of those over 75 [11].

Important research highlights that NI will face a chronic disease epidemic over the next fifteen years and presents the key challenges faced by the Northern Irish health and social care system [12]. They reported that the population prevalence of the four conditions studied (hypertension, angina/heart attack, stroke and diabetes) result in poorer quality of life for many people in NI.

Aim

The aim of the audit is to examine and review current practice in line with the specific GAIN diabetes standards, identify aspects of good practice and areas for improvement to ensure that those people in care homes receive high quality care.

Objectives

The objective is to identify the percentage of-

- Care homes who have implemented the GAIN standards.

- For those care homes who have implemented the standards identify their compliance with each of the standards as follows:

Standard 1 Each adult resident in a care home will be screened annually for diabetes. When an annual health check takes place, a fasting blood sample will be checked for glucose using an accredited laboratory method. Blood glucose concentration or any other abnormality will be reported to the General Practitioner and documented in the resident's care plan.

Standard 2 Each Resident with diabetes will have their diabetes care documented in their care plan. When possible each resident (or relative) should be involved in developing their diabetes care plan. The diabetes care plan will be written by a registered nurse. This may be a practice nurse or community nurse if there is not a registered nurse working in the care home. Diabetes care will be evaluated at least annually (at the annual review) and more frequently if necessary.

• Diabetes care plans should include:
• Name and telephone number of General Practitioner
• Name and telephone number of the trained member of staff for contact
• Name of advising community pharmacist
• A full list of medications, doses and times taken
• Frequency of review of diabetes (minimum annual)
• Where review will take place and transport arrangements where necessary
• A detailed list of diabetes related complications and treatments including foot and pressure damage risk assessments, so that potential risks are identified
• Agreed metabolic targets (blood glucose, blood pressure and cholesterol)
• Frequency and method of monitoring

• Details of diet plan

• Frequency of foot checks and care required and referral to appropriate practitioner where indicated

• Injection site care if on insulin

Registered nurses will use a problem-orientated approach. This will identify potential and actual diabetes related problems; state the goal of care for each problem and the plans to achieve these goals. Community nurses will document their assessment, plan and evaluations on their Trust's healthcare record sheets. Nurses working in Care homes will use their Home's documentation record sheets. To ensure continuity of care community nurses and care home staff must read each other's records and communicate all changes to each other verbally.

Standard 3 Each Resident with diabetes will have an annual review of their diabetes in the most appropriate setting. The review will take place at the GP's surgery or if this is not possible, in the care home. Some patients will attend a hospital diabetes clinic. The frequency of this review and where it will take place will be documented in the care plan. Transport plans should be included when necessary. Local optometrists may, in special cases, visit homes to provide eye screening.

Standard 4 Each resident with diabetes will have access to a named member of staff appropriately trained in the care of people with diabetes. Training should include:

- Classification and diagnosis of diabetes (including screening)
- Long-term complications and prevention
- Annual review
- Blood glucose monitoring and use of blood glucose meters
- Foot care
- Hypoglycaemia – recognition, prevention and treatment
- Hyperglycaemia – recognition, prevention and treatment
- Oral hypoglycaemic medication
- Insulin therapy
- How to test urine and interpret results
- Quality and risk management issues in diabetes care
- Cultural and ethical issues involved in diabetes care
- Nutritional issues

- Care in inter-current illness
- Roles and responsibilities in diabetes care
- Role of Diabetes UK and voluntary bodies
- Training and education sessions should be provided by healthcare professionals trained in diabetes care.
- Education and training should be available for nurses and health care staff, including chefs and cooks.
- Staff should attend update sessions every 3 years.

Audit Methodology

In order to conduct the audit, all care homes across the five Northern Ireland Health and Social Care trusts were approached in order to attain some basic information regarding the number of persons with diabetes being cared for in a care home setting. This information was used to ascertain which homes were willing to participate in the audit with the primary aim of registering the total number of case notes which were available to be looked at as part of the study. In order to meet the objectives of the audit a manager's questionnaire and case note review was carried out. The manager's questionnaire was used to assess if residents were screened annually for diabetes and to determine if appropriate staff training was being delivered in the care home setting. The case note review was used to determine if residents had their diabetes care documented in a diabetes care plan and if an annual review had been carried out in the most appropriate setting. This audit examined anonymous data and any reports that arise will not identify specific care homes. A summary of the key findings will be available to participants.

Settings for audit

The various care home settings are defined as:

- Private Nursing home- A home registered for nursing will provide personal care (help with washing, dressing and giving medication), and will also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks
- EMI stands for Elderly Mentally Infirm and is used to signify a home that is suitable for people with dementia or other mental illnesses
- Statutory EMI –as above but provided by the HSC trust
- Dual registered- is a home that is registered for people who meet the criteria for Private Nursing home and for EMI homes.

Data Collection Method

An initial questionnaire was sent out to all care homes throughout Northern Ireland (Appendix 1). This identified the number of homes willing to take part in the study. From this a sample of care homes were identified to take part. Two data collection tools were designed to capture the required information to meet the objectives of the study. Firstly a case note review was undertaken to capture information which was/should be recorded within the participating patient records (Appendix 2). Secondly a Managers interview survey was designed to gather related information which could not be identified within the case notes (Appendix 3).

These questionnaires were tested within a sample by experienced research staff. Data was collected between Wednesday 30 June 2012 and Friday 19 October 2012.

Patient Selection

Case Note Review: The auditors completed case note reviews from all the resident care plans available on the day of the visit. No patient identifiable information was recorded in the conduct of the case note review. Participants were designed unique identification numbers.

Managers Interview Survey: A managers survey was completed within the care homes were residents with diabetes were identified and were a case note review had been carried out. Again a unique identification number was used to ensure confidentiality.

Data Management

Data was collecting manually and entered into a Microsoft Access 2010 database. To ensure consistency each auditor had undergone training in the use of the data collection tools. Robustness of data entry was tested using double blind entry techniques. Data cleansing occurred with the help of an expert in this field.

Results

For ease of interpretation the findings will be presented primarily as results obtained from the case note review/ Managers interview survey. Data will be presented broken down into trust level and will be linked back to the standard being measured against.

The initial questionnaire was sent to 497 care homes across Northern Ireland. A total of 261 (53%) care homes accounting for 8055 residents completed and returned the questionnaire. From this 1369 were identified as having diabetes equating to 17%. This equates to 17% of residents living in a care home setting presenting with diabetes. Table 1 below shows the types of diabetes each resident presented with.

Table 1: Types of diabetes treatments in care homes

Type of diabetic residents	Number
Number of diabetes residents on diet control only	404
Number of diabetes residents on diet control plus tablet	653
Number of diabetes residents on diet control plus insulin	205
Number of diabetes residents on diet control plus table plus insulin	107

From the 261 care homes a sample of 184 homes were selected. From this 915 case note reviews were carried out across the five Health and Social Care Trust.

Table 2: Total number of case notes audited across each HSC area

Health And Social Care Trust	Number of Case Note Reviews Carried out
Belfast HSCT (BHSCT)	184
Northern HSCT (NSHCT)	239
South Eastern HSCT (SEHSCT)	154
Southern HSCTN (SHSCT)	144
Western HSCT (WHSCT)	194
Grand Total	915

A total of 60% (109) of all data collected for the purpose of the audit was obtained from private nursing homes. 17% (32) of all residents were residing in a private residential home.

10% (n=19) of care home held statutory residential registration, while a further 9% (n=14) of care homes held dual registration. Other care homes accounted for 2% (n=4) of the total figures. The remaining 2% of results were attained from case notes in private Elderly Medical Infirm (EMI) (n=2), statutory EMI (n=1) and Private Nursing homes (n=1).

Figure 1: Numbers of care homes by HSC Trust area

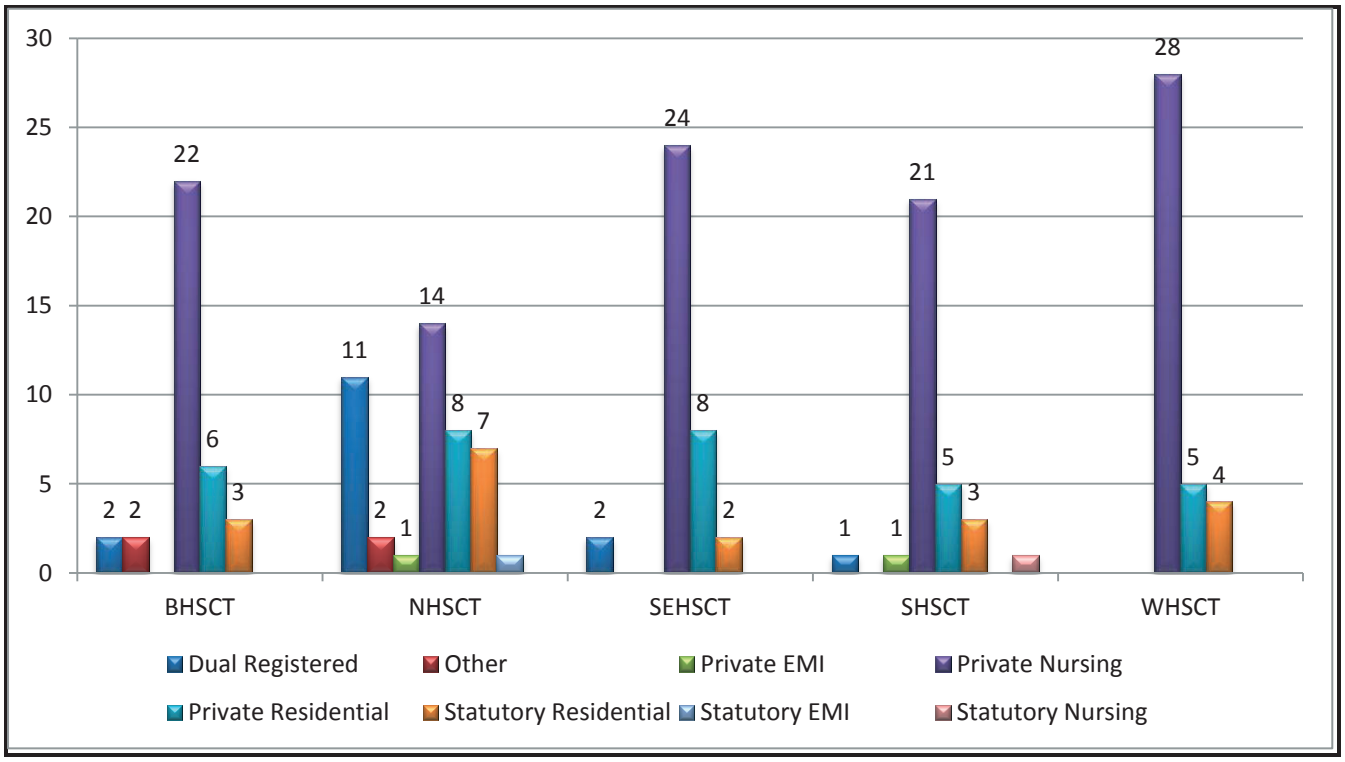
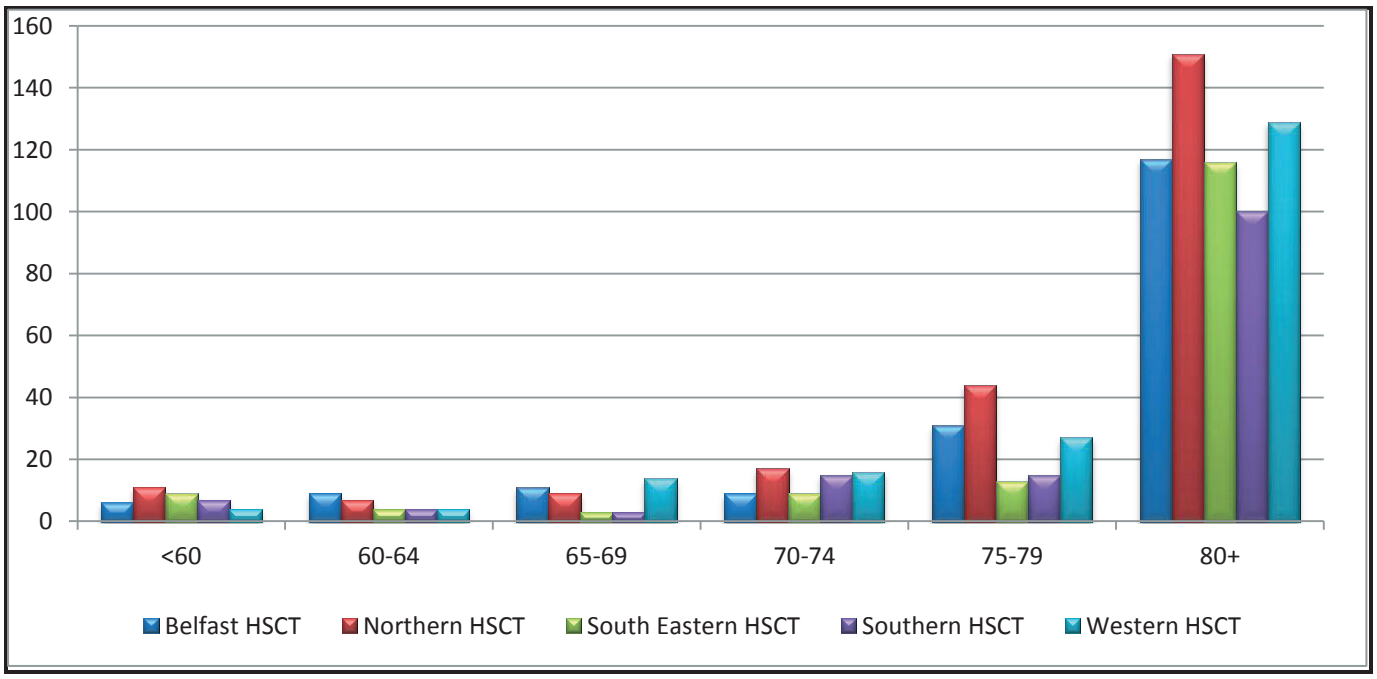


Figure 2: Number of residents broken down by age and HSC Trust area



The most common age group, accounting for 67% (614 out of 915) of all residents, was the 80+ category, 14% (130) were 75 – 79 years of age, 7% (66) were 70 – 74 years of age, 5% (40) were 65 – 69 years of age, 4% (37) were under 60 years of age and 3% (28) were 60 – 64 years of age.

Figure 3: Number of residents broken down by age and care home setting

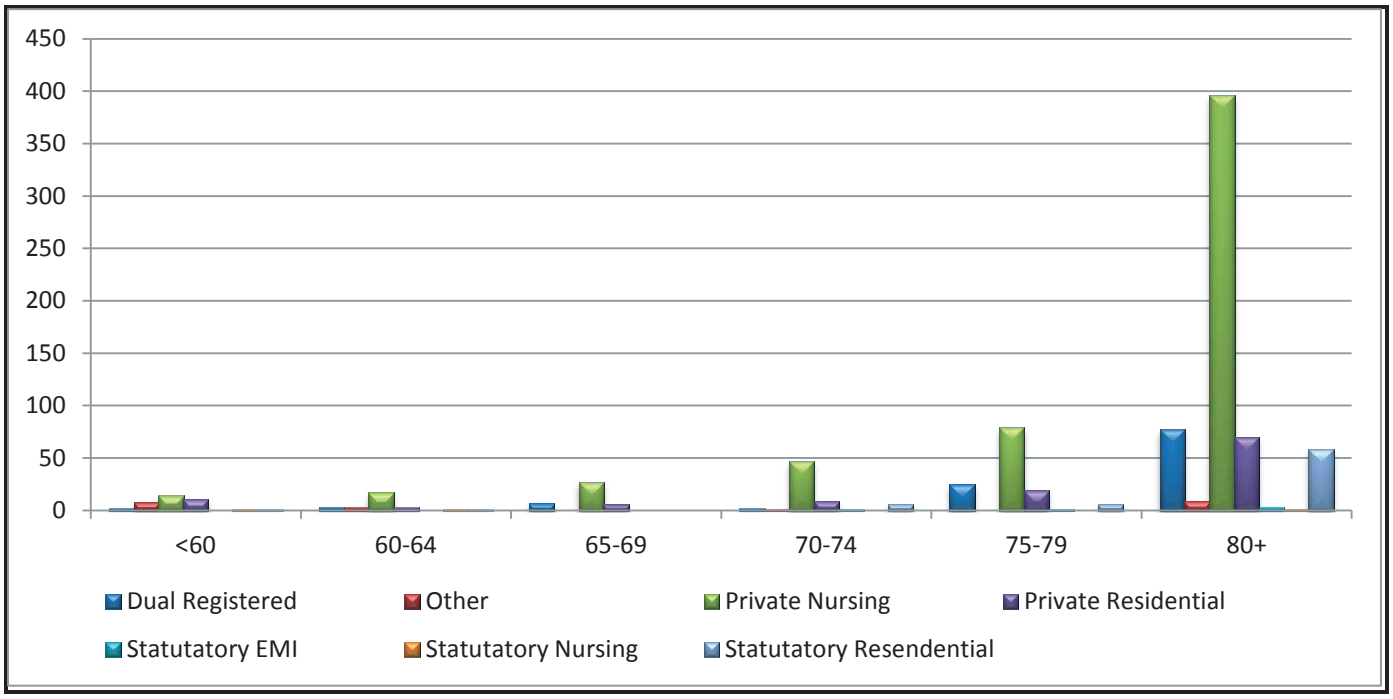
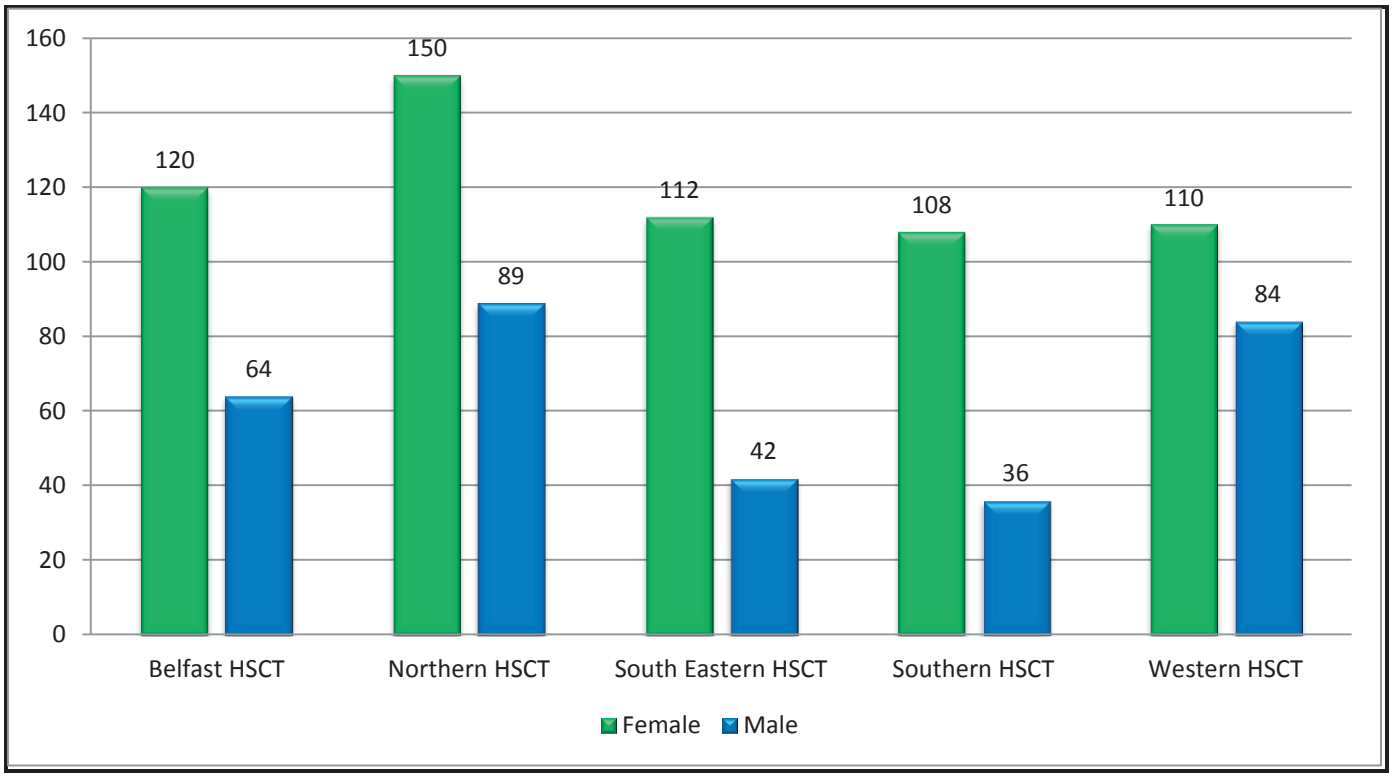
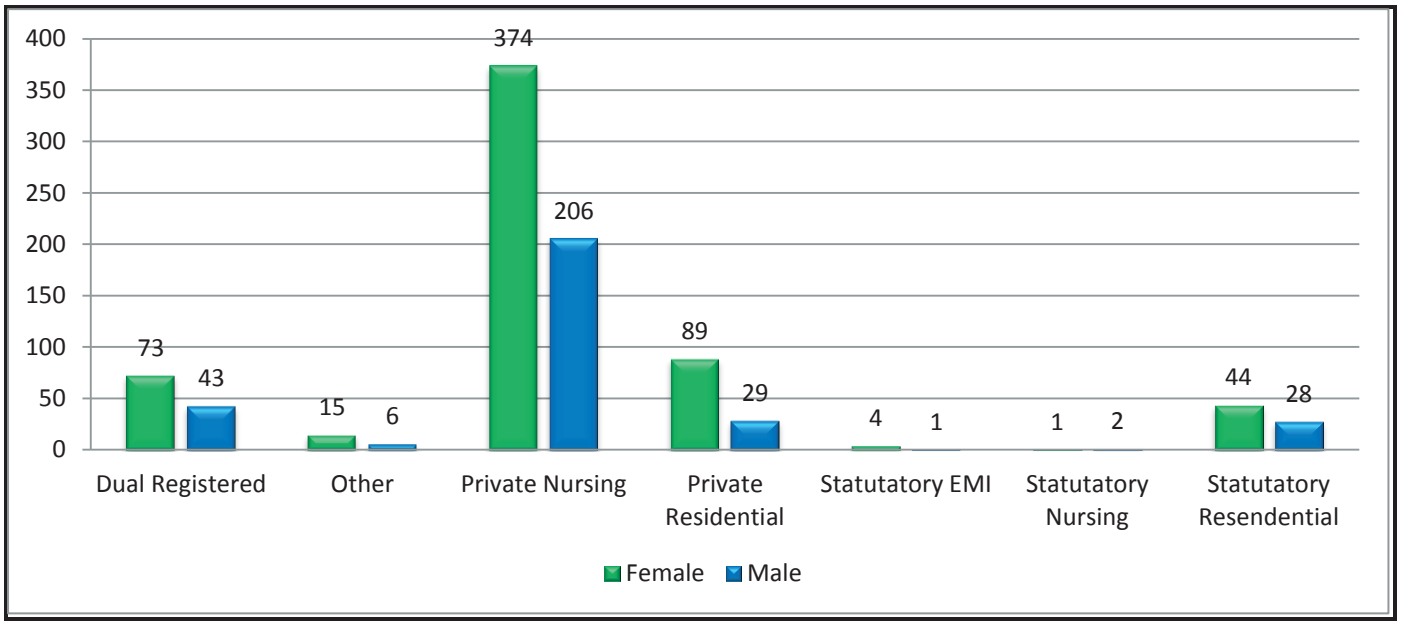


Figure 4: Number of residents by gender and HSC Trust area



A total of 66% (n=600) of all residents reviewed during the process of the audit were female with the remaining 34% (n=315) classified as male. There were more females in all trust areas compared to male residents in the sample audited. This finding was comparable across all different types of care home settings.

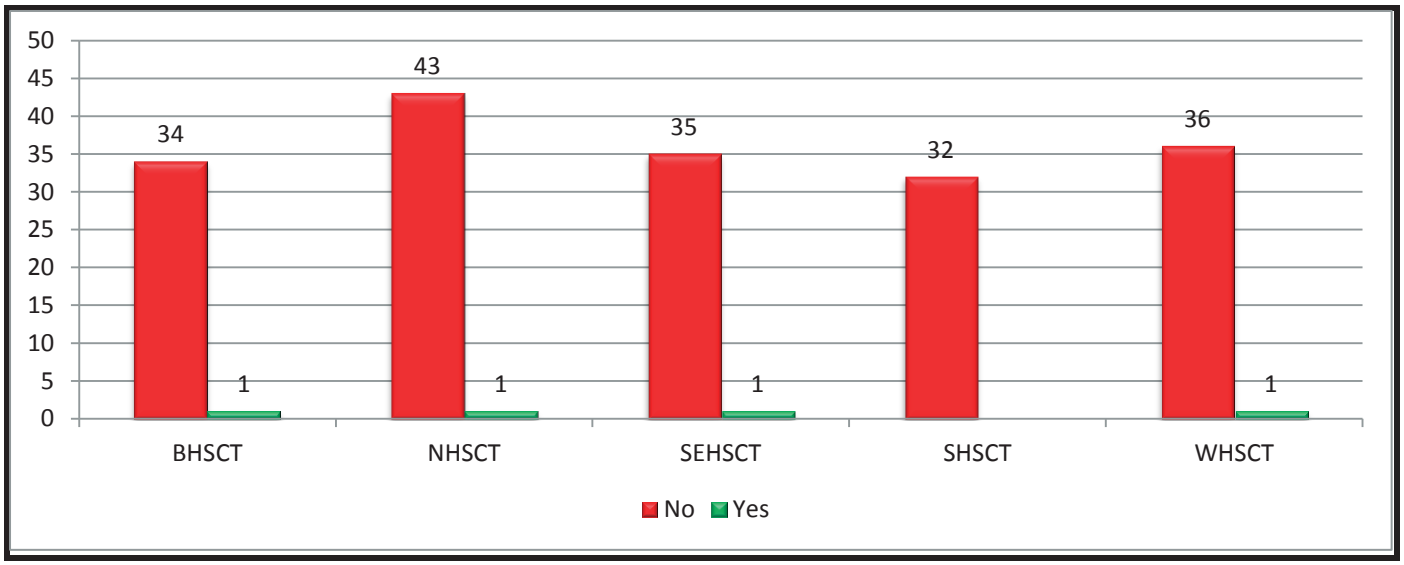
Figure 5: Number of residents by gender and care home setting



Test Standard 1: Each adult resident in a care home will be screened annually for diabetes

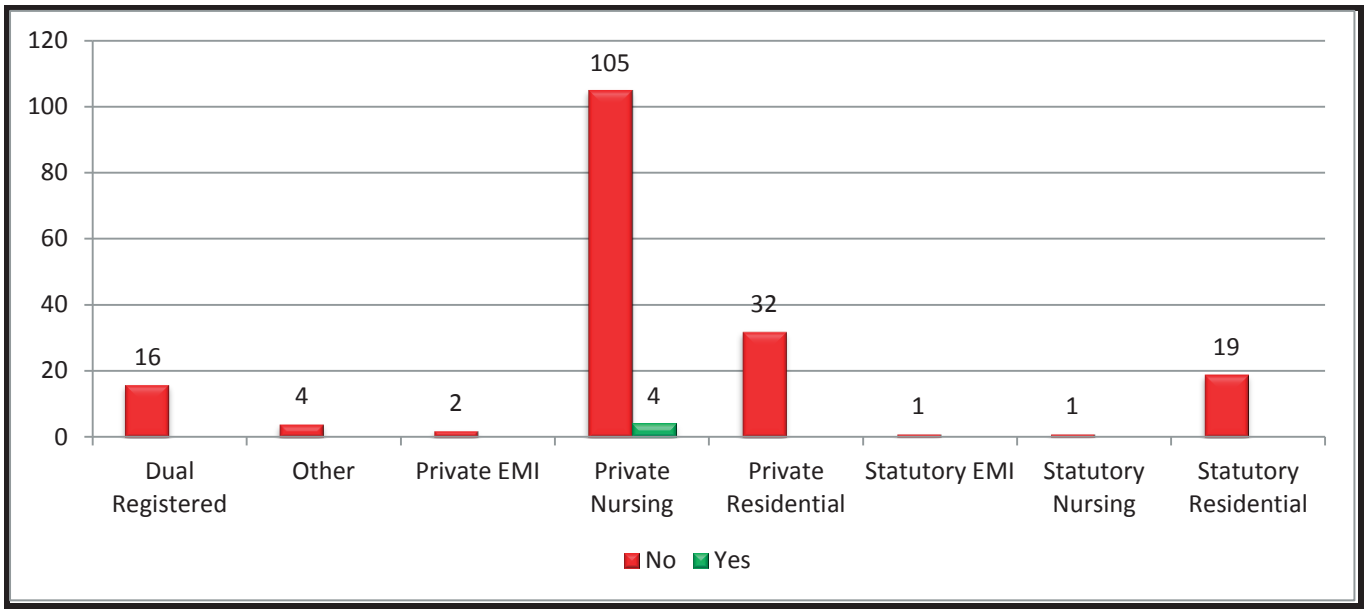
The following analysis describes the findings against Standard 1. Figure 6 shows that only 2% (4 out of 184) of care homes audited provided sufficient evidence to suggest that all residents had access to annual screening for diabetes. This equated to only one home in each of 4 HSC trust areas.

Figure 6: Number of care homes who screen all residents for diabetes by Trust



A total of 98% of care homes reviewed did not screen all residents annually as set out in Standard One of Gain Guidelines (2010). Figure 7 demonstrates that all 4 homes were Private Nursing Homes.

Figure 7: Number of care homes who screen all residents for diabetes by care home setting



Test Standard 2: Each Resident with diabetes will have their diabetes care documented in their care plan

The following analysis describes the findings against Standard 2. During the course of the study it was found that 80% (n=732) of all people with diabetes had been involved in developing their own diabetes care plan. The remaining 20% (n=183) had little or no involvement. This may have been due to physical or mental health issues and was most notably witnessed amongst those suffering with dementia. The largest percentage of people who were not involved in developing their care plans were found in the Northern Trust area.

Figure 8: Numbers of residents involved in developing their own care plan by HSC Trust area

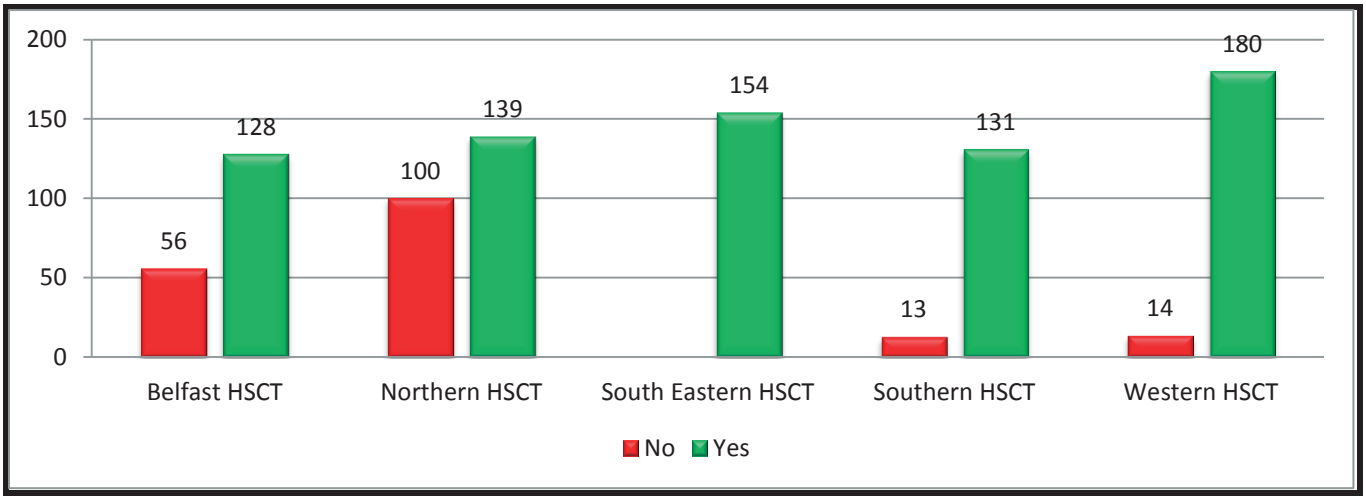


Figure 9 shows that when the type of care home was considered 52% (60/116) of residents in dual registered homes of all people with diabetes had been involved in developing their own diabetes care plan.

Figure 9: Numbers of residents involved in developing their own care plan by care home setting

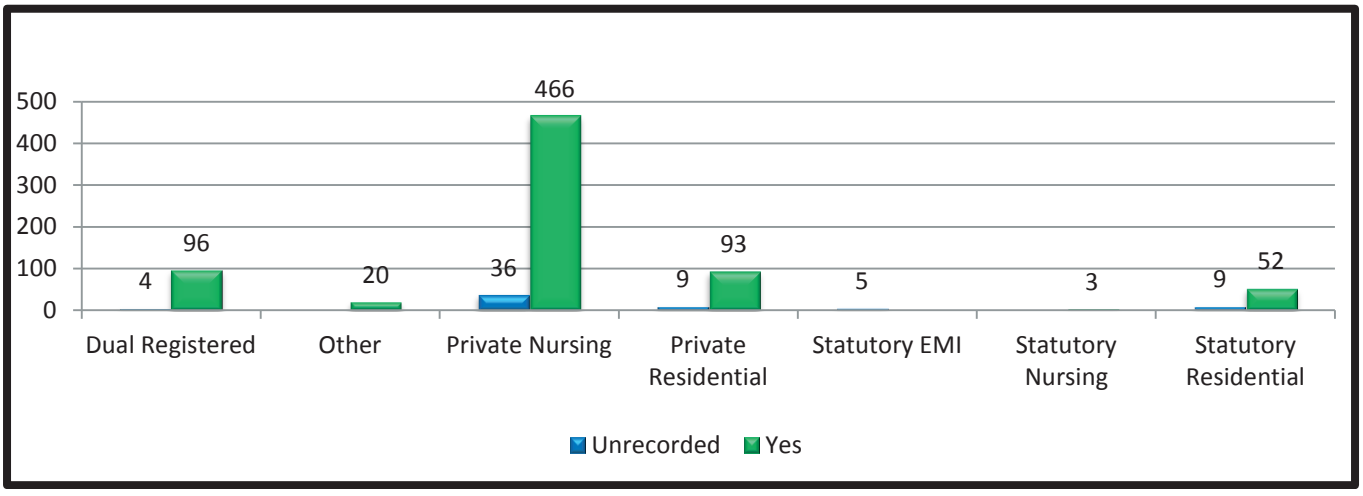
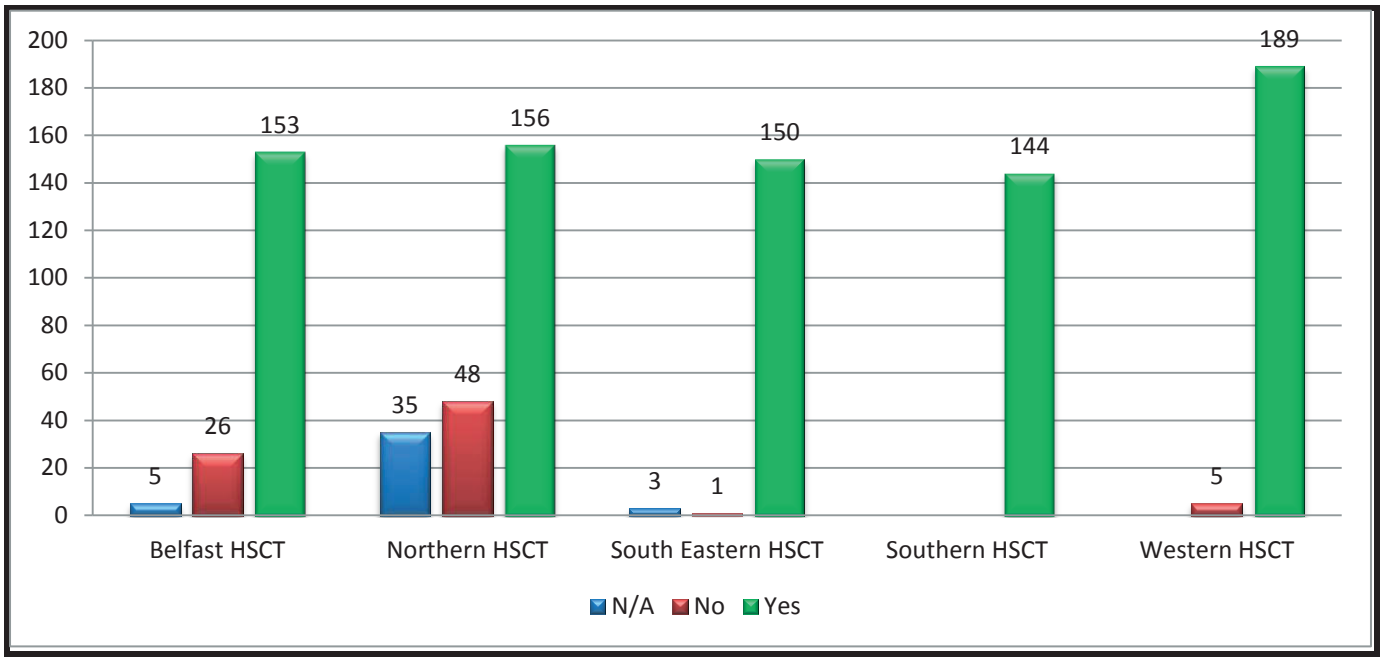


Figure 10: Numbers of relatives involved in developing the residents care plan by HSC Trust area



A total of 87% (n=792) of all care plans reviewed during the process showed evidence of a relative's involvement while 9% of residents (n=80) where found to have had no involvement. A further 4% (n=43) were reported as being not appropriate. This would have been the case if the resident had no relatives.

Figure 11: Numbers of relatives involved in developing the residents care plan by care home setting

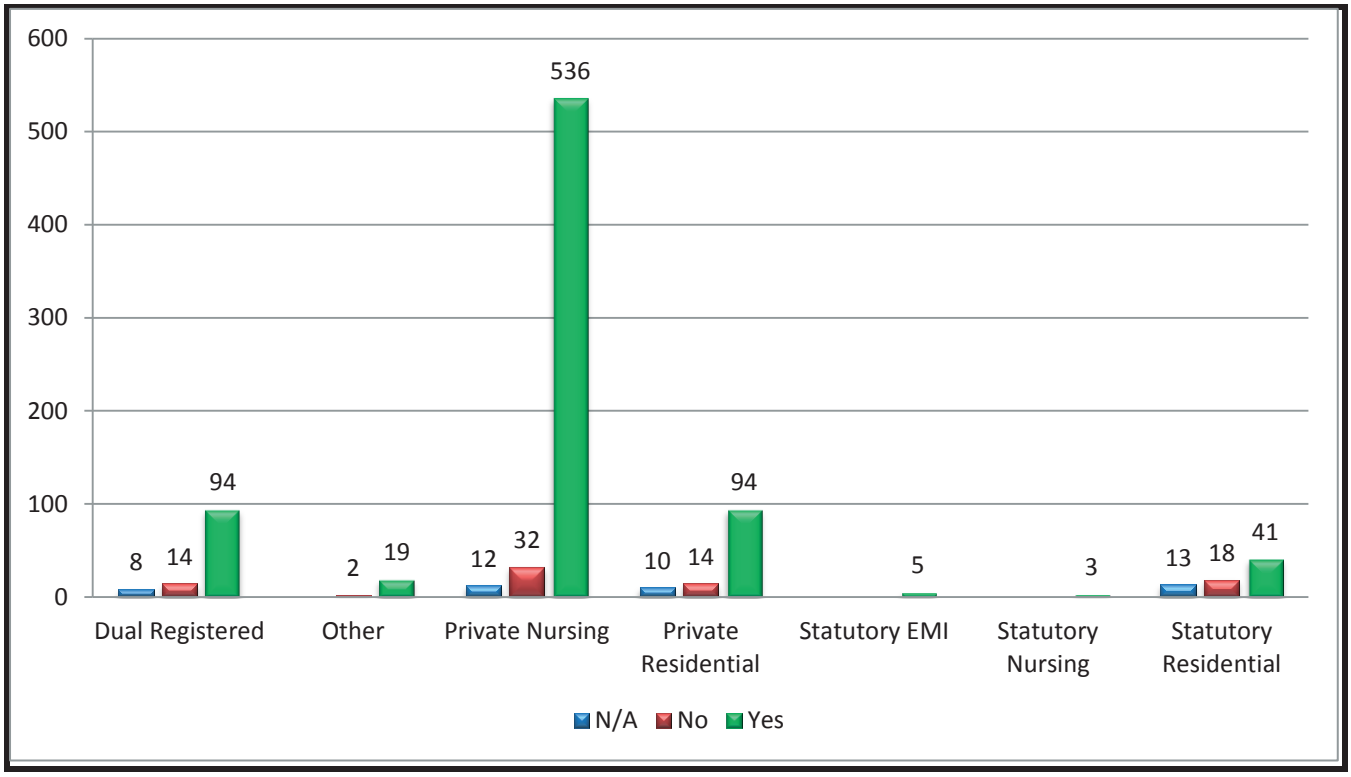
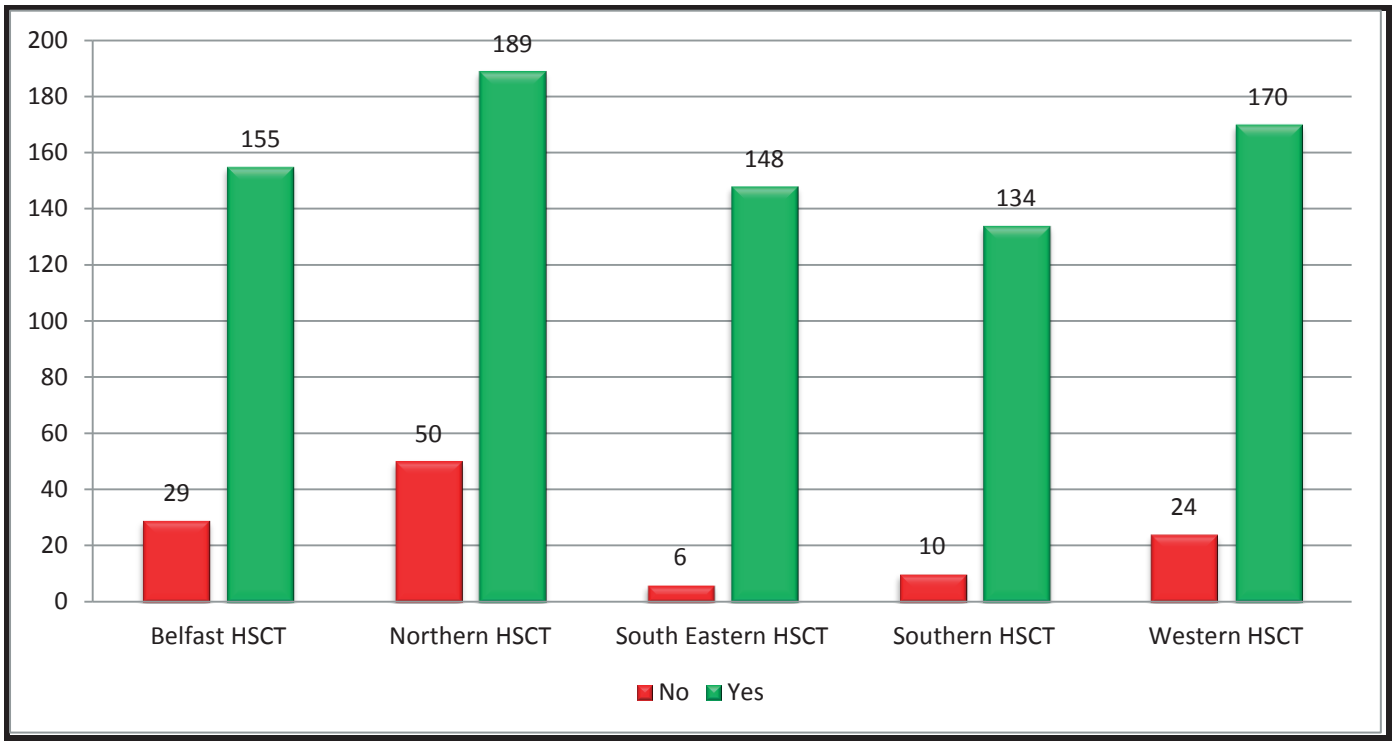


Figure 12: Numbers of residents who have had their diabetes care plan written by a registered nurse by HSC Trust area



It was established that 87% (n=796) of all residents had their care plans written by a registered nurse. The remaining 13% (n=119) of residents had their care plan written by someone other than a registered nurse.

Figure 13: Numbers of Residents who have had their diabetes care plan written by a registered nurse by care home setting

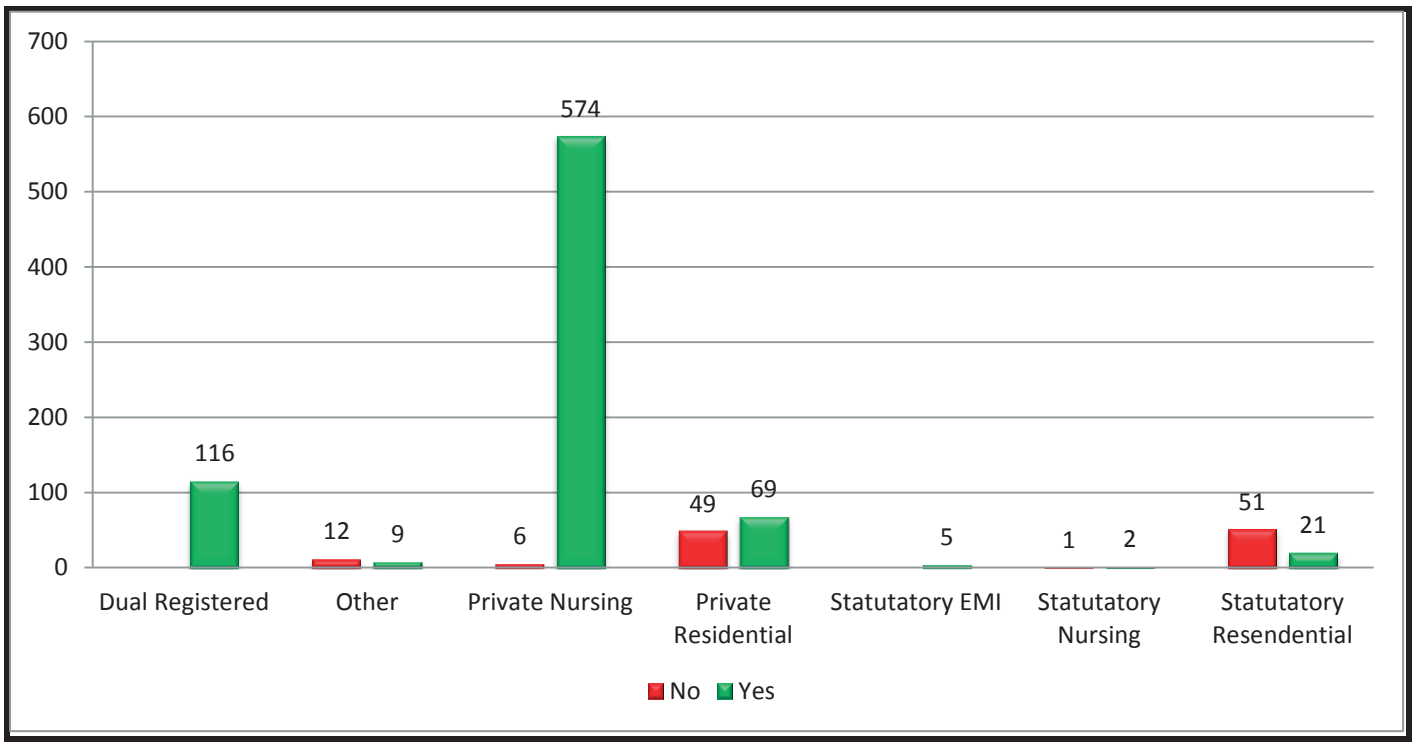


Table 3: Number of care plans written by registered nurses by HSC Trust area

	Nurse in Care Home	Community Nurse	Practice Nurse	Senior Care Assistant (With Diabetes Training)	Total
BHSCT	85	64	6	0	155
NHSCT	172	3	1	13	189
SEHSCT	72	72	4	0	148
SHSCT	114	8	12	0	134
WHSCT	170	0	0	0	170
Total	613	147	23	13	796

The study highlighted that 77% (613/796) of all diabetes care plans were found to have been written by a nurse within the care home setting. A total of 18% (147/796) of all care plans reviewed were written by a Community Nurse. Practice nurses accounted for 3% (23/796) of written care plans while senior care assistants with diabetes training had generated 2% (n=13) of all written care plans.

66% (n=79) of 119 (n=13%) total care plans not written by a registered nurse were found to have been produced by Senior Care Staff. A total of 34% (n=40) of care plans had no evidence to suggest who the care plan had been written by.

Table 4 on the next page clearly shows the breakdown of the information that was found in the residents care plans across the HSC Trust areas. It is important to note that the injection sites of insulin figures are low due to the low number of residents receiving insulin injections.

Table 4: Details of information contained in residents care plans by HSC Trust area

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Grand Total
Name & Phone No of GP	184	239	154	144	192	913
Name & Phone No of Trained Member of Staff	182	223	153	144	189	891
Name of Advising Community Pharmacist	127	230	98	125	184	764
List of Medication, doses and times taken	182	238	150	144	187	901
Where review will take place and transport arrangements	178	202	148	134	182	844
Detailed list of of Diabetes related Complication	90	234	25	83	90	522
Agreed Metabolic Targets	117	19	151	114	158	559
Frequency and method of monitoring	180	235	153	133	176	877
Details of Diet Plan	173	238	150	124	151	836
Frequency of Foot Checks	108	210	120	135	186	759
Injection site if on Insulin	34	48	31	25	23	161

Name & Number of G.P

Almost 100% (n=913) of all case notes reviewed during the study contained the name and contact number of the residents general practitioner.

Name & Phone number of trained member of staff

A total of 97% (n=891) of all care plans reviewed appropriately documented the name and contact number of the trained member of staff in charge of the residents care in line with GAIN (2010) Guidelines.

Name of Advising Community Pharmacist

The name of the advising community pharmacist was documented in 83% (n=764) of all care plans.17% (n=151) of all case notes were found to be missing this information.

List of Medication, doses and times taken

The study found that 98% (n=901) of all resident case notes contained an appropriate medication list which detailed doses and times taken.

Where review will take place and transport arrangements made.

A total of 92% (n=844) of all case notes had documentation to verify the location of where the review would take place and how the resident was to get there. This information was missing from 8% (n=71) of all care plans audited.

Detailed list of diabetes related complications

Results from the study show that only 57% (n=522) of case notes reviewed during the process of the audit had detailed information relating specifically to any diabetes complications which may arise for the resident. Only 43% (n=393) of case notes were found to lack the necessary information needed.

Agreed metabolic targets

A total of 61% (n=559) of all care plans reviewed held information stating agreed metabolic targets on residents. Only 39% (n=356) of case notes reviewed lacked any substantial information and it was therefore deemed missing.

Frequency and method of monitoring blood glucose levels

Information detailing the frequency and methods used to record and monitor residents blood glucose levels where clearly noted in 96% (n=877) of all residents care plans. Only 4% (41) of all care plans were lacking the necessary information required.

Details of diet plan

A total of 92% (n=836) of all residents' care plans had a detailed section outlining their specific requirements relating to diet. Only 8% (n=79) of all care plans were found to be missing this information.

Frequency of foot checks

A total of 83% (759) of all care plans were found to contain information recording the frequency and other information relating to foot checks carried out. Only 17% (n=156) of all care plans were found to be missing this information.

Injection site if on insulin

A total of 18% (n=161) of all care plans included an appropriate site map which charted the location of each injection site. Documentation detailing information on injection sites was missing from 82% (n=825) of all care plans. It must be noted that only residents who were insulin requiring will need/have this information recorded.

Test Standard 3: Each Resident with diabetes will have an annual review of their diabetes in the most appropriate setting

Figure 14 illustrates that 98% (n=897) of residents who had a review date to examine their diabetes at least once annually. A total of 18 residents (2%) did not have a review date set or the necessary evidence was unrecorded. The NHSCT area (3% of total residents) and SEHSCT area (3% of total residents) contributed to the highest number of residents not having their annual review date set or recorded in their care plan.

Figure 14: Numbers of residents who have had a review date set for their diabetes care plan by HSC Trust area

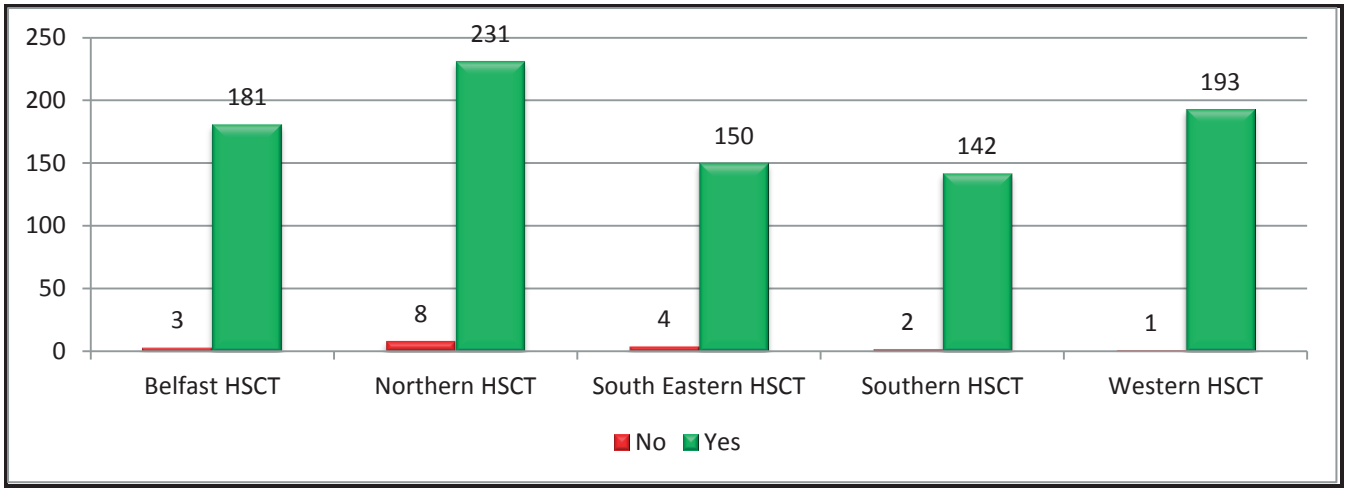
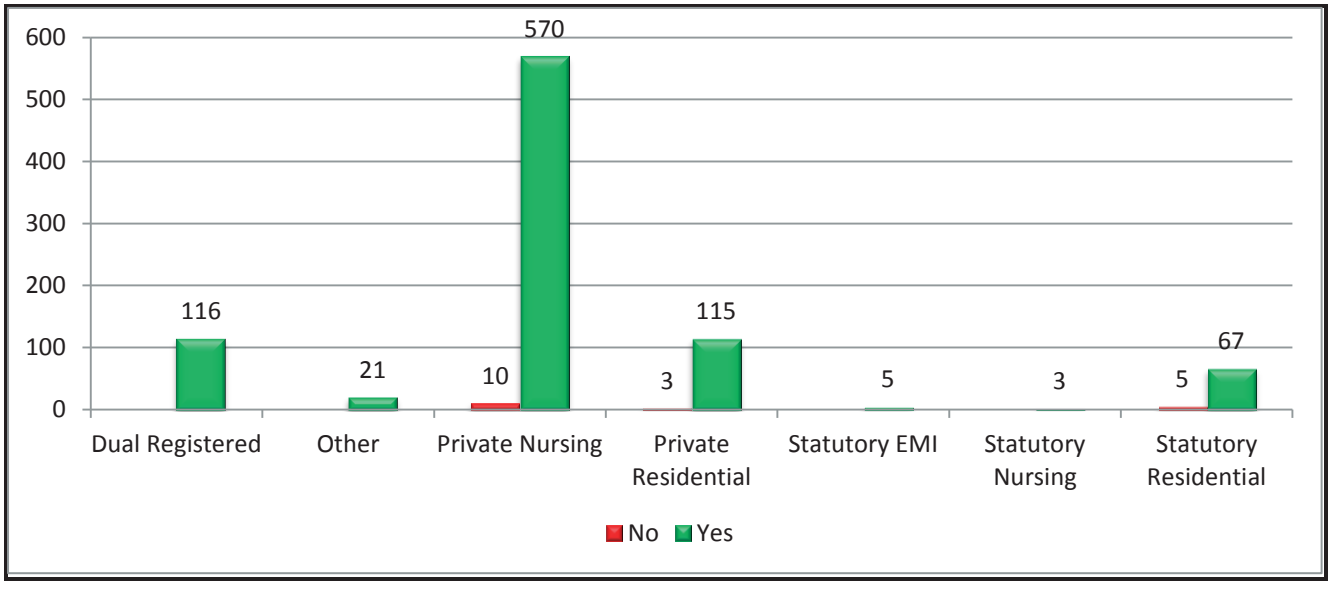


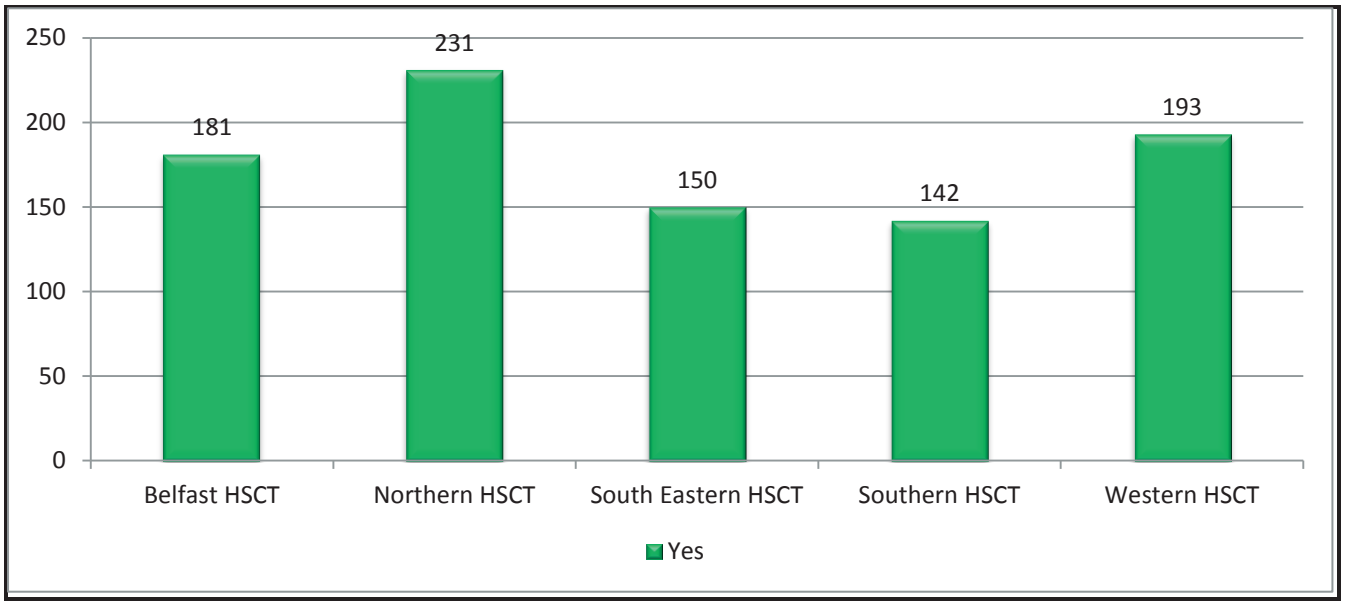
Figure 15 demonstrates that these residents were from private nursing home (equating to 2% of total residents) or statutory residential home settings (equating to 7% of total residents).

Figure 15: Numbers of residents who have had a review date set for their diabetes care plan by care home setting



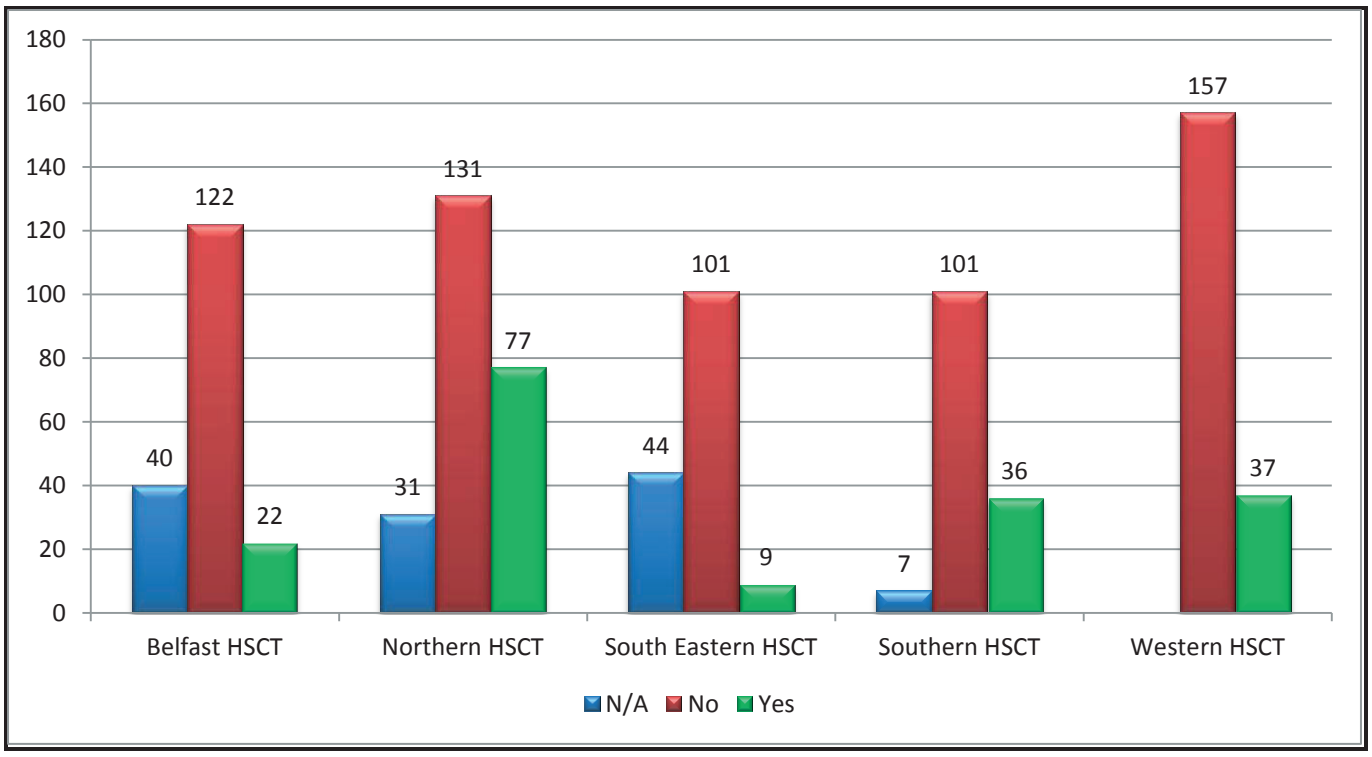
It was found that 100% of all residents (n=897) who had a review date set out in their diabetes care plan were due to be reviewed annually or more frequently that an annual appointment.

Figure 16: Numbers of residents with a review date set annually or more frequently by HSC Trust area



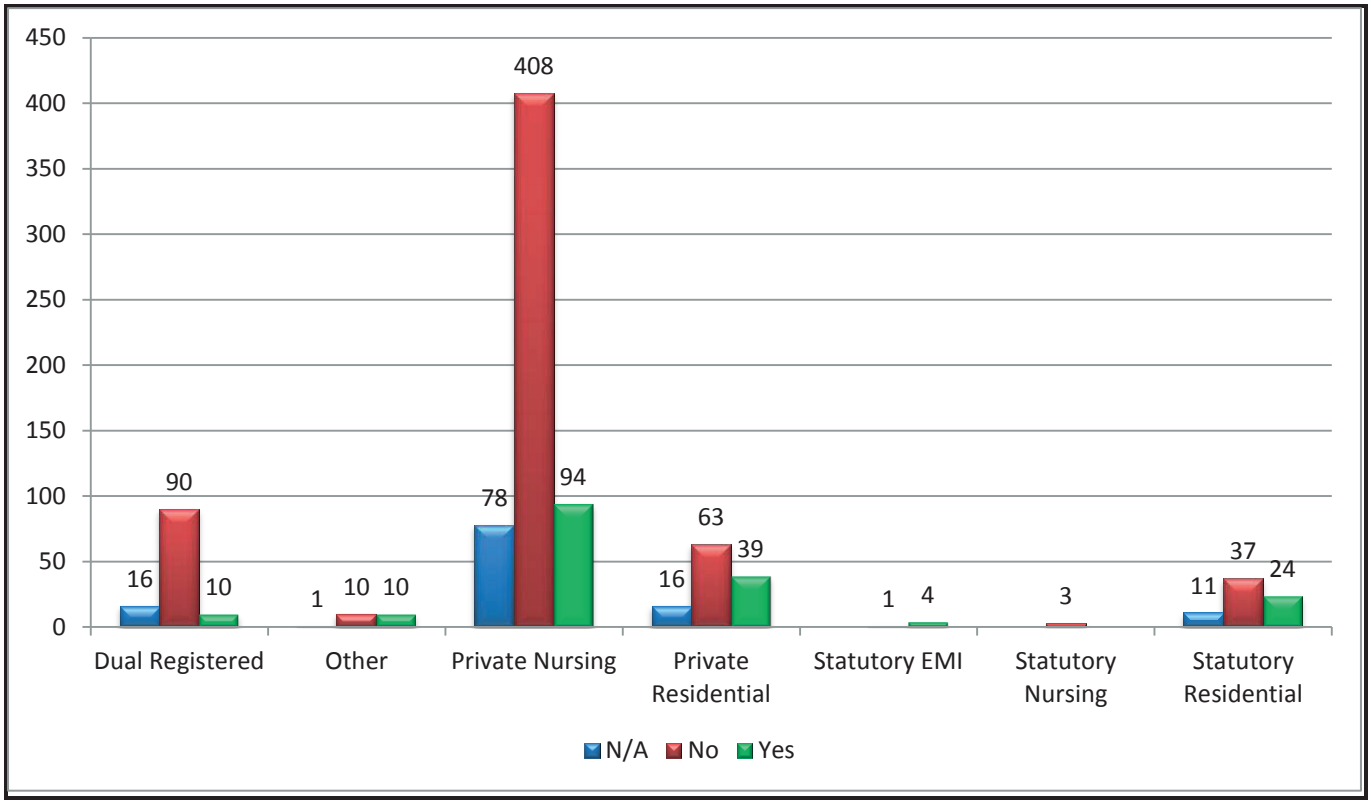
A total of 20% (181/793) of the residents who had an annual review of their diabetes completed were found to have this undertaken in the GP surgery.

Figure 17: Numbers of reviews carried out in GP setting by HSC Trust area



The remaining 67% (n=612) of reviews were carried out in other locations as detailed in Figure 18 below. The most common setting for the annual review outside the GP setting was the care home. A total of 95% (579/612) of all residents were reviewed within this setting.

Figure 18: Numbers of reviews carried out in GP setting by care home setting



Care home staff gather health information from a variety of sources such as community nursing, residents records and provide this information to the general practitioner for the review. From the study it was found that GP's were provided with all relevant health information in 87% (690/793) of all reviews carried out. There was no evidence to suggest that the GP had been provided with all relevant information in 15% (122/793) of all care plans audited. It is important to note that 29% of all care plans reviewed within the SEHSCT failed to provide enough evidence to suggest that the GP had access to all the relevant information necessary for the review.

Figure 19: Numbers of patients whose General Practitioner was provided with all relevant health information for their annual review by HSC Trust area

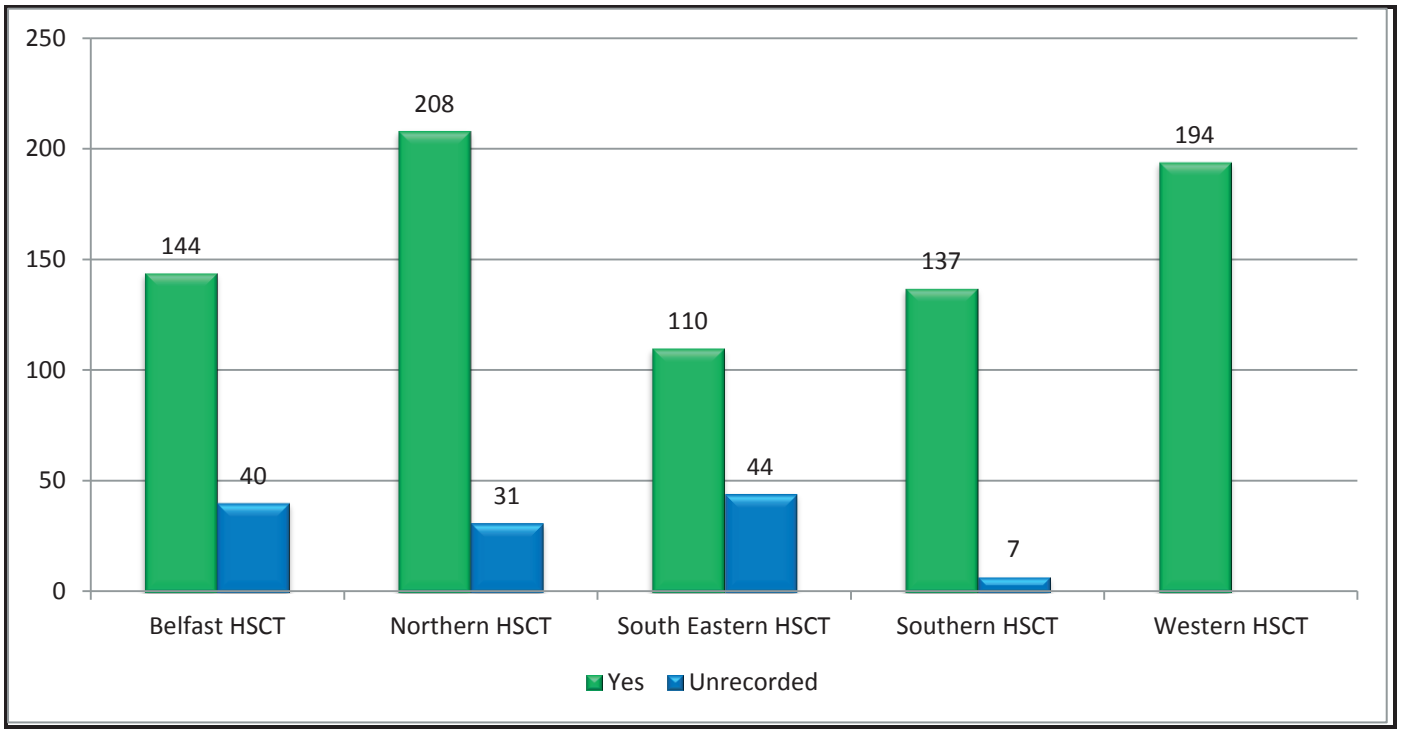


Figure 20 highlights that 99% (n=789) of all residents reviewed had a general review of their physical and mental wellbeing completed. The remaining 1% (n=4) of residents did not have the necessary information recorded within their care plan to ascertain whether their physical and mental wellbeing had been reviewed or not.

Figure 20: Count of the number of residents who had a review of their physical and mental wellbeing by HSC Trust area

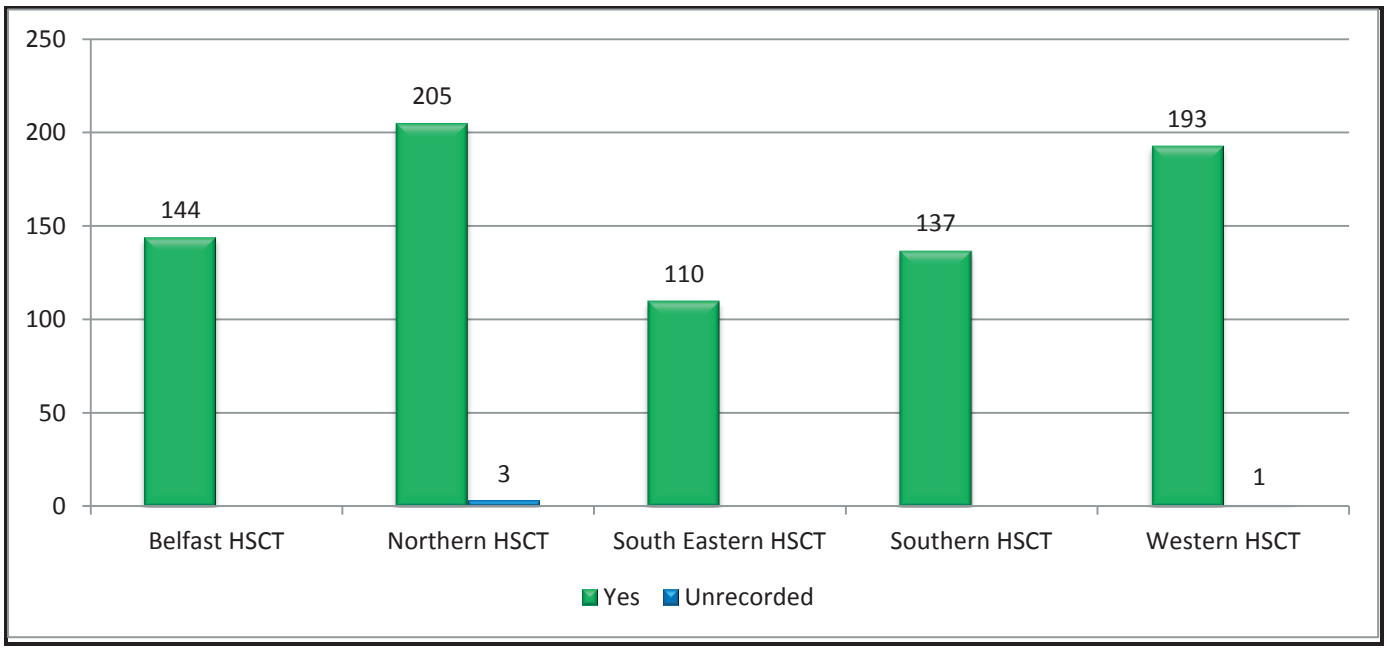
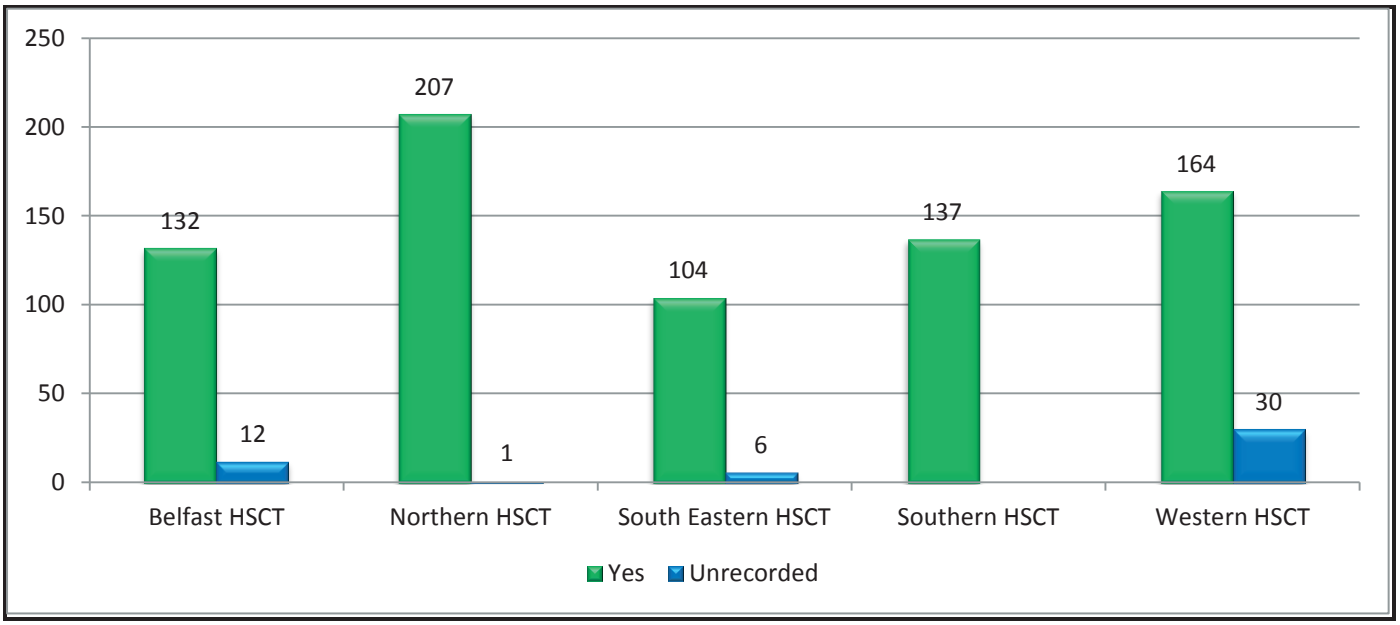


Figure 21: Count of the number of residents who had a review of their medication by HSC Trust area



Results from Figure 21 show that 94% (n=744) of all residents reviewed had evidence in their care plans to show that a review of their medication had been completed. Residents in the NHSCT and SHSCT all had medication reviews completed. A total of 15% (n=30) of the care plans reviewed in the WHSCT failed to mention whether a review of resident's medication had been undertaken. Figure 22 highlights that these all occurred in Private Nursing home settings.

Figure 22: Count of the number of residents who had a review of their medication by care home setting

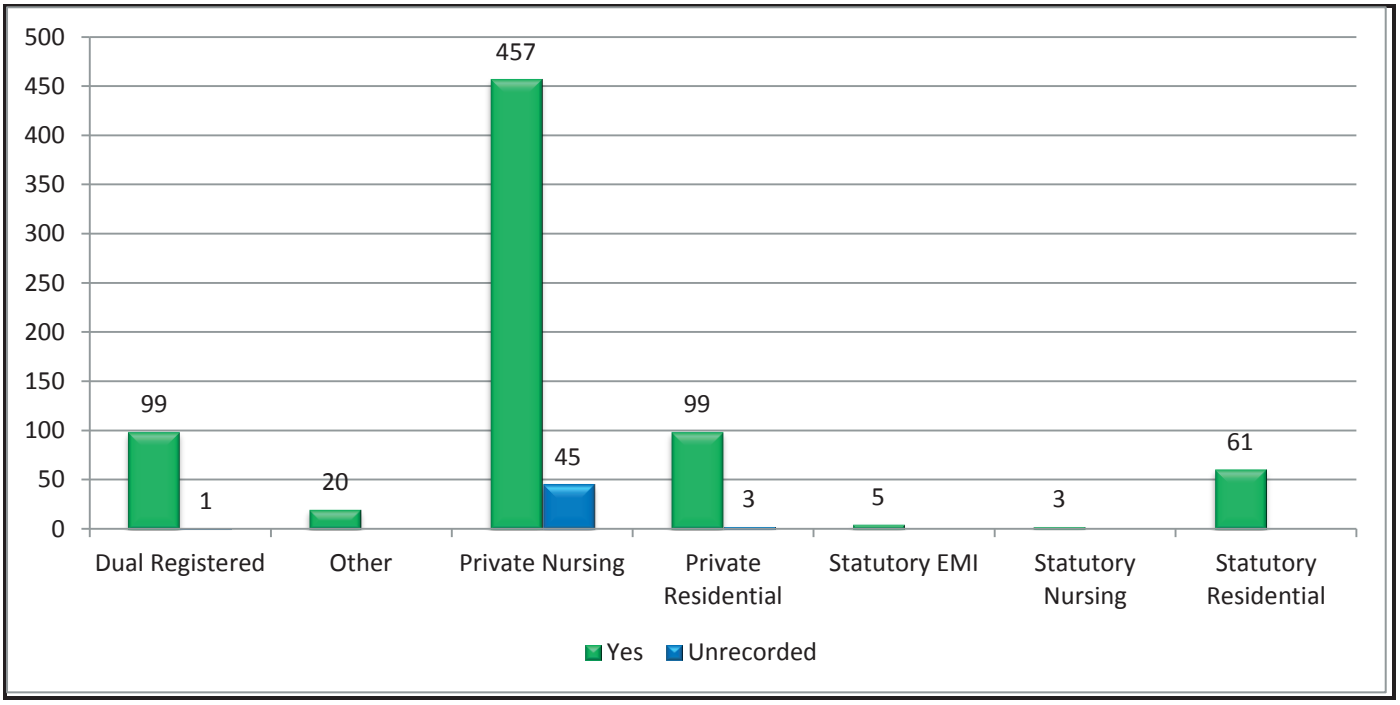
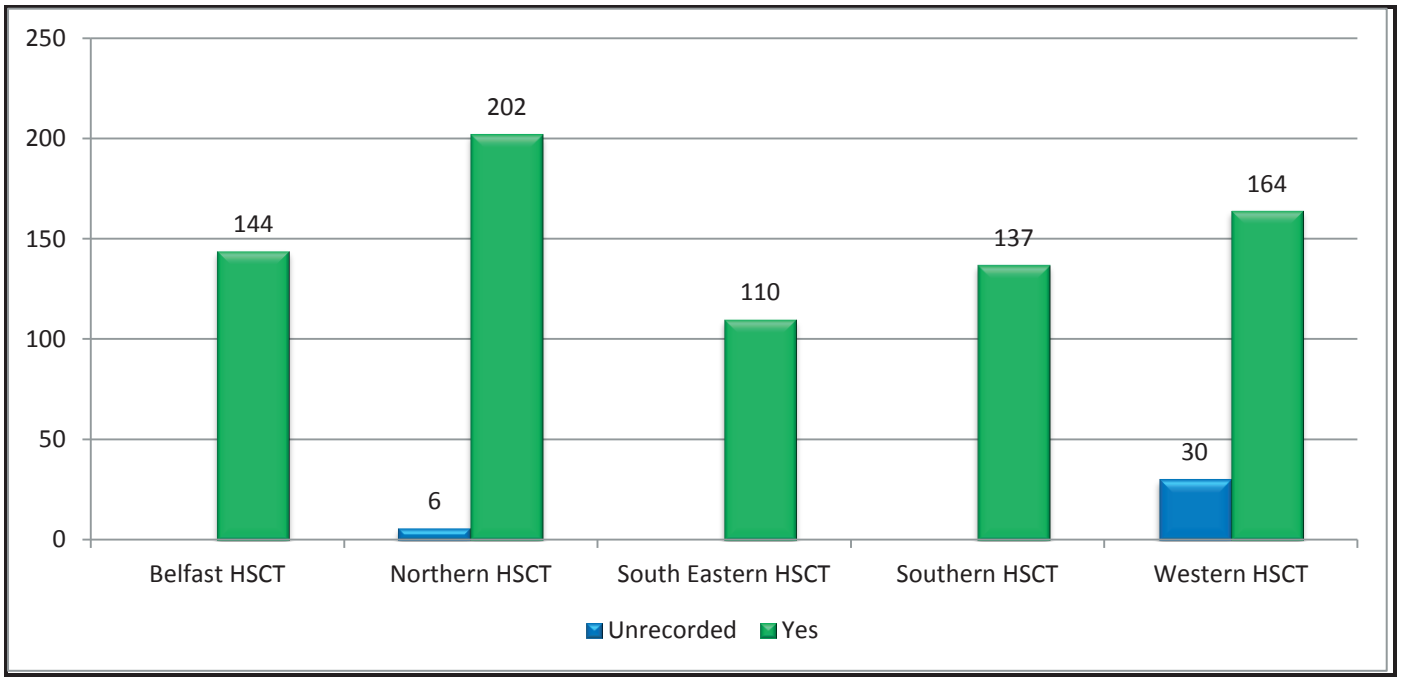


Figure 23: Count of the number of residents who had a review of their height and weight (BMI) by Trust area



The study found that 95% (n=757) of all residents had a review of their height and weight (BMI) documented in their care plan (Figure 22). The 5% (n=36) of care plans which lacked the required evidence were recorded in the private nursing and residential settings.

Figure 24: Count of the number of residents who had a review of their height and weight (BMI) by Care Home setting

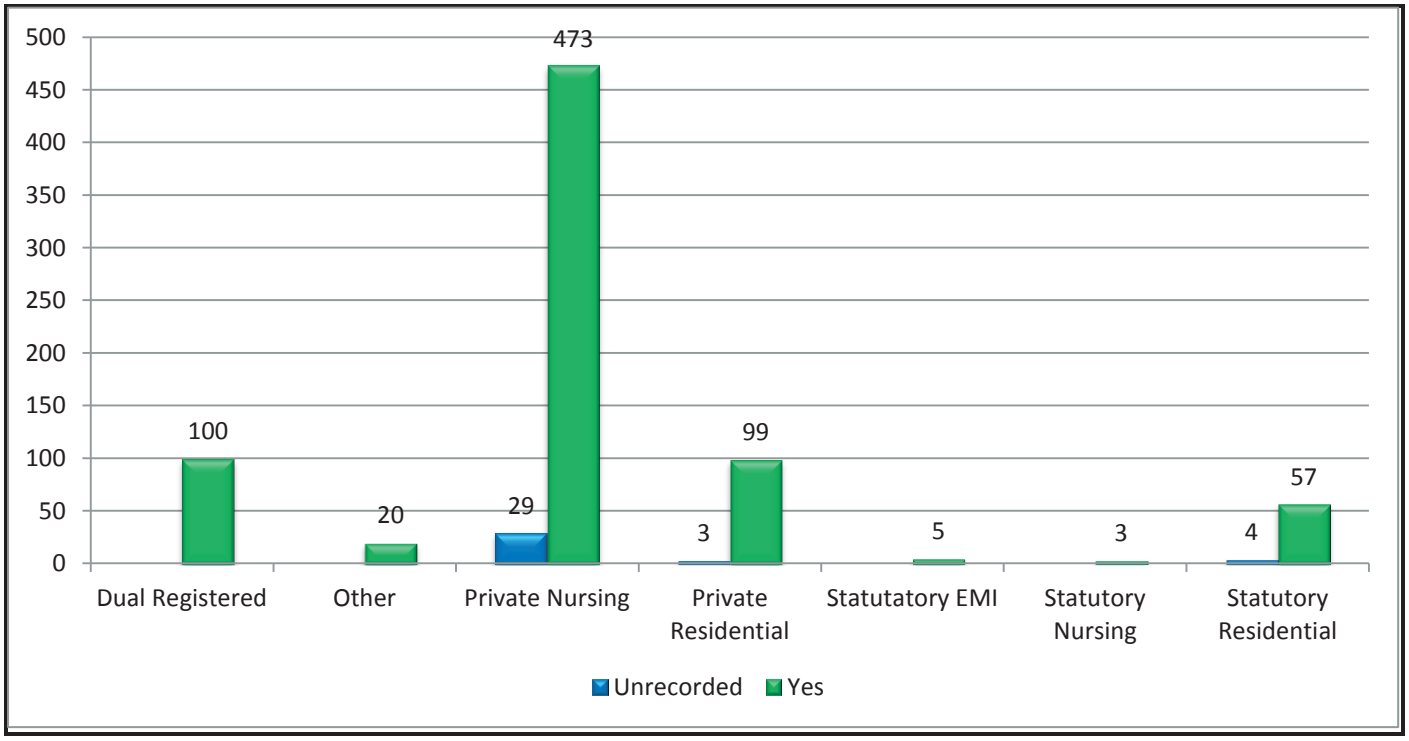
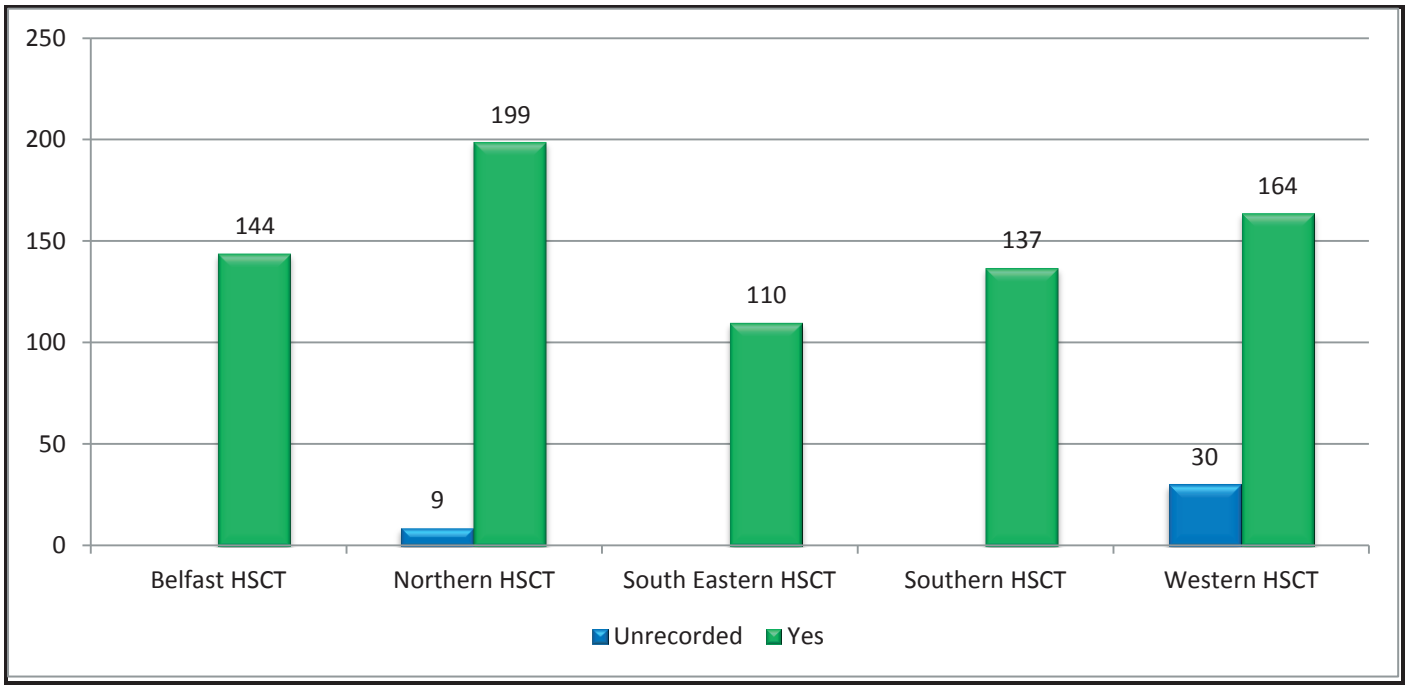


Figure 25: Count of the number of residents who had an examination of feet, legs and skin by HSC Trust area



From the study it was found that 95% (n=754) of all residents had an examination of feet, legs and general skin condition completed and documented in their case notes. A total of 5% (n=39) of case notes audited failed to document any information relating to an examination of feet, legs and general skin condition as part of any review. As seen in Figure 26 below this occurred most frequently in the Private Nursing Home setting (28/39).

Figure 26: Count of the number of residents who had an examination of feet, legs and skin by care home setting

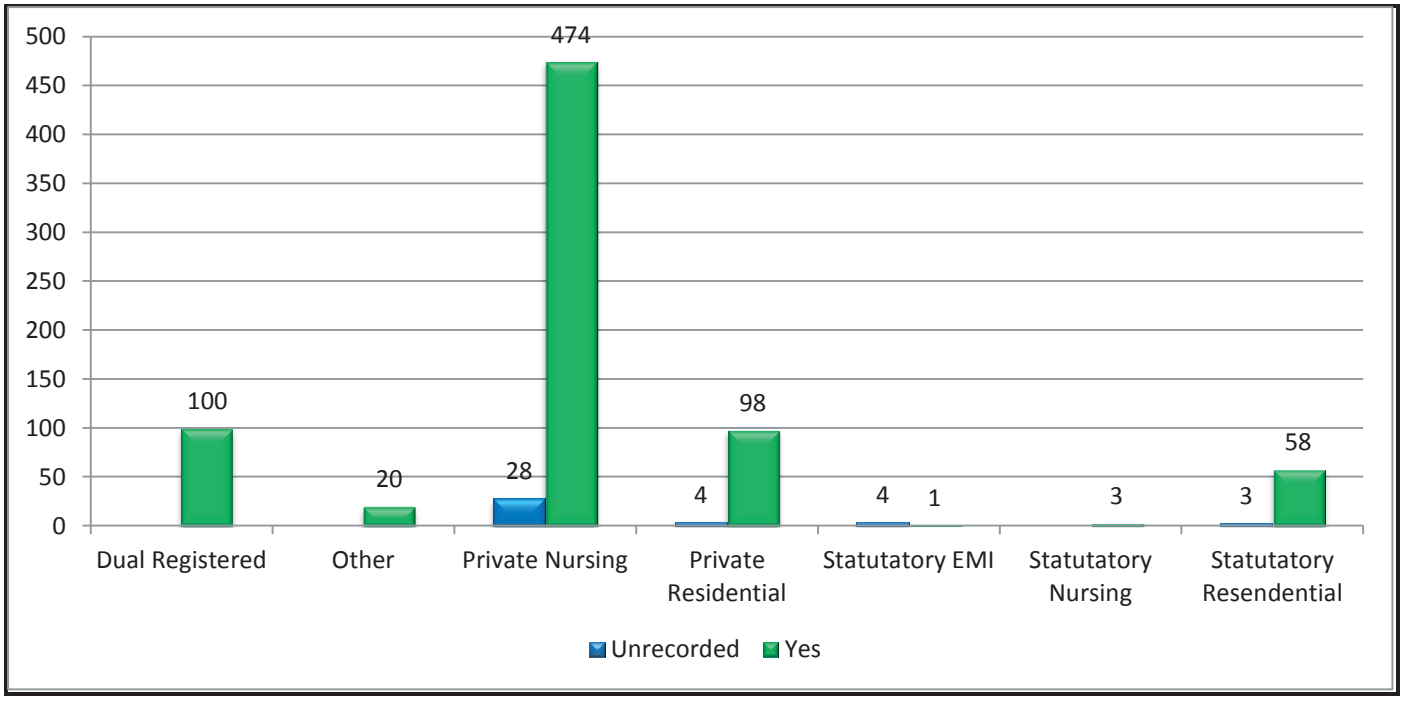


Figure 27: Count of the number of residents who had a pressure damage risk assessment completed by HSC Trust area

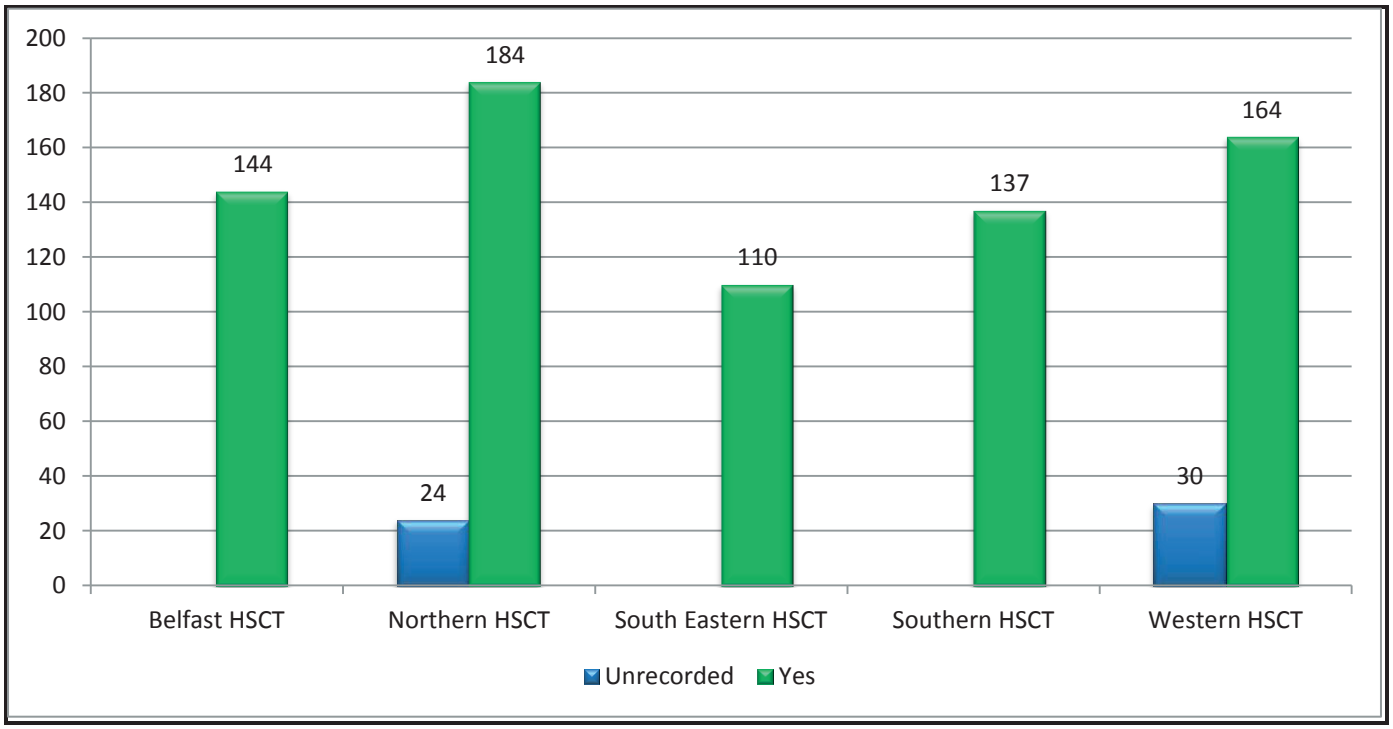


Figure 27 above shows that 93% (n=739) of all residents reviewed had a pressure damage risk assessment completed and documented in their case notes. The remaining 7% (n=54) of case notes did not have the necessary information to ascertain whether this examination had taken place. As previously noted this occurred most frequently in the Private Nursing Home setting (35/54).

Figure 28: Count of the number of residents who had a pressure damage risk assessment completed and documented by care home setting

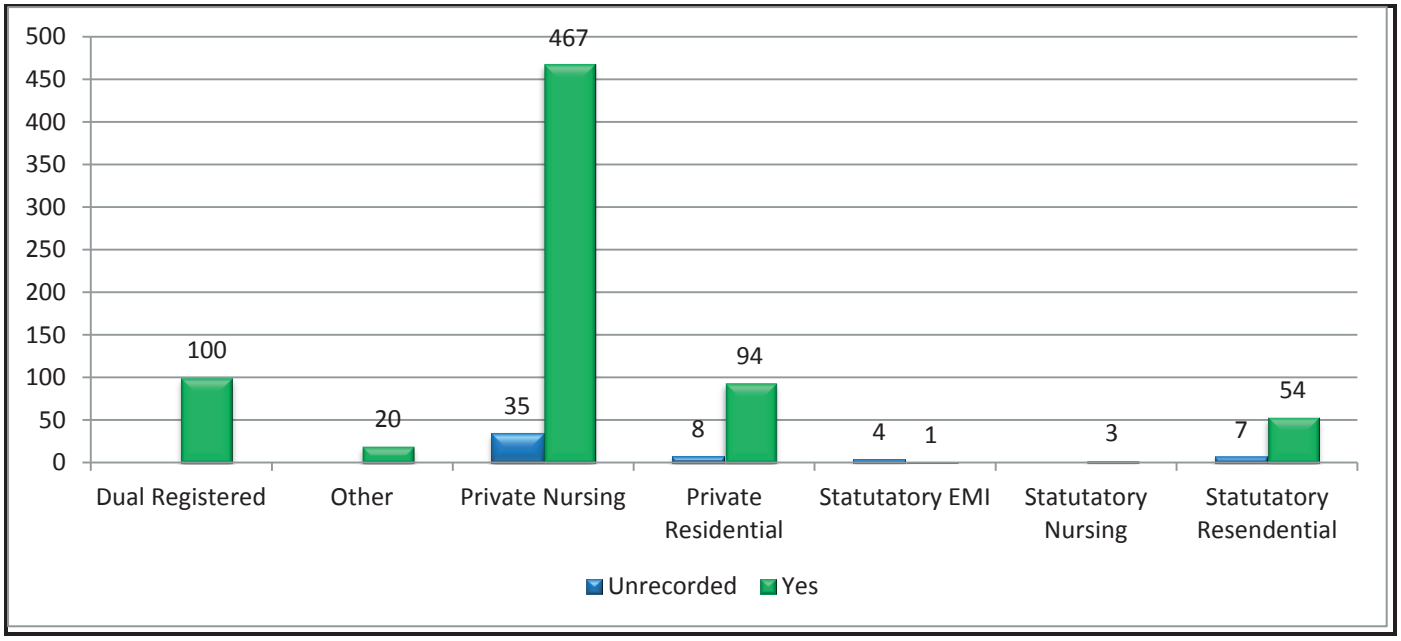
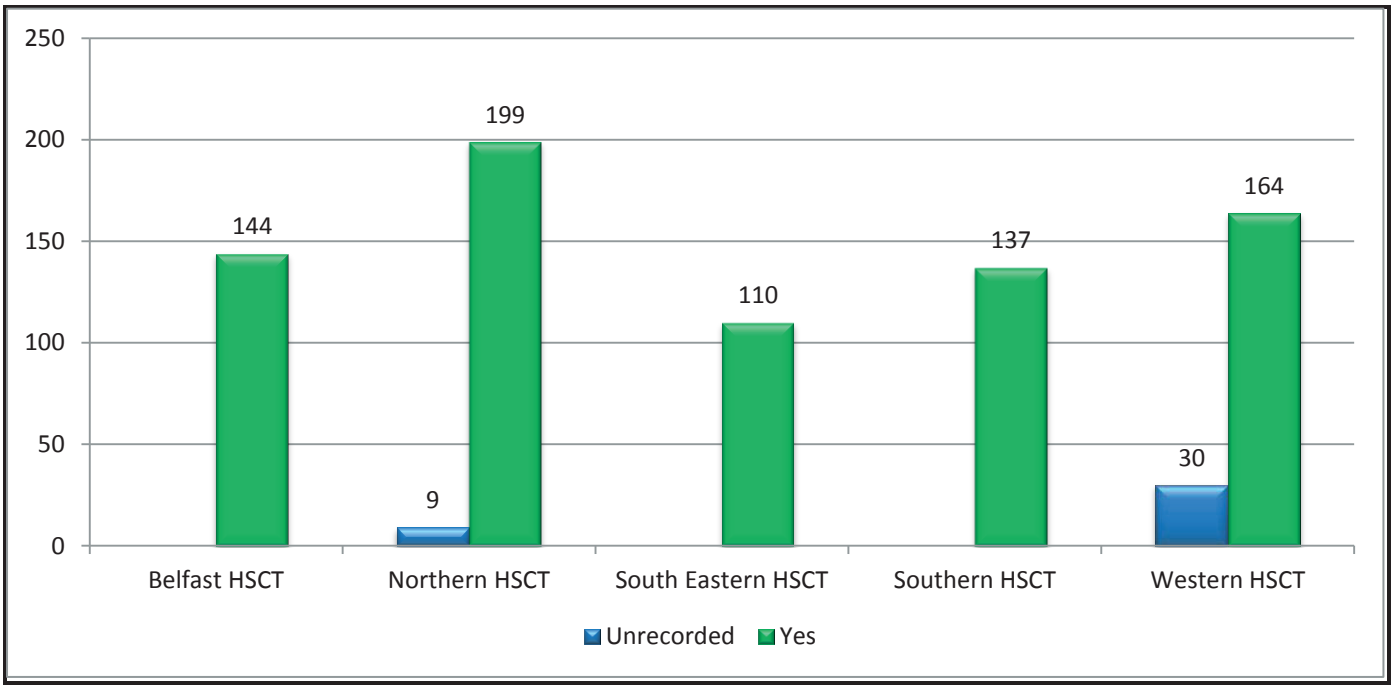


Figure 29: Count of the number of residents who had a blood pressure measurement recorded by HSC Trust area



From the audit it is evident that 95% (n=755) of all residents who had an annual review of their diabetes also had a blood pressure measurement recorded and documented in their case notes. The remaining 5% (n=39) of case notes did not contain any information relating to blood pressure measurements. A total of 15% (n=30) of WHSCT case notes and 4% (n=9) of NHSCT case notes were found to be missing any evidence that a blood pressure measurement had been recorded. This occurred most frequently in the Private Nursing Home Setting (28/39).

Figure 30: Count of the number of residents who had a blood pressure measurement recorded by care home setting

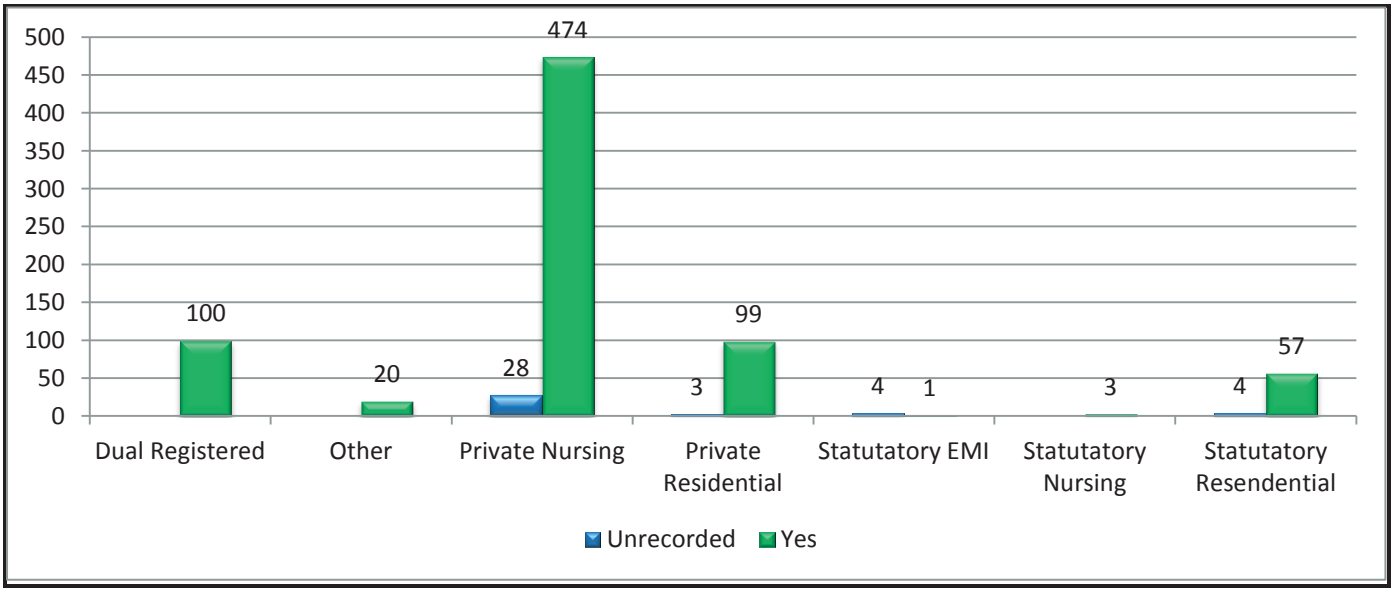
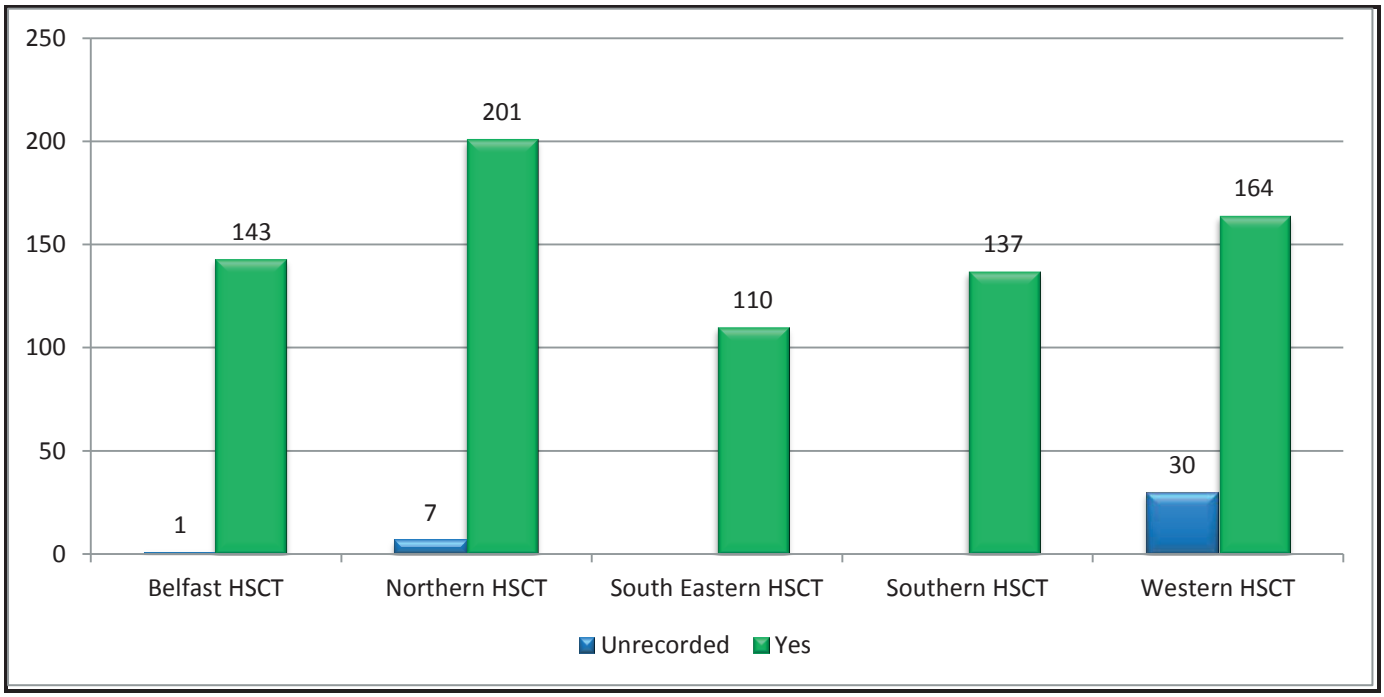


Figure 31: Count of the number of residents who had received an annual eye sight test by HSC Trust area



Results from the audit determined that 95% (n=755) of all residents reviewed had an eye sight test carried out and results documented in their care plan (Figure 31). A total of 5% (n=38) of case notes reviewed lacked the necessary information to determine whether any eye sight test had been undertaken. Figure 32 details that this occurred most frequently in the Private Nursing Home Setting (29/39).

Figure 32: Count of the number of residents who had received annual eye test by care home setting

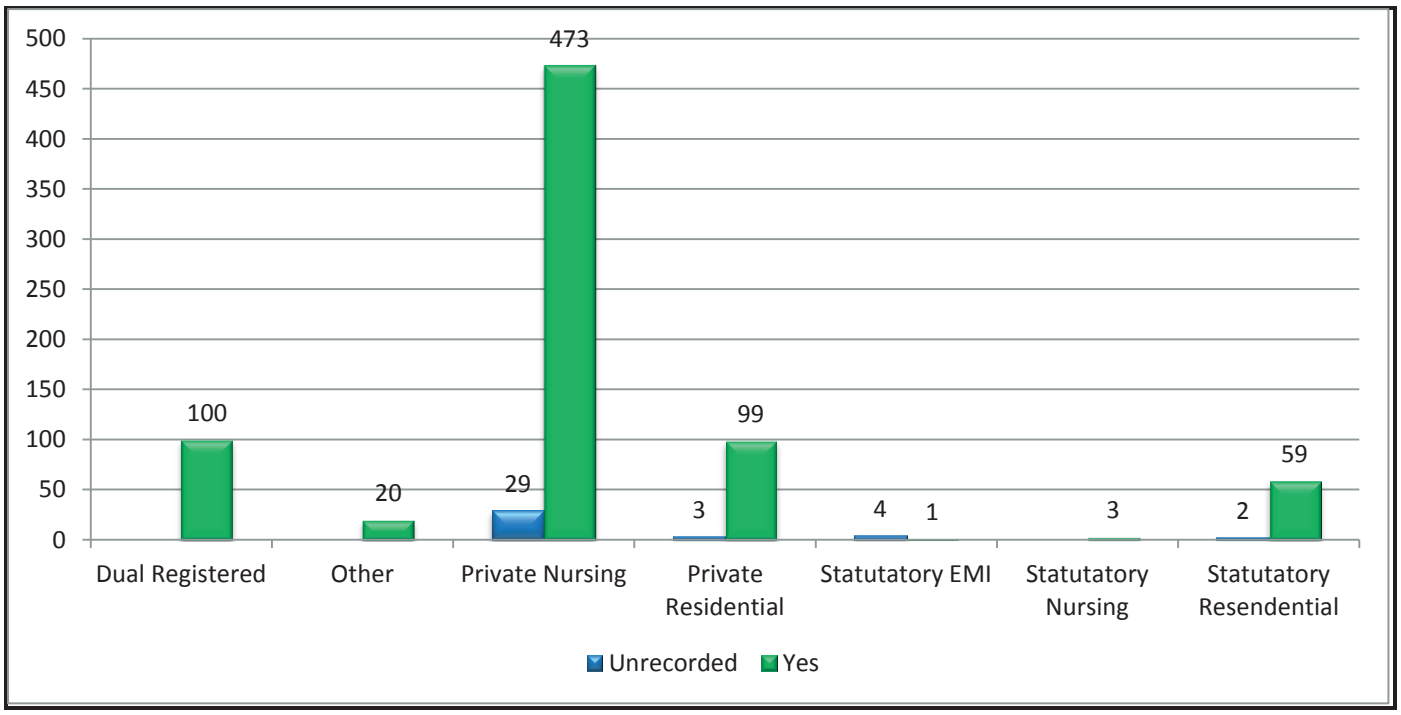


Figure 33: Count of the number of residents who had received annual retinal screening by HSC Trust area

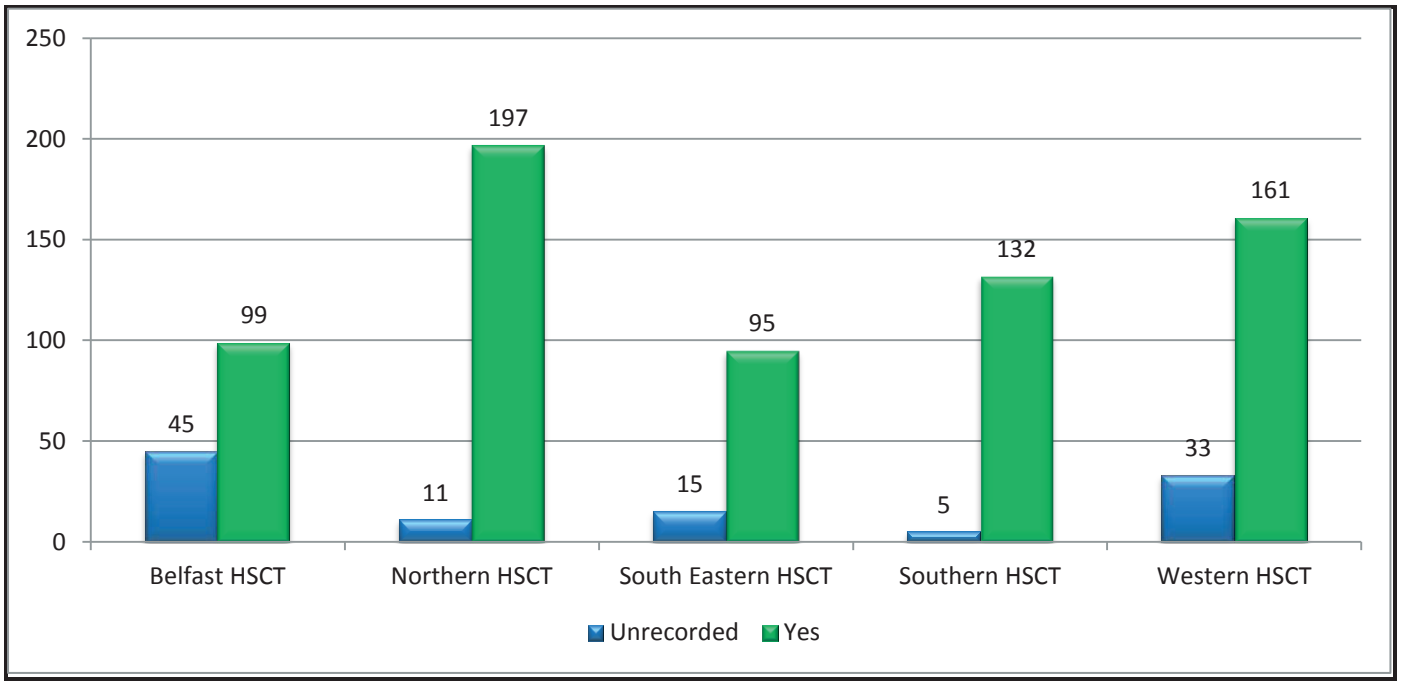


Figure 33 above shows that 86% (n=684) of all residents reviewed had undergone retinal screening. A total of 14% (n=109) of all residents did not have any evidence documented in their case notes to suggest that they had access to retinal screening within the last year. A total of 31% of residents reviewed in the BHSCT and 17% of all residents reviewed in the WHSCT failed to have an annual retinal screen carried out and documented in their case notes. This occurred most frequently in the Private Nursing Home Setting (81/421).

Figure 34: Count of the number of residents who had received annual retinal screening by care home setting

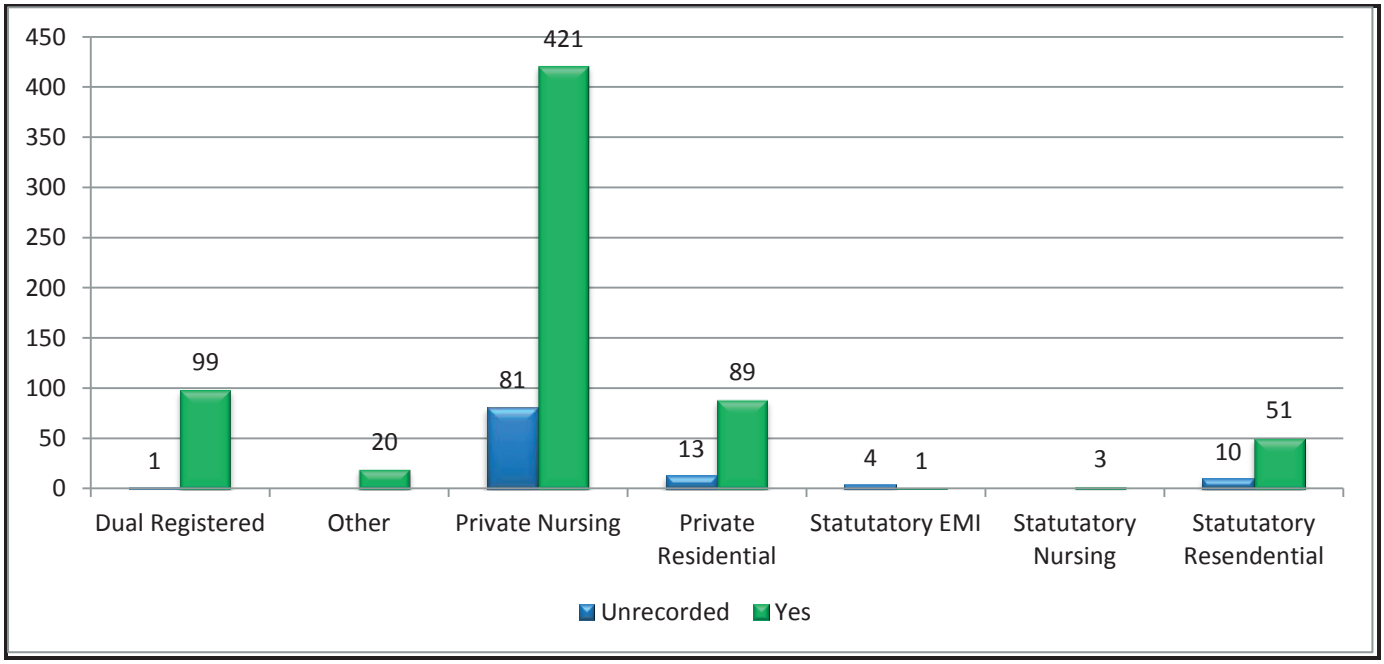
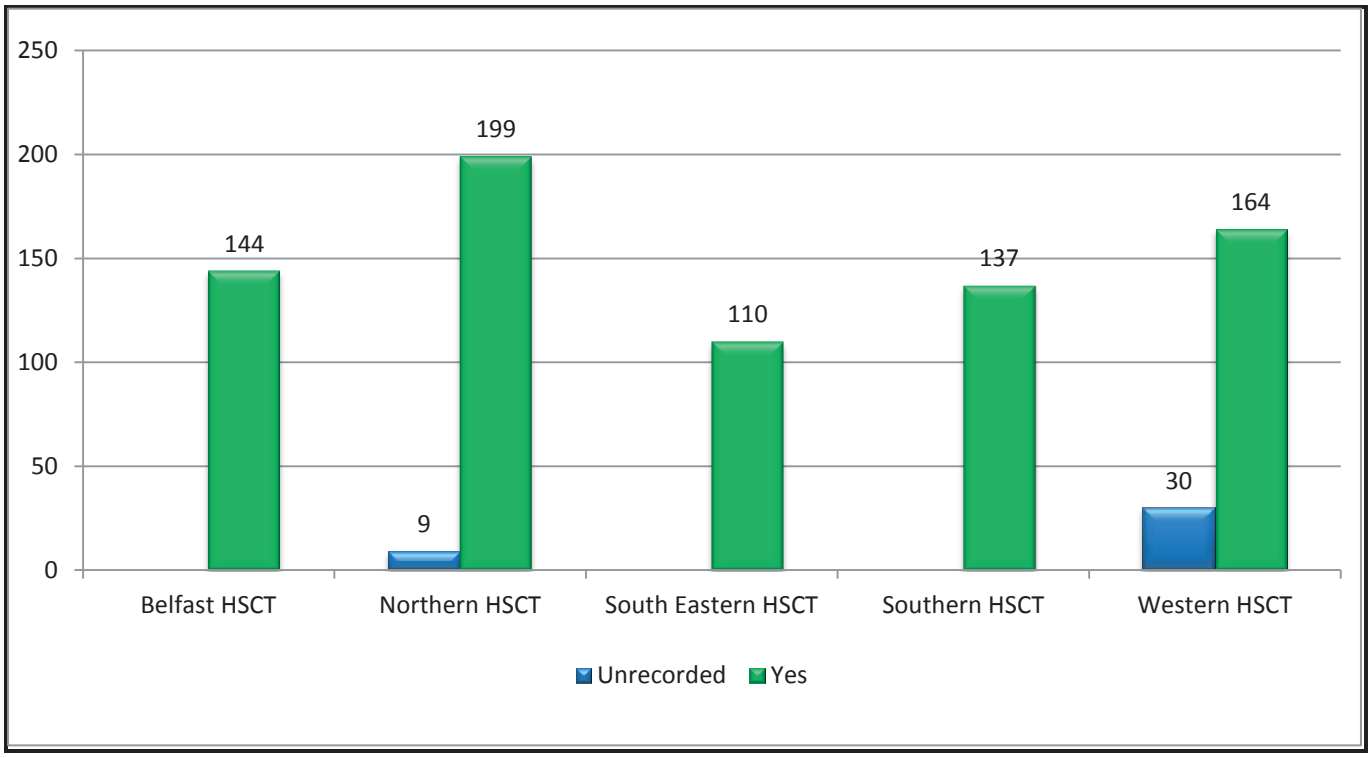


Figure 35: Count of the number of residents who had an assessment of blood glucose control by HSC Trust area



From the results of the audit we found that 95% (n=754) of all residents had an assessment of blood glucose control. A total of 5% (n=39) of all documented reviews lacked the evidence needed to determine whether or not an assessment of blood glucose control had been carried out. This occurred most frequently in the Private Nursing Home Setting (28/39).

Figure 36: Count of the number of residents who had an assessment of blood glucose control by care home setting

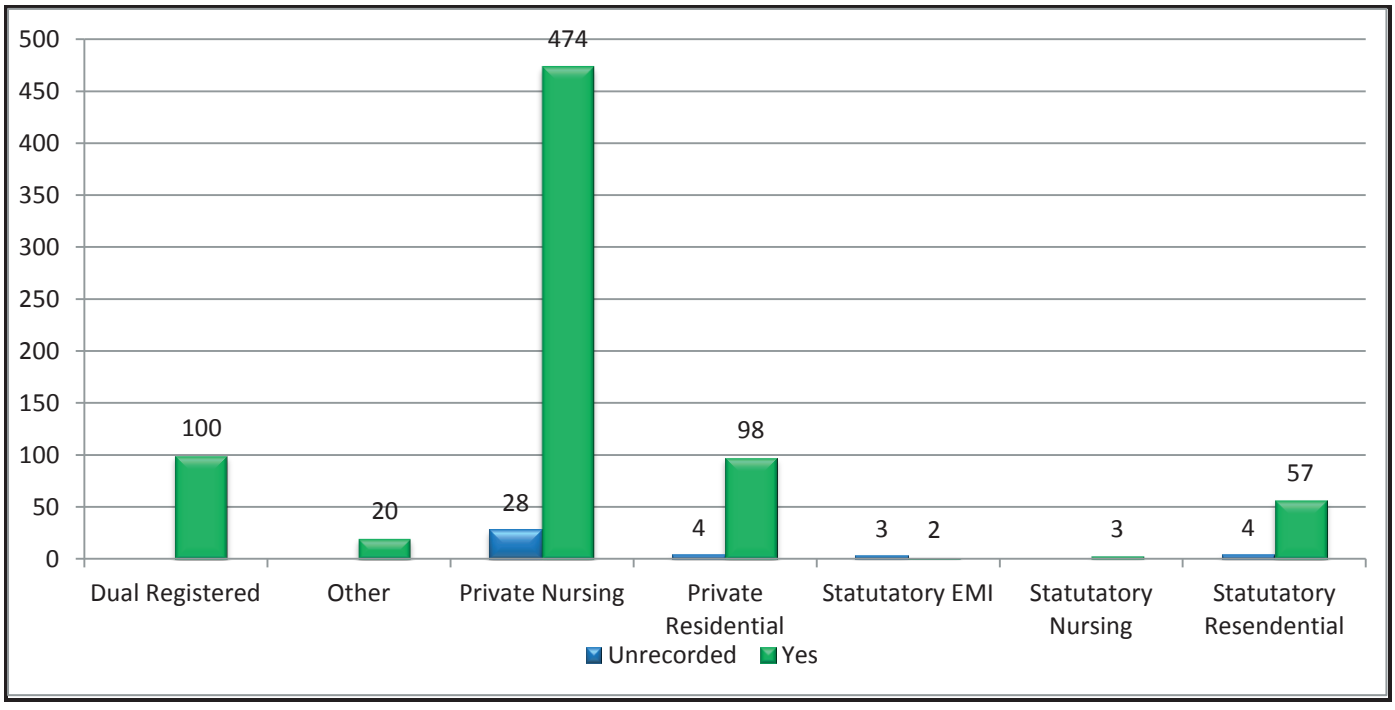
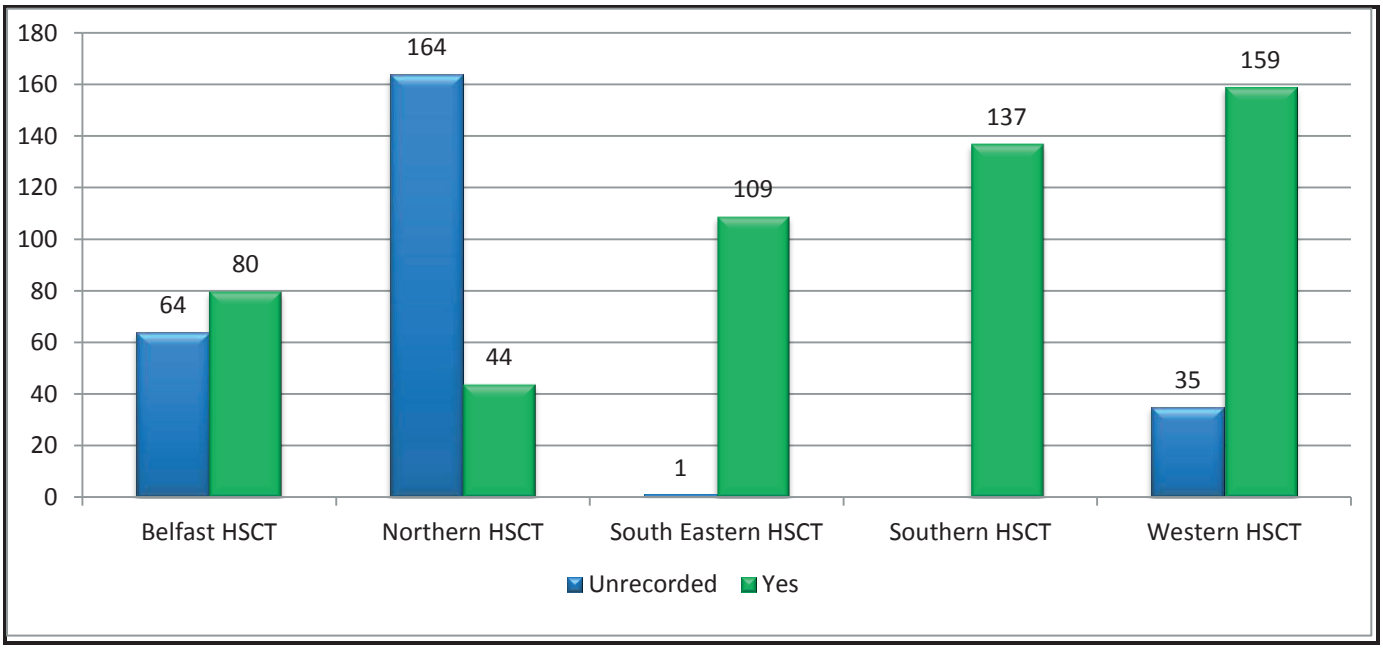


Figure 37: Count of the number of residents who had a review of their incidence of hypoglycaemia by HSC Trust area



It was found that only 67% (n=529) of residents had undergone a review of their incidence of hypoglycaemia. A total of 33% (n=264) of residents did not have a review of their incidence of hypoglycaemia recorded in their case notes. It is not known what percentage of the sample was on a treatment (e.g. insulin or a sulphonylurea) that might lead to hypoglycaemia. It is possible that residents who were diet controlled and on no medication or insulin therapy did not have this section filled in. Other reasons for lack of documentation include that hypoglycaemia did not occur or it may be that the information was not documented correctly.

Figure 38: Count of the number of residents who had a review of their incidence of hypoglycaemia by care home setting

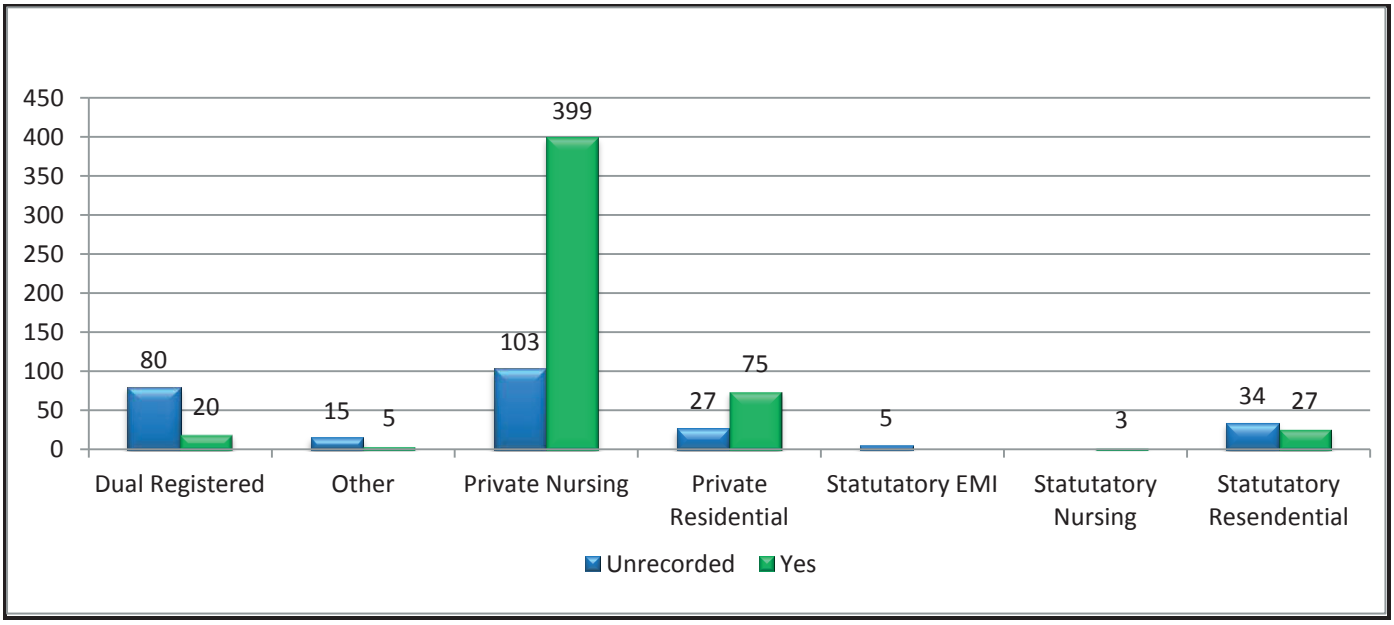
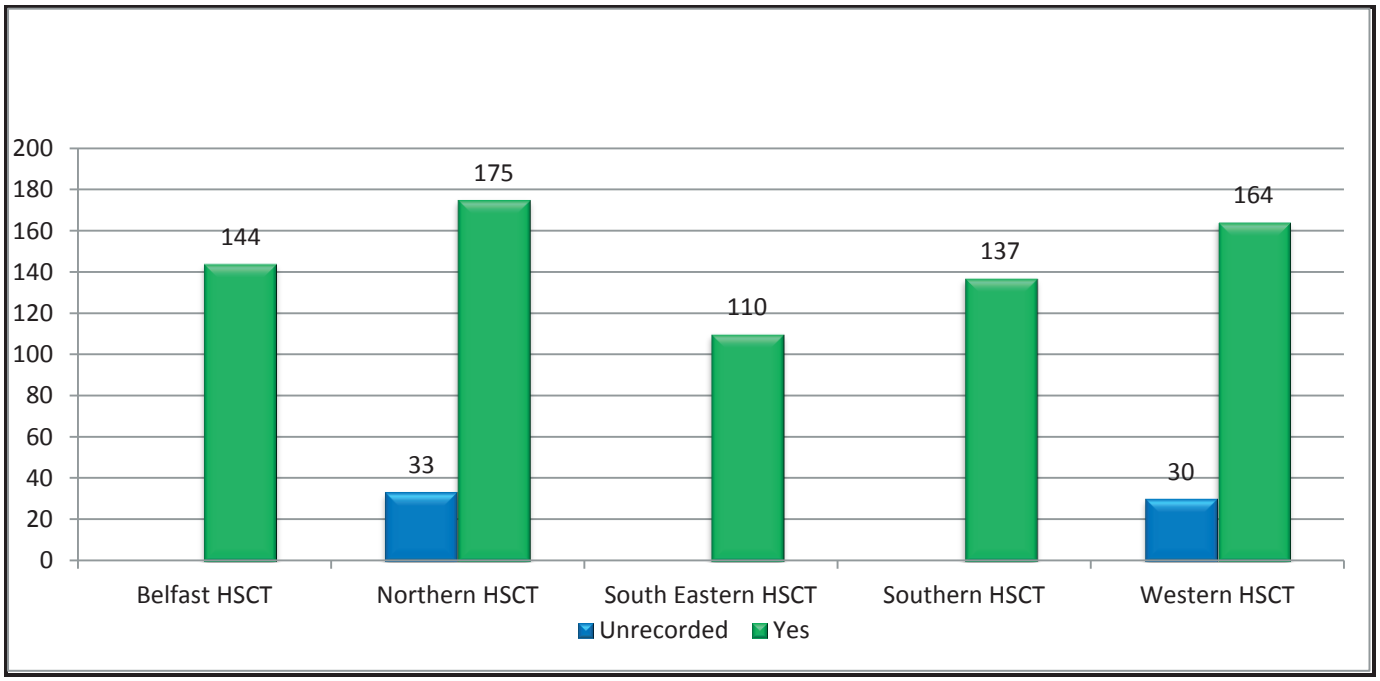


Figure 39: Count of the number of residents who had an assessment of kidney function and lipids by HSC Trust area



A total of 92% (n=730) of all case notes reviewed during the process of the audit documented an assessment of kidney function and lipids. Only 8% (n=63) of the residents reviewed had no recorded information to confirm that this review had ever been followed up. It is visible from Figure 42 that NHSCT and WHSCT accounted for 100% of all residents who had not had this review information recorded.

Figure 40: Count of the number of residents who had an assessment of kidney function and lipids by care home setting

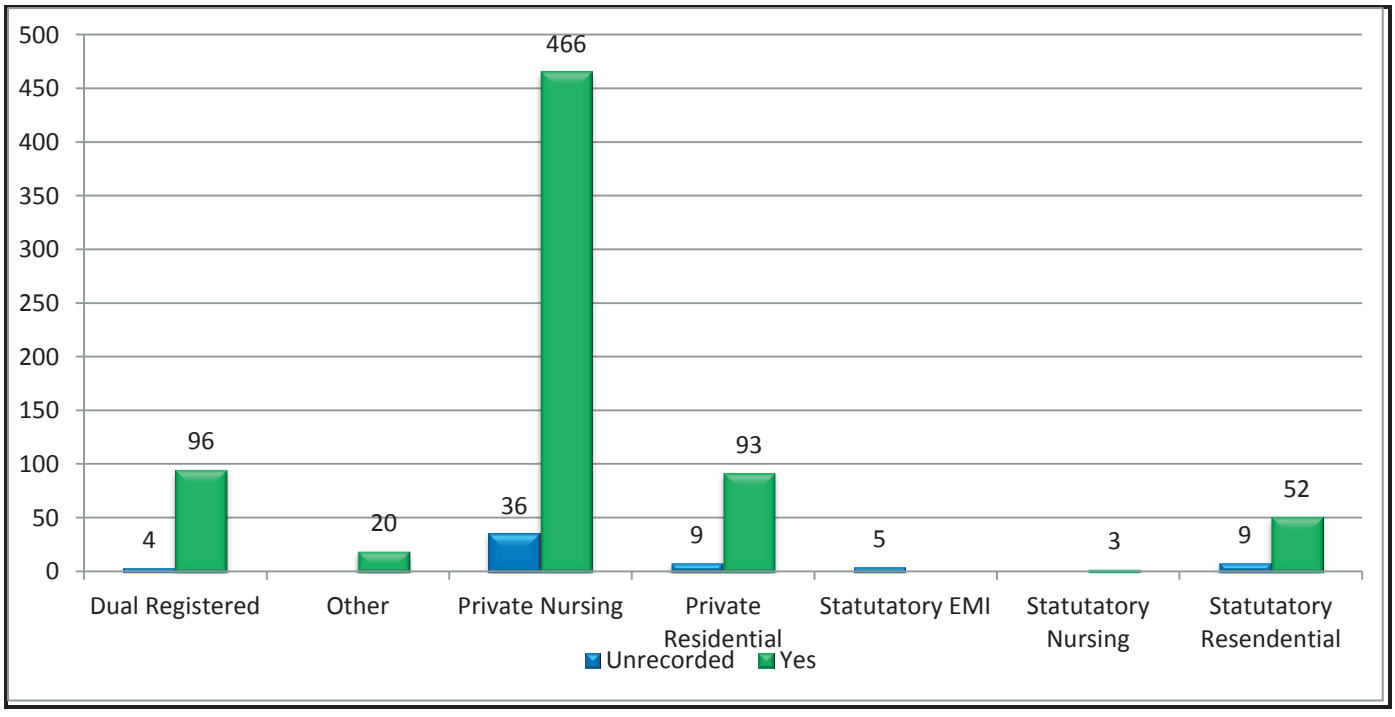
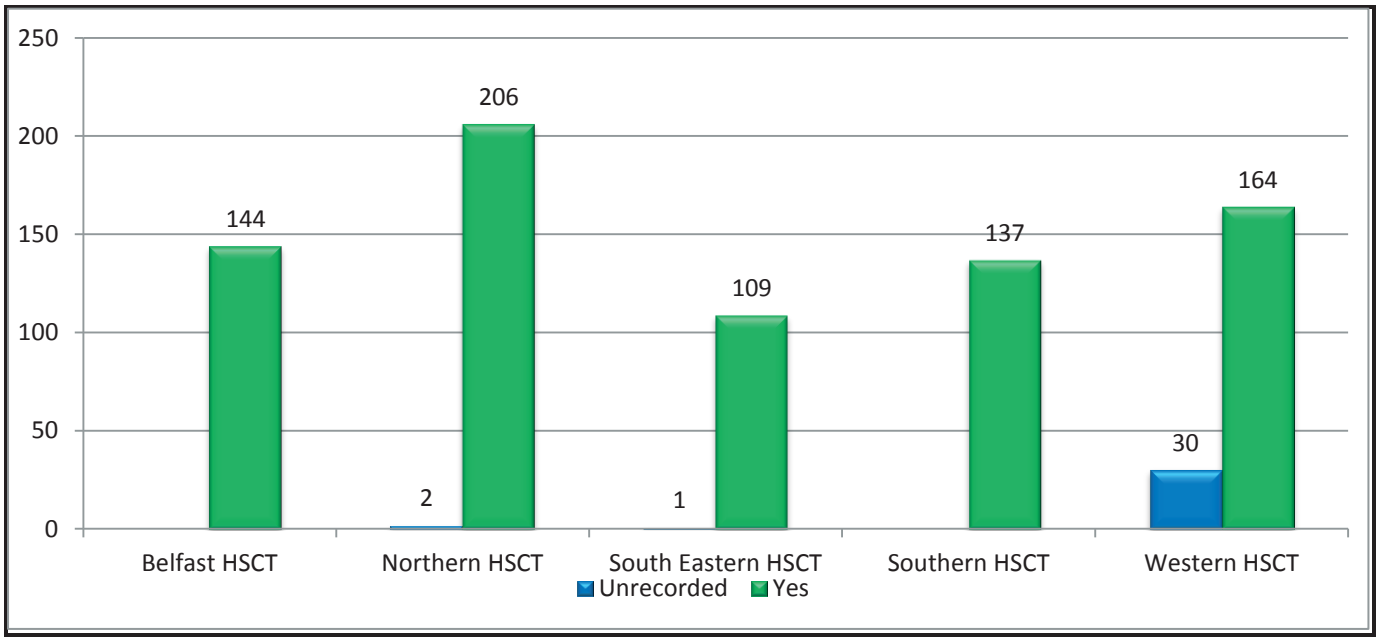


Figure 41: Count of the number of residents who had a review of their diet by HSC Trust area



During data collection it became apparent that residents were being reviewed thoroughly with regards to their diet. This was reflected in Figure 41 which shows that 96% (n=760) of all case notes contained documentation detailing a diet review within the last twelve months. Only 4% of case notes lacked the sufficient documentation to ascertain whether a review had been carried out. It must be noted that the WHSCT had a total of 30 case notes where details relating to any review were unrecorded or missing and these occurred within the Private Nursing Home setting.

Figure 42: Count of the number of residents who had a review of their diet by care home setting

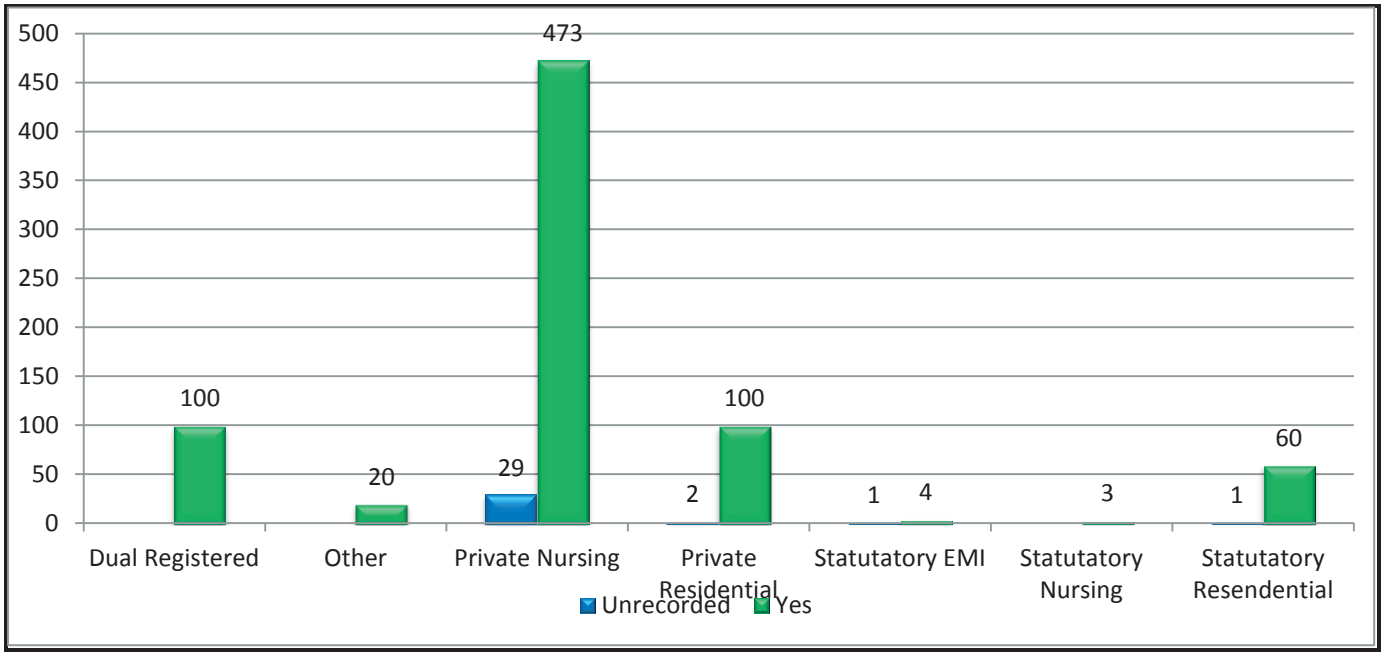


Figure 43: Count of the number of residents who had a review of their lifestyle by HSC Trust area

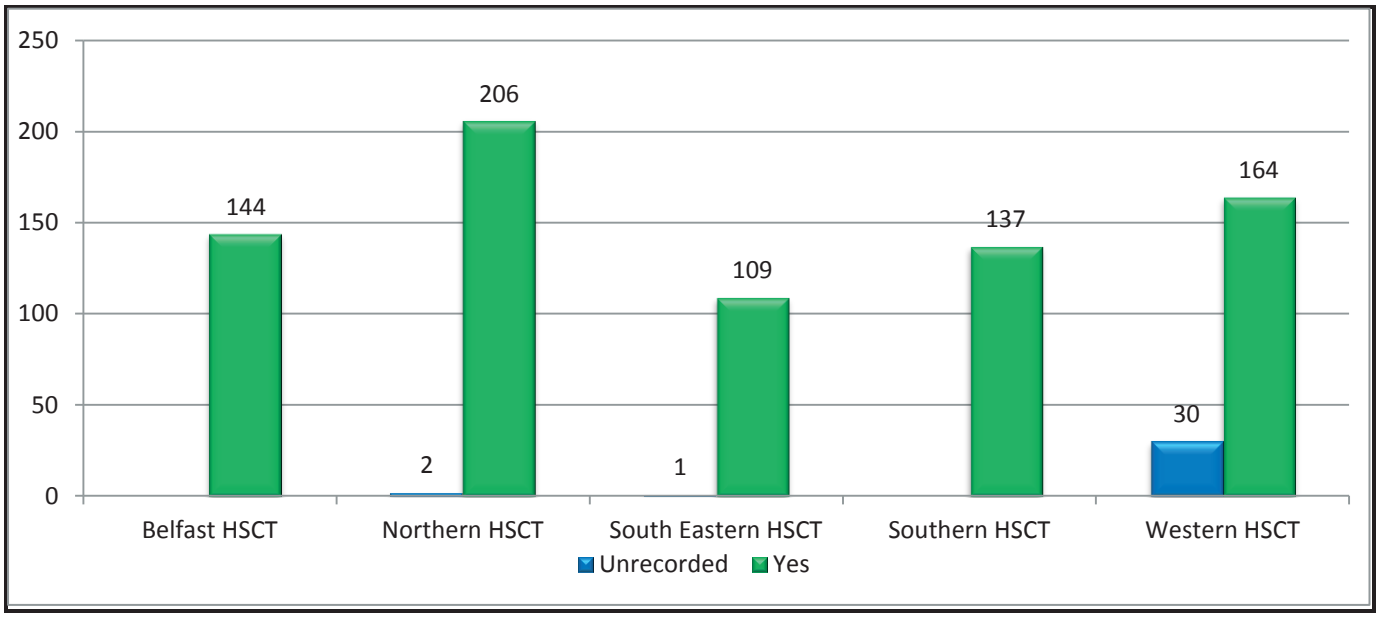
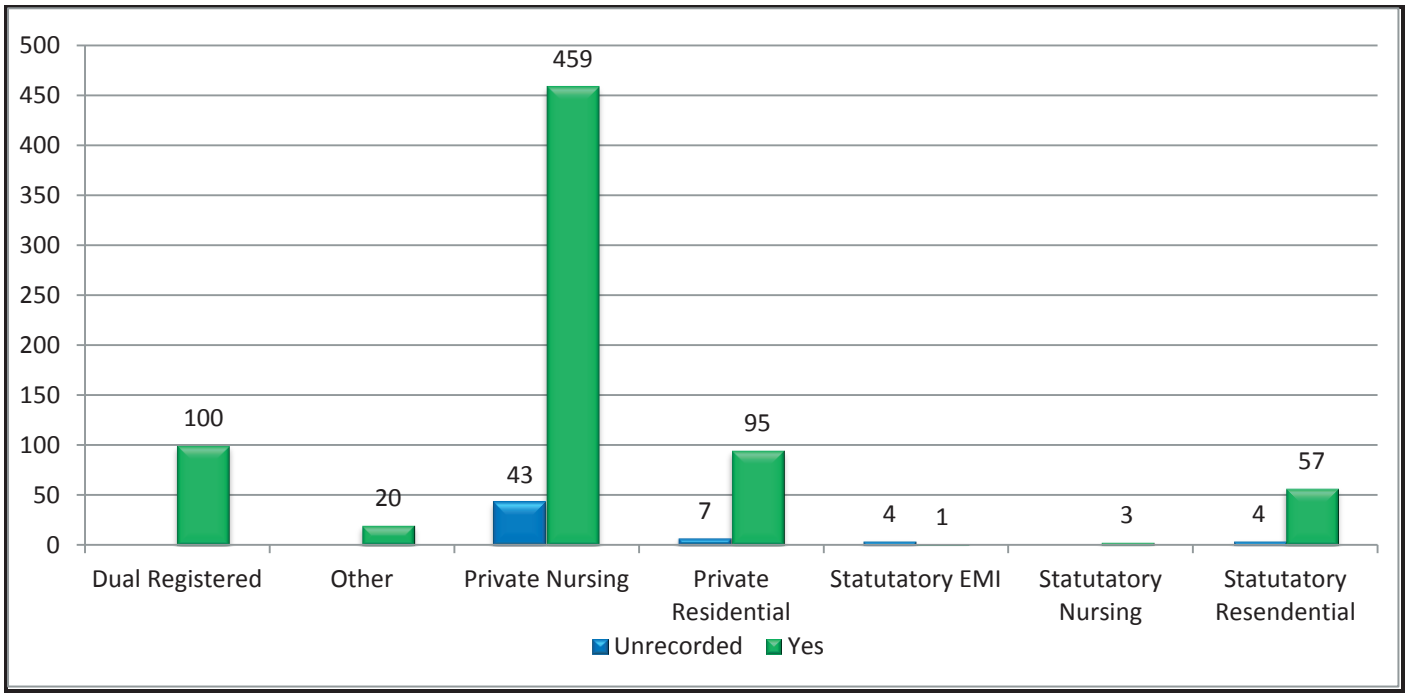


Figure 43 shows that 96% of residents had a review of their lifestyle factors carried out within the previous year. This included diet, smoking and activity levels. Sufficient evidence was missing or unrecorded in 4% of case notes audited. Once again it must be noted that care homes within the WHSCT area had 30 unrecorded case notes, accounting for almost 100% of all case notes which lacked sufficient evidence to suggest that a review had taken place. These occurred most commonly within the Private Nursing home settings.

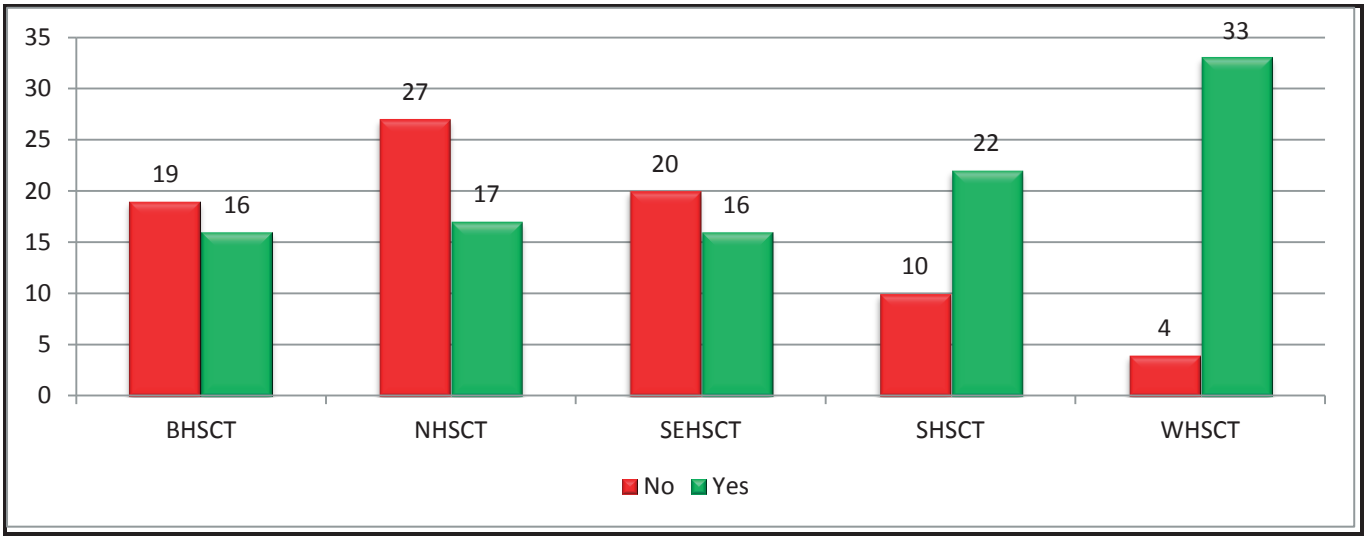
Figure 44: Count of the number of residents who had a review of their lifestyle by care home setting



Standard 4: Each resident with diabetes will have access to a named member of staff appropriately trained in the care of people with diabetes.

A total of 54% (n=104) of all Care Homes audited within NI provided residents with access to a named member of staff trained in the care of people with diabetes. It is of interest to note that 46% (n=80) of all Care Homes do not meet the conditions of standard 4.

Figure 45: Does the care home environment have a dedicated named member of staff trained in the care of people with diabetes (HSC Trust area)?



The highest levels of compliance to standard 4 were recorded in the WHSCT. Figure 45 demonstrates that a greater percentage of staff in the dual registered homes did not have a dedicated named member of staff trained in care of people with diabetes.

Figure 46: Does the care home environment have a dedicated named member of staff trained in the care of people with diabetes (care home setting)?

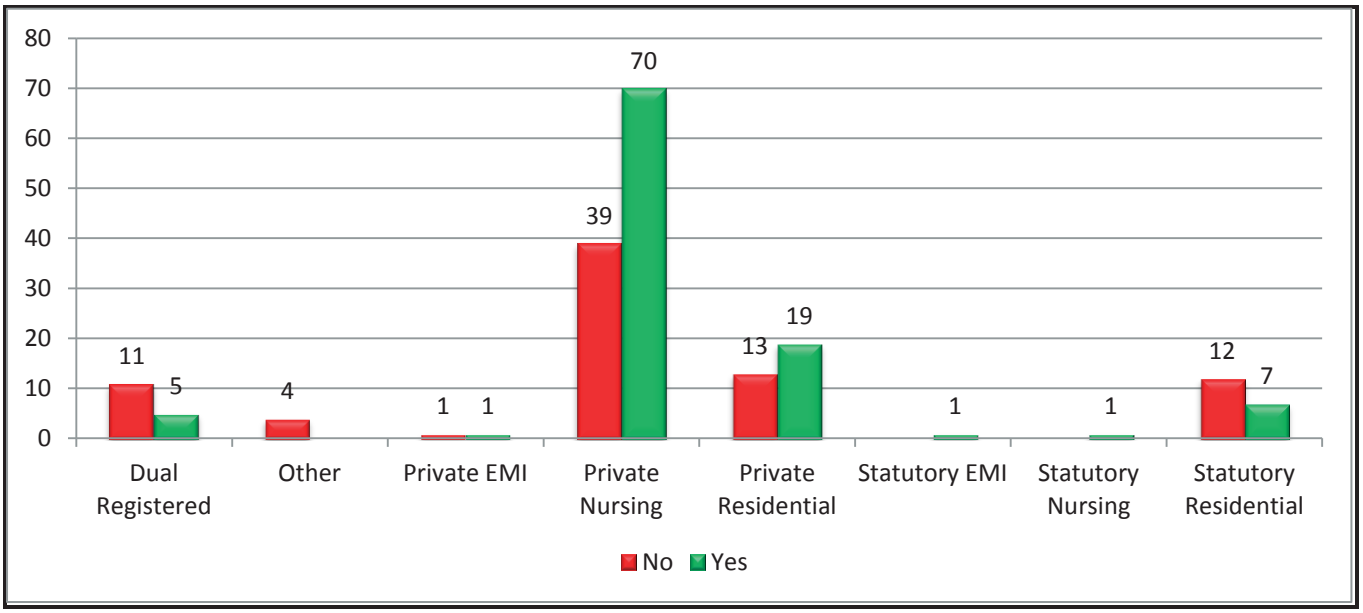


Figure 47: Have identified staff attended training sessions within the last three years (HSC Trust area)?

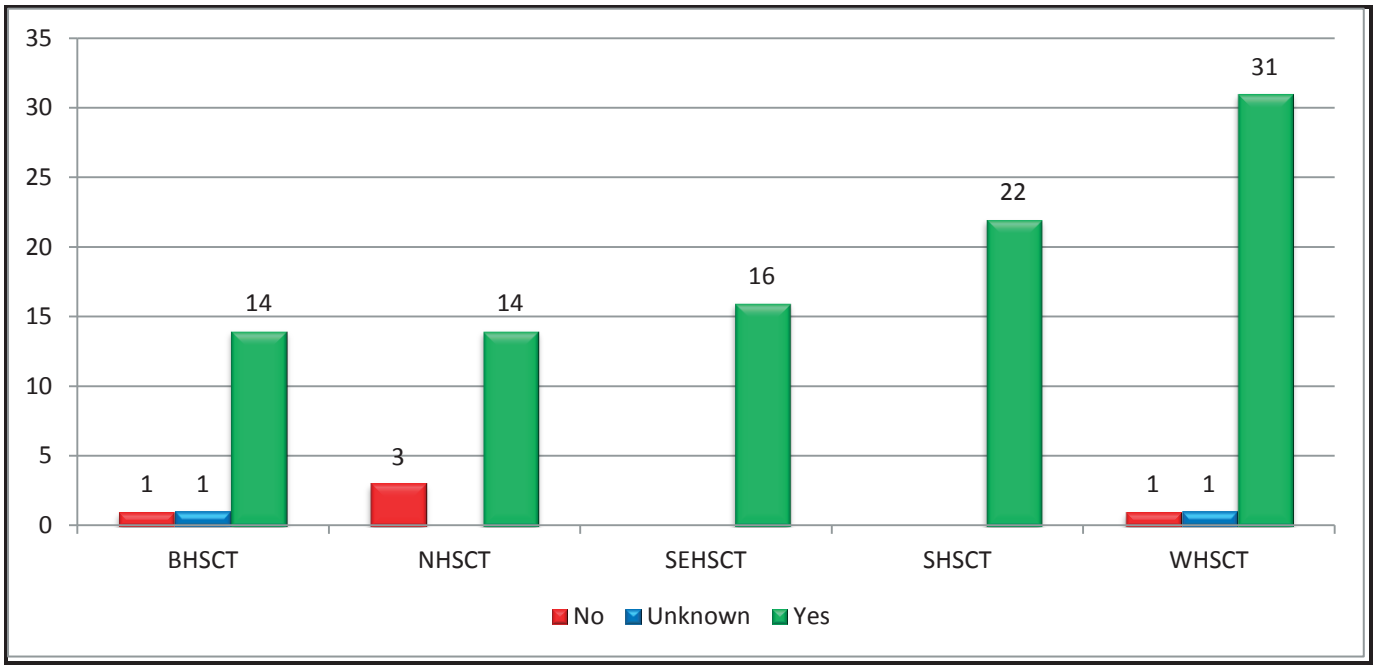


Figure 50 above shows 93% (n=97) of named staff trained in the care of people with diabetes were found to have attended training sessions within the last three years. A total of 5% (n=5) of named staff had not had any training within the last three years while the remaining 2% (n=2) were classed as unknown.

Figure 48: Details of whether identified staff attended training sessions within the last three years by care home setting

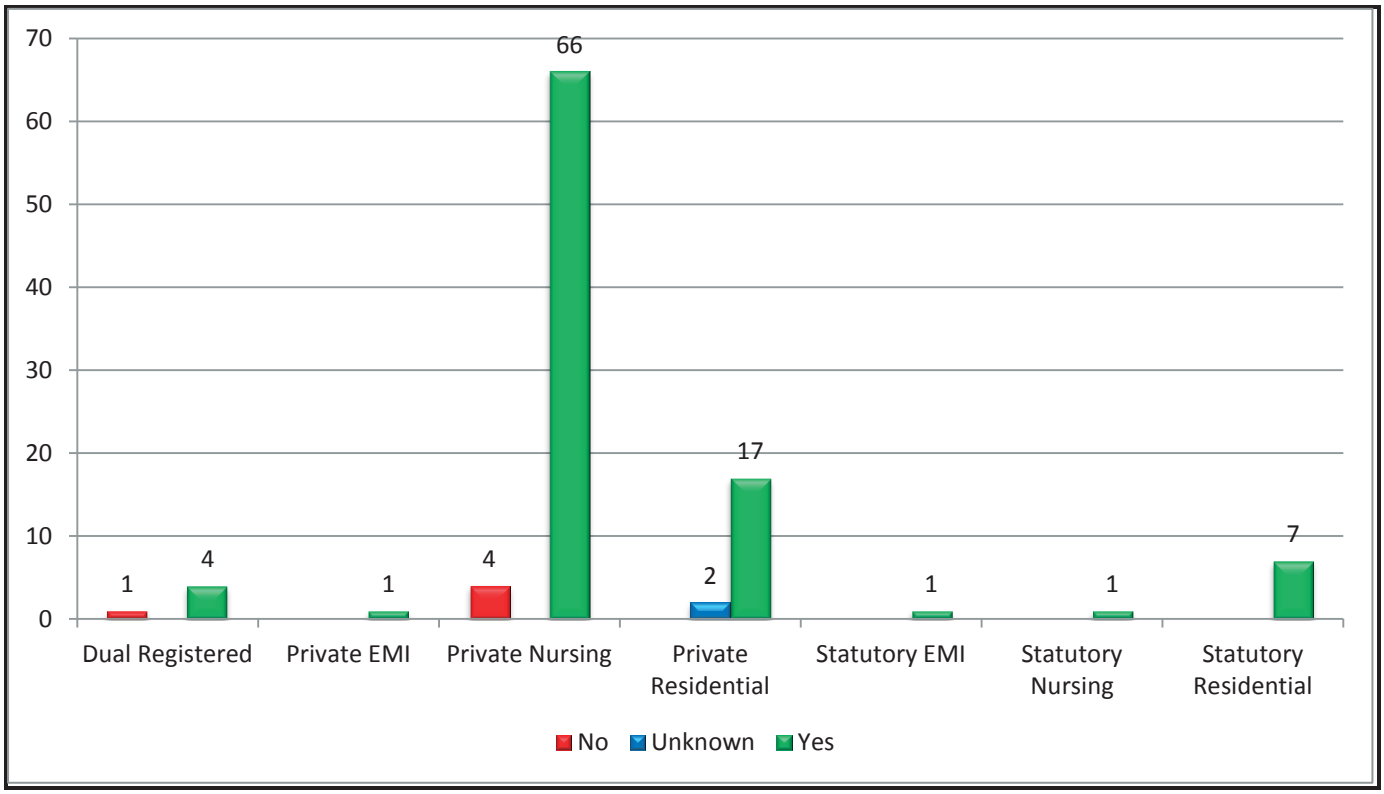
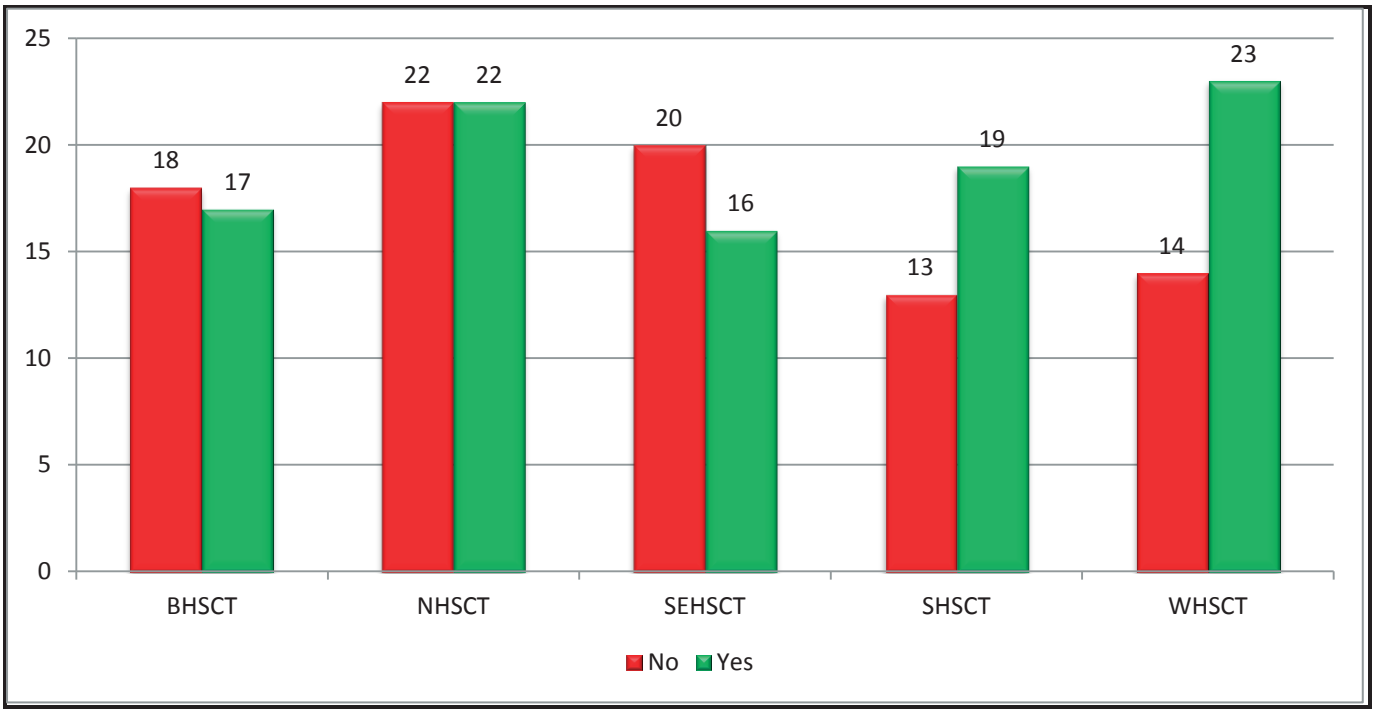
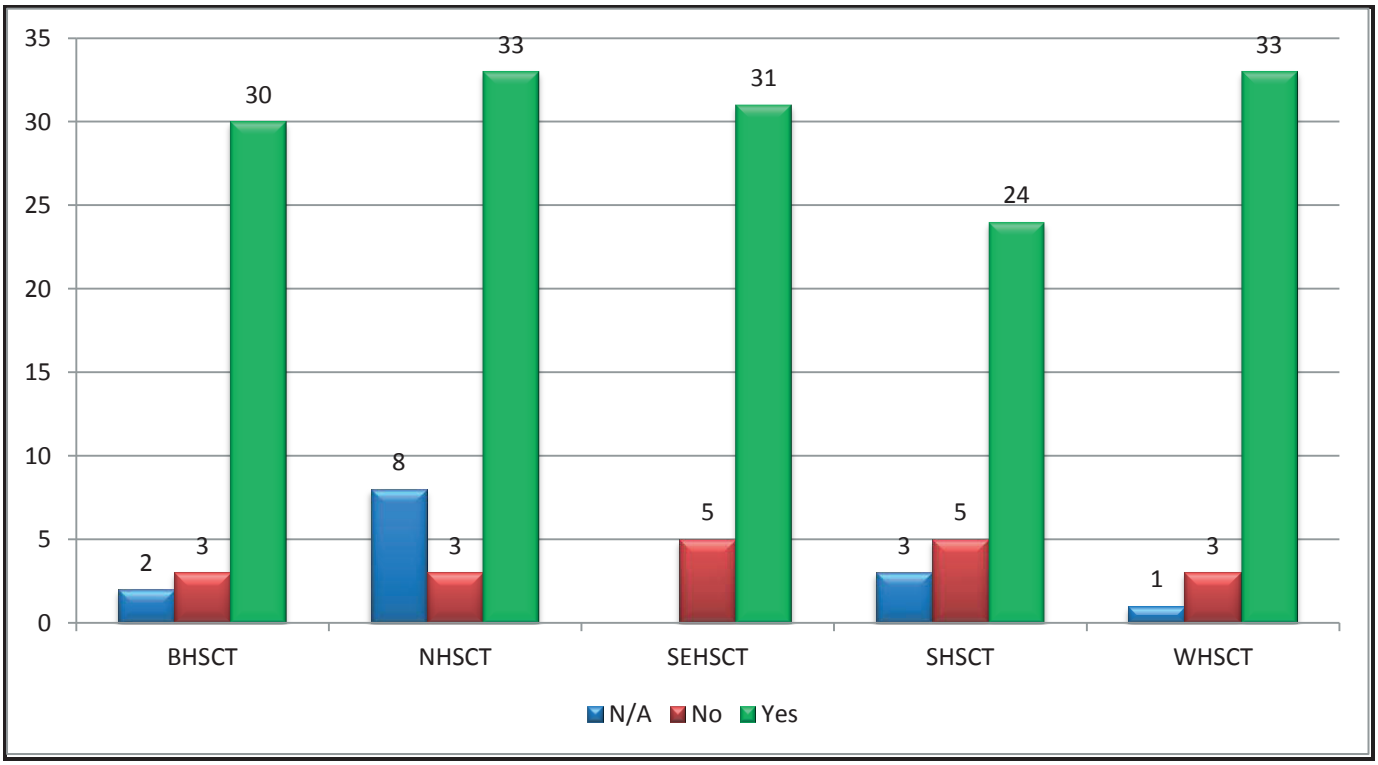


Figure 49: Does the care home environment run training sessions in the care home environment (HSC Trust area)?



It was found during the manager's interview that 53% (n=97) of all care homes provided training sessions on diabetes care within the care home. The remaining 47% (87) of Care Homes did not run training sessions for staff in relation to the care of people with diabetes

Figure 50: Is training provided by healthcare professionals trained in diabetes care by HSC Trust area?



A total of 82% of all training was provided by healthcare professionals trained in the care of people with diabetes. A total of 10% of all training was provided by others while the remaining 8% of results were recorded as not applicable.

Figure 51: Is training provided by healthcare professionals trained in diabetes care by care home setting?

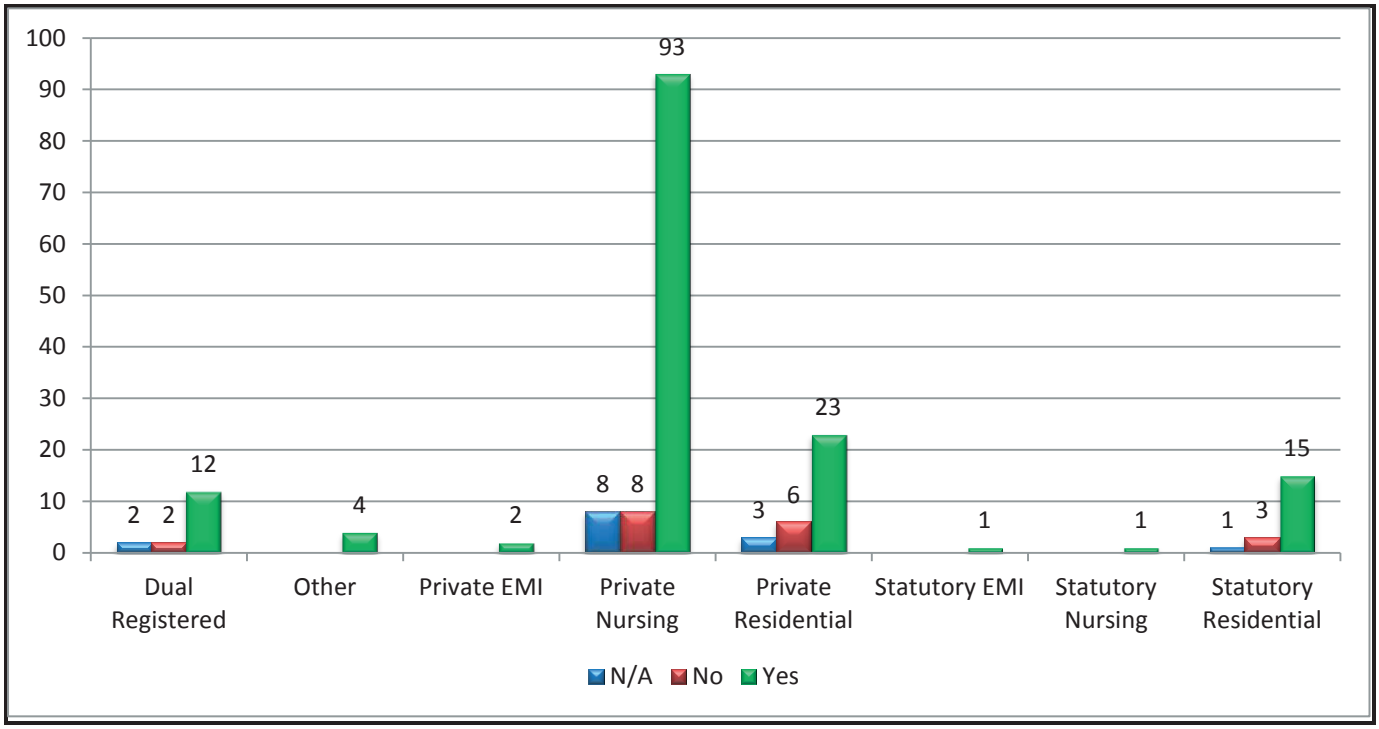


Table 4: Training received inside the care home setting broken down by topic.

	No	Unknown	Yes	Grand Total	Yes %
Classification and diagnosis of Diabetes	7	6	84	97	87
Long term complications and prevention	7	5	85	97	88
Annual Review	14	6	77	97	89
Blood Glucose Monitoring and use of blood glucose monitors	12	4	81	97	84
Foot Care	9	5	83	97	86
Hypoglycaemia recognition, prevention and treatment	6	5	86	97	89
Hyperglycaemia recognition, prevention and treatment	6	5	86	97	89
Oral Hypoglycaemic Medication	6	5	86	97	89
Insulin Therapy	12	5	80	97	82
How to Test Urine & Interpret Results	24	5	68	97	70
Quality Risk Management issues involved in Diabetes Care	20	5	72	97	74
Cultural & Ethical Issues involved in Diabetes Care	39	5	53	97	55
Nutritional Issues	4	5	88	97	91
Care in inter-current illness	19	5	73	97	75
Role & Responsibilities in Diabetes Care	9	6	82	97	85
Role of Diabetes UK & other Voluntary Bodies	22	7	68	97	70

Table 5: Training received outside the care home setting broken down by topic.

	No	Unknown	Yes	Grand Total	Yes %
Classification and diagnosis of Diabetes	7	13	120	140	86
Long term complications and prevention	8	12	120	140	86
Annual Review	18	13	109	140	78
Blood Glucose Monitoring and use of blood glucose monitors	11	11	118	140	84
Foot Care	8	12	120	140	86
Hypoglycaemia recognition, prevention and treatment	4	12	124	140	89
Hyperglycaemia recognition, prevention and treatment	4	12	124	140	89
Oral Hypoglycaemic Medication	5	12	123	140	88
Insulin Therapy	12	13	115	140	82
How to Test Urine & Interpret Results	30	12	98	140	70
Quality Risk Management issues involved in Diabetes Care	24	12	104	140	74
Cultural & Ethical Issues involved in Diabetes Care	48	13	79	140	56
Nutritional Issues	5	12	123	140	88
Care in inter-current illness	26	12	102	140	73
Role & Responsibilities in Diabetes Care	15	13	112	140	80
Role of Diabetes UK & other Voluntary Bodies	31	16	93	140	66

Classification and diagnosis of Diabetes

A total of 87% (84/97) of care homes had received this topic of training inside the home.

86% (120/140) of all care home had access to this training outside the care home.

Long term complications and prevention

A total of 88% (85/97) of care homes audited had completed this training within the home. 86% of all care homes stated that they had accessed this topic of training outside the home.

Annual Review

Table 4 shows that 89% (77/97) of all care homes received formal training covering the annual review inside the care home setting. Table 5 above shows that 78 % (109/140) of all care homes received training on this topic outside the care home setting.

Blood Glucose Monitoring and use of blood glucose monitors

The study found that 84% (81/97) of care homes had delivered a training session inside the home detailing blood glucose monitoring and the use of blood glucose monitors. 84% (118/140) of all care homes had accessed this training externally.

Foot Care

Results show that 86% (83/97) of all care homes had delivered a formal training session which outlined the importance of foot care within diabetes care. 86% (120/140) of all care homes received this training externally.

Hypoglycaemia recognition, prevention and treatment

Table 4 shows that 89% (86/97) of all care homes delivered training on hypoglycaemic recognition, prevention and treatment. 89 % (120/140) of all the care homes who had received this training had done so outside the care home setting.

Hyperglycaemia recognition, prevention and treatment

A total of 89% (86/97) of all care homes delivered training on hyperglycaemic recognition, prevention and treatment. 89% (124/140) of all the care homes who had received this training had done so outside the care home setting. It was found that the hyper and hypoglycaemic recognition, prevention and treatment where most often taught in conjunction.

Oral Hypoglycaemic Medication

A total of 89% (86/97) of all care homes delivered training detailing the use of oral glycaemic medication. 88% (123/140) of all the care homes who had received this training had done so outside the care home setting.

Insulin Therapy

A total of 82% (80/97) of all care homes received training on Insulin therapy within the care home setting. 82% (115/140) of all care homes stated that they have availed of training in relation to Insulin therapy outside the home.

How to Test Urine & Interpret Results

The study showed that 70% (68/97) of care homes provided training on testing and interpreting the results of a urine test. In total 70% (98/140) of all care homes had received training on testing and interpreting the results of urine tests from an external body outside the care home setting.

Quality Risk Management issues involved in Diabetes Care

A total of 74% (72/97) of care homes delivered training on quality risk management issues involved in diabetes care. 74% of all care home also received external training on this topic.

Cultural & Ethical Issues involved in Diabetes Care

The study highlighted that only 55% (53/97) of care homes delivered training on cultural & ethical issues involved in diabetes care. 56% (79/140) of all care homes received this training from a source outside the care home setting.

Nutritional Issues

It was found that 91% (88/97) of care homes delivered a training session on national issues relating to diabetes care. 88% (123/140) of care homes also received detailed training on this topic from outside the care home setting.

Care in inter-current illness

A total of 75% (73/97) of care homes provided staff with training which covered the topic care in inter-current illness. 73% (102/140) of Care homes also received this training outside the care home setting.

Role & Responsibilities in Diabetes Care

The study found that 85% (82/97) of care homes delivered training on the role and responsibilities within diabetes care 80% (112/140) of care homes stated that they had also received this training via an external provider.

Role of Diabetes UK & other Voluntary Bodies

Table 4 shows that 70% (68/97) of care homes had received training on the role of Diabetes U.K. and other voluntary bodies. Table 5 shows that 66% (93/140) of all care homes had received this topic of training from an external source outside the care home setting.

Discussion

As stated at the beginning the primary purposes of this audit are

- to ascertain what areas of diabetes care within care home settings can be further supported
- to gain better insight into the difficulties of providing enhanced care.

Residents with diabetes within institutional settings are a highly vulnerable population and are susceptible to macro vascular complications, infections, increased. Hospitalisation rates compared with ambulatory patients with diabetes, and high levels of physical and cognitive disability [13].

In this audit the most common age group accounting for 67% (n=614) of all residents were aged <80 years thus highlighting the ever ageing population and the increasing need for high quality diabetes care within the context of care homes. Currently this care is provided in many different care settings tailored to each individual's circumstances but the majority of residents who have diabetes have their diabetes care provided in the care home environment

In relation to Standard 1 the audit found that only 2% (n=4) of all care homes provided evidence that all residents within the care home had access to annual screening for diabetes. Standard 1 remains very important given the high prevalence of diabetes in those over 70 years and the risks of chronic hyperglycaemia and other vascular complications of diabetes if left undiagnosed lead to preventable hospitalisation with increased morbidity and mortality. This low response suggests that there may be difficulties with agreement on delivery of the Standard and / or resource of this standard to enable it to succeed. Diabetes UK has recommended blood glucose screening for all care home residents every two years and this may be a more realistic aim. This needs further investigation.

Standard 2 clearly states that all residents should have a care plan written by a registered nurse. 87% of all care plans reviewed were found to be written by a registered nurse. This is an excellent achievement. 80% (n=732) of all people with diabetes had been involved in developing their own diabetes care plan .9% of residents (n=80) where found to have had no involvement from themselves or from a relative. Encouraging greater personal and family involvement in developing diabetes care plans will help to promote better dignity and care for all residents. However it must be noted that some residents are unable to engage due to physical or cognitive medical conditions.

The results listed below were used to measure compliance with standard 2. "Each resident with diabetes will have their diabetes care documented in their care plan. High levels of compliance were witnessed throughout the audit process however it must be noted that some important information was missing.

- 17% of care plans were found to be missing any information detailing the name of advising community pharmacist.
- 43% of resident care plans lacked the required information detailing a list of diabetes related complications. Information relating to complications could prove vital during an emergency situation or in relation to other co-morbidities.
- 39% of all care plans lacked the required information relating to the residents agreed metabolic targets. This information is remains important for the resident with diabetes and for staff caring for the resident with diabetes as deviation out with the agreed targets can be addressed with specialist staff.

Standard 3- 98% (n=897) of residents had an annual review date set to examine their diabetes. A total of 18 residents (2%) did not have a review date set out or the necessary evidence was unrecorded. 99% (n=-789) of those residents reviewed, also had a general review of their physical and mental wellbeing completed to assess other areas of the patients health and fitness.
In general there was high compliance with a variety of elements of the annual review as laid out in the Results section.

During the course of the audit it was highlighted that the most common setting for the annual review outside the GP surgery was the care home setting. A total of 95% (n=579) of all residents were reviewed within this setting. The audit did highlight high levels of compliance with standards relating to the relevant information being documented. Using the GAIN proforma for capturing such data may support staff to optimise data collection.

Standard 4- It is important that all staff working with individuals with diabetes have regular and up to date training and knowledge in order to ensure best practice for patient care. Just 53% (n=97) of all care homes audited provided staff training sessions on diabetes care. It was not within the scope of this audit to investigate why staff training was not provided to 47% of care homes however it could be related to difficulties in releasing staff and / or ready provision of training from appropriate health care professionals. Standardisation and equitable provision of training to all care home staff is recommended Regular training is

necessary to ensure all relevant topics relating to diabetes care can be utilised by care home staff in order that high quality diabetes care within care homes is optimised.

The study also showed that just 54% (n=104) of all care homes audited within NI provided residents with access to a named member of staff trained in the care of people with diabetes (Standard 4). Within this group it was found that 93% (n=97) of named staff trained in the care of people with diabetes had attended update meetings and further training sessions within the previous three year period. The evidence shows a high level of compliance with training updates and would suggest that training is followed up regularly should this be implemented. All training topics had a compliance rate greater than 70%. There remains concern that a significant number of care home staff do not have access to training and further work is required to elicit barriers preventing access to training.

RECOMMENDATIONS

1. A working group should be established to develop an approach to screening all residents within care homes for diabetes. This should general practitioners, care home managers and health care staff

2. Each resident in a care home should have a diabetes care plan

3. Where possible each resident (or relative) should be involved in developing their diabetes care plan

4. The diabetes care plan will be written by a registered nurse. This may be a practice nurse or community nurse if there is not a registered nurse working in the care home.

5. Each resident shall have a review of their diabetes care plan at least annually or more frequently depending on clinical need

6. Each resident will have an annual review of their diabetes in the most appropriate setting

7. At the annual review the care home will the GP with details of the residents diet, monitoring results, medication and the residents general condition

8. Consideration should be given to adopting the GAIN documentation on annual review or agree on documentation to support high quality diabetes care

9. Each resident should have access to a named member of staff trained in the care of people with diabetes

10. Each home should have a named member of staff trained in the care of people with diabetes

11. Consideration should be given to the development of a regional training package that can be delivered by appropriately qualified staff across the provience

12. Training and education sessions should be provided by healthcare professionals trained in diabetes care

13. Education and training should be available for all staff including nurses, health care staff, chefs and cooks

14. Staff should attend update sessions every 3 years

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Glossary

NHSCT - Northern Health & Social Care Trust

BHSCT - Belfast Health & Social Care Trust

SEHSCT - South Eastern Health & Social Care Trust

SHSCT - Southern Health & Social Care Trust

WHSCT - Western Health & Social Care Trust

GAIN - Guidelines Audit & Implementation Network

RQIA - Regulation and Quality Improvement Authority

HSC - Health and Social Care Trust

BMI - Body Mass Index

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Appendix 1

Diabetes in Care Homes– Are we Getting it Right Now?

Name of Care Home: _____
(Please Print)

Total Number of Residents in Care Home	
Number of Residents on Diet Control Only	
Number of Residents on Diet Control plus Tablet	
Number of Residents on Diet Control plus Insulin	
Number of Residents on Diet Control plus Tablet plus Insulin	

Signature: _____ Print Name: _____

Contact Number: _____ Date: _____

Please complete and return in the enclosed envelope by Friday 4 May 2012

Health and Social Care

GAIN
GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

Appendix 2

HSC Area		Nursing Home	Private		Statutory		Audit Reference Number	
BHSCT		Residential Home	Private		Statutory			
WHSCT		Total Number of Residents						
SHSCT		Number of Residents with Type 1 Diabetes						
SEHSCT		Number of Residents with Type 2 Diabetes						
NHSCT								

Staff Audit: Manager Questionnaire

		YES	NO	NOTES
1	Does the Care Home environment have a dedicated named member of staff trained in the care of people with diabetes?			
2	Is the individual a Registered Nurse			
3	Have identified staff attended training sessions in the last 3 years?			
4	Does the Care Home Environment run Training Sessions in the Home?			
5	Do staff receive training outside the Care Home Environment (ie External Trainer / Provider)?			
6	Is training provided by Health Care Professionals trained in Diabetes Care?			
7	Is training available for all types of staff?			

Appendix 2 continued

Standard 4: Each Care Home will have a named member of staff, trained in the care of people with diabetes				
		YES	NO	NOTES
8	Did the staff training include			
	Classification & Diagnosis of Diabetes			
	Long-term complications and prevention			
	Annual review			
	Blood glucose monitoring and use of blood glucose monitors			
	Foot care			
	Hypoglycaemia – recognition, prevention & treatment			
	Hyperglycaemia – recognition, prevention & treatment			
	Oral hypoglycaemic medication			
	Insulin therapy			
	How to test urine & interpret results			
	Quality risk management issues in Diabetes care			
	Cultural & ethical issues involved in diabetes care			
	Nutritional issues			
	Care in intercurrent illness			
	Role & responsibilities in diabetes care			
	Role of Diabetes UK and other voluntary bodies			
9	Is education and training available to nurses and other health care staff			

Health and Social Care

GAIN GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

Appendix 3 QUESTIONNAIRE 2: CASE NOTE / RECORD REVIEW FORM

HSc Area		Type of Care Home: eg PNH / HSC NH	

Care Home ID Number	

Case Note Number		Gender	M / F	Age Range	<60	60 - 64	65 – 69	70 - 74	75 - 79	80+

Standard 1: Each Adult Resident in a Care Home will be screened annually for diabetes

Q				
1	Date the Resident was Admitted to Care Home			
		YES	**NO**	**NOTES**
2	Has the Resident been screened in the last 12 months for diabetes?			
3	Was the Resident fasting when the sample was taken?			
4	Were the results recorded in the Care Plan?			

Standard 2: Each Resident with diabetes will have their diabetes care documented in their care plan

		YES	**NO**	**NOTES**
6	Is there evidence that the Resident has been involved in developing their diabetes care plan?			
7	Is there evidence that a relative of the Resident has been involved in developing their diabetes care plan?			
8	Is there evidence that the Diabetes Care Plan was written by a Registered Nurse?			

9	If yes to Q8, was it:			
	Nurse in the Care Home			
	Community Nurse			
	GP Practice Nurse			
	Senior Care Staff (with diabetes training)			
10	Was a review date set?			
11	Was the review date set annually or more frequently?			
12	Does the Diabetes Care Plan / Patient Notes include the following?			
	Name & Phone No of GP			
	Name & Phone number of Trained member of staff			
	Name of Advising Community Pharmacist			
	List of Medication, doses & times taken			
	Where review will take place & Transport arrangements			
	Detailed list of Diabetes related complications			
	Agreed metabolic targets			
	Frequency and method of monitoring			
	Details of Diet Plan			
	Frequency of Foot checks			
	Injection site care if on insulin			

Standard 3: Each Resident will have an annual review of their diabetes in the most appropriate setting.

13	Was the residents review carried out at the GP Surgery?			
14	Was the GP provided with all relevant health			

	information for the review?			
15	Did the review consist of the following?			
	General review of mental & physical wellbeing?			
	Review of medication			
	Height & Weight (BMI)			
	Examination of feet, legs & general skin condition			
	Pressure damage risk assessment			
	Blood Pressure measurement			
	Eye sight test (when possible)			
	Ensuring individual has received annual retinal screening assessment			
	Assessment of Blood glucose control			
	Incidence of hypoglycaemia			
	Assessment of kidney function & cholesterol or lipids			
	Review of diet			
	Review of lifestyle issues			

Appendix 4

Steering Team

Membership of the Diabetes in Care Homes– Are we Getting it Right Now? Steering Team

Name	Designation	Trust / Organisation
Chairperson		
Dr Marina Lupari	Assistant Director Nursing – Research & Development	Northern HSC Trust
Members		
Richard Bigger	Audit Lead	Northern HSC Trust
Jonathan Wright	Project Facilitator	Northern HSC Trust
Christine Thompson	Director	IHCP
Janet Montgomery	Director	IHCP
Florence Findlay White	National Care Advisor at Diabetes UK NI	Diabetes UK
Dr Welby Henry	Consultant Physician	Belfast HSC Trust
Prof Patrick Bell	Consultant Physician & honorary Professor of Medicine	Belfast HSC Trust
Dr Darren McLaughlin	Consultant Physician	South Eastern HSC Trust
Liz Williams	Community Diabetes Specialist Nurse	Western HSC Trust
Dr Michael Ryan	Consultant chemical Pathologist	Northern HSC Trust
Elaine Davidson	Podiatrist	Northern HSC Trust
Mary Glass	Diabetes Specialist Nurse	Northern HSC Trust
Patricia Herron	Community Diabetes Specialist Nurse	Northern HSC Trust
Karen Wallace	Community Dietitian	Northern HSC Trust
Ruth McDonald	Clinical Audit Manager	Northern HSC Trust

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