

Nursing management of a chronic illness – diabetes type ii

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The impact of diabetes mellitus is manifold and adapting to and managing diabetes has been described as a fine balancing act (Lubkin & Curtin, 1990). It involves balancing the demands of diabetes management with the desire to live a 'normal' life. This is an intricate process, requiring compromises between self-control and professional expertise. It is arguably the role of the nurse to strive to understand the complexity of this balance and to offer realistic advice, support and education that pertains to the individual and not just prescriptively to the illness.

Person-centred care is currently one such approach and is certainly the buzzword of current literature (Paterson, 2001). From a professional perspective it is imperative to examine the impact of diabetes mellitus, a condition that affects not only the individual but also their respective families. Diabetes is an all-encompassing condition and is one of the biggest health challenges of the twenty first century (Diabetes UK, 2011). Experts agree that the UK's diabetes prevalence is on the increase and the impact of the condition is manifold (WHO, 2004).

Despite recent strides in the self-management of diabetes, many sufferers do not achieve optimal outcomes and suffer devastating complications of macrovascular and microvascular disease (Kumar & Clark, 2002). Indeed, the list of complications is endless; sufferers are at risk of retinopathy, nephropathy, cardiovascular disease, erectile dysfunction and strokes. The consequences of such an illness therefore dictate a professional obligation to pursue further examination. The motivation to scrutinize this subject from a

personal perspective stems from a desire to understand the mismanagement of this condition.

A gap currently exists between the promise and reality of diabetes care (Funnell, 2003). Current literature suggests that practice is the key to successful self management (Taylor & Bury, 2007). However, the reality is that many nurses fail to recognise this and subsequently fail to understand the sheer magnitude of the diabetes regime (Paterson, 2001). A lack of empathy with regards to the impracticalities of total adherence leads to goals that are prescriptive in nature. Consequently, a vast literature in non-compliance exists (Albright, 1994).

It is therefore arguably the responsibility of the nurse to strive to understand and assist the patient to overcome the barriers faced by this chronic and debilitating condition. A 76 year old gentleman with a 2 year history of diabetes mellitus type II presented to the emergency care centre (ECC) with a fractured right wrist. Mr Jones¹ had fallen due to a suspected hypoglycaemic attack brought about by the mismanagement of his diabetes. On admittance to ECC, Mr Jones' vital observations were taken and it was documented that he was tachycardic at 110bpm, had a raised blood pressure of 220/93 and was noticeably anxious.

Conversations with his daughter ascertained that he managed his diabetes by administering insulin usually prior to meals. He took no oral medication for his diabetes such was the severity of his diagnosis. She intimated that her father was very 'hit and miss' with his injection regime and with his glucose

monitoring and that his 'sweet tooth' often 'won the day'. She also stated that her father enjoyed his nightly brandies. Essentially, she felt he was uncomprehending of the serious nature of his condition.

Mr Jones was transferred to our rehabilitation ward after surgery on his wrist with the hope that re-enablement back into the community would eventually be feasible. We understood that Mr Jones currently lived in sheltered accommodation with a package that included twice daily carers and daily meals on wheels. His daughter visited him when she could but we were informed she was increasingly finding her father unable to cope at home. His co-morbidities included osteoporosis, rheumatoid arthritis and suspected retinopathy.

His previous past medical history included four coronary artery bypass graphs, a bilateral orchiectomy, two myocardial infarctions and more recently a pacemaker had been put in-situ. He was taking over ten different types of medication as well as attempting to adhere to his daily insulin regime. The goal was to help Mr Jones self-manage his diabetes whilst recognising the demands of his co-morbidities. We also wanted to work with his daughter, recognising her needs and the pressures she was facing looking after an increasingly dependent relative.

It was felt that fulfilling his needs would require the assistance from occupational therapy, physiotherapy as well as social services. He would also need to maintain contact with a wide range of professionals to meet his diabetes needs. The first stage of managing Mr Jones' care would involve a

complete, holistic nursing assessment of the patient's needs, regardless of the reason for admission (Prigmore, 2006). This assessment is a multidisciplinary activity. It would include a full nursing history of the patient, followed by a psychological examination and then a physical examination.

The latter examination would include the use of a range of assessment tools including the Barthel index, the index of independence (activities of daily living) and the Glasgow Coma Scale. Information gathered could then be used to form the basis of the care plan which would include any goals thought advantageous to achieve by nurse and patient alike. Adult Diabetes Services (2009) suggests that the role of the nurse is to offer Mr Jones help and advice about the importance of insulin, diet and exercise then refer him to a specialist dietician for advice on portion sizes, eating habits and food groups.

Diabetes UK (2009) also emphasises the importance of managing good glucose control in order to successfully self-manage the condition, another area Mr Jones was poor in. Indeed, the goals that the ward set for Mr Jones in his pathway, reiterated the recommendations given by these organisations. Mr Jones needed to be told the requisite information so he could manage his condition effectively. He may, for his own reasons, choose not to follow the information. However, Holman & Lorig (2000) and Metcalfe (2005) both believe that patient education is fundamental in enabling patients to be active in the management of their chronic condition.

To manage his diabetes the nurse must help Mr Jones to understand that he needs to aim for a haemoglobin of 6.5% and a total cholesterol of below 5mmol/L (NICE, 2009). This can be achieved through effective self management of Mr Jones' insulin regime. The nurse should seek to ensure Mr Jones understands the relationship between insulin and glucose and diet and exercise, between timing of injections and timing of snacks. The nurse should talk through with Mr Jones his injection technique and provide him the right kind of pen to inject so he can feel the insulin measurement if he has trouble seeing it.

The nurse should also make Mr Jones is aware of the problems of eating sweets as this can cause his blood sugars to spike and can lead to hyperglycaemia. Likewise, if he insists on drinking alcohol in the evening, the nurse must advise that he eats plenty of carbohydrates when drinking so that his blood sugars remain as steady as possible. (Diabetes UK, 2011). Some sheltered accommodations now provide forums where those with the same chronic condition can get together and talk about their difficulties and offer each other support (Diabetes UK, 2009).

The nurse could find out if Mr Jones' sheltered accommodation holds such meetings. The nurse could also offer Mr Jones and his daughter access to a follow up support programme such as DESMOND (Diabetes and self management for ongoing and newly diagnosed). This programme is especially supportive of families and carers and currently holds family days catering specifically for the needs of those who care for people with diabetes

(www.desmond-project.org.uk). The nurse therefore should also act as a conduit to other healthcare professionals.

Mr Jones needs to be made aware, not only of his blood glucose control and insulin regime but also aware that diabetes can affect his feet, eyes, renal ability and cause erectile dysfunction and macrovascular disease. These professionals would include a diabetes specialist nurse, district nurse, his G. P. , an ophthalmologist, an optometrist, a pharmacist, a podiatrist and a psychologist if required. The Department of Health's Expert Patient Programme (2001) also recommends the use of a named professional as a contact within the diabetes team.

This way Mr Jones will feel personally supported whilst also providing continuity of care. The National Service framework for diabetes (2003, p. 7) states that all adults with diabetes will receive high quality of care throughout their lifetime, including support to optimise their all risk factors and developing complications. Therefore, Mr Jones is entitled to compassion, re-education and open access to health care professionals. As a team we were very conscious of making changes that were feasible to Mr Jones' age and personality.

We were conscious that it is the role of the nurse alongside other healthcare professional to help Mr Jones with his self-management and assist him to empower himself and thus increase his internal locus of control (Rother, 1954). Thorne & Paterson (1998) believe strongly in the expert patient and the competence the chronically ill have with regards to decision-making. The

nurse therefore should work alongside Mr Jones to try to work out a plan of action that involves shared decision-making and shared goals.

To do so, we felt would enable Mr Jones to maintain a comfortable existence at level one of the Kaiser triangle. It is felt, at this level, that the service user is able to self-manage their long-term illness from home (Department of Health (DofH), 2007). Ultimately however, it was Mr Jones who needed to learn to self manage. It was therefore imperative that the multi-professional team work collaboratively to try to facilitate this. Motivational interviewing should take place where Mr Jones does not feel imposed to change by the diabetes team but imposed to change from within (Rollnick, 1991).

It is important to teach Mr Jones at his rate of learning and not to overload him with medical jargon if it is unlikely that he will understand. It may be helpful to invite his daughter to visit with other members of the diabetes team so she also understands and he feels he has support. Crucially, it is important that nurses recognise that any so called 'non-compliance' by Mr Jones may well stem from a very reasoned rationale. Mr Jones is clearly not sabotaging himself deliberately.

It is important for the nurse to understand that the actions of a patient are due to a myriad of reasons. Indeed, in light of a day of particularly painful arthritis it may seem a very reasonable action and a risk worth taking for Mr Jones to have a brandy. Viewing Mr Jones as a whole person and not just as a condition is arguably paramount if effective care is to be delivered. This case study has illustrated that in order for nursing practice to be enhanced

patients needs to be view holistically and a person-centred approach needs to be taken.

In the past care has been reactive rather than proactive and this has led to a sporadic model of care which has allowed chronic conditions to become acute interventions (Funnell, 2003). Indeed, traditionally the success of diabetes management has been measured by the level of adherence to a prescribed therapeutic regimen. This paternalistic, mode of treatment reflects the bio-medical paradigm of old and is now pilloried by most academic literature. The emphasis is now on the empowerment of the patient. This emphasis often incorporates a multidisciplinary, collaborative approach and encourages self-management programmes, as has been seen.

Taylor & Bury (2007) believe these programmes should be dictated by the individual rather than the individual's condition and state that making improved methods for self-management is at the crux of treating chronic illnesses successfully. Funnell (2003) goes onto say that because patients suffer the direct consequences of their decisions they have both the right and the responsibility to manage their condition in a way that mirrors the culture and the context of their lives. It is within this context that nursing practice can be enhanced.

The analysis illustrates that shared decision-making and a collaborative approach not only improves customer satisfaction but it also decreases hospital admissions and re-admissions. Sharing decisions with professionals also allows patients to retain autonomy in the presence of a debilitating

illness. According to Dow et al (2004) there is a strong sense that they have some control over their illness. Moreover because the person centred approach advocates self management within the home where possible, the service user is able feel more autonomous because of their environment.

Dow et al (2004) also point out that service users associated being at home with their family and friends and having friendly, caring staff visiting. All of which they felt was conducive to managing their illness. Family members felt that the person centred approach appreciated their role in dealing with family members with chronic illness. More paternal approaches only cater for the patient. Providers also felt that the home environment allowed for a more realistic assessment to be conducted and therefore assessment was better individually tailored.

With specific reference to diabetes the nursing profession has often been criticised for lack of understanding especially regarding the complexities of the regime. Indeed, medicine management is no easy task and the sheer magnitude of the insulin regime is as daunting as it is cumbersome. If nursing practice is to be enhanced, current literature states that nurses must recognise that broad areas of diabetes self management are not just single tasks but multiple tasks. For example, the insulin process alone involves approximately forty steps (Funnell, 2003).

Taylor & Bury (2007) argue that nursing must learn from this and adapt their teachings accordingly. It is therefore more reasonable for the nurse to ask the service user about adherence to specific parts of the regimen tasks

rather than adherence to broad areas. It is therefore also arguably an understanding of the minutia that enhances nursing practice. It is therefore clear that an increasing body of literature and evidence has accumulated detailing the different aspects of living with a chronic illness.

The meaning and significance of chronic illness to the individual is no longer ignored but is now a keen area of interest. This shift has marked the move to a more person centred approach to nursing which favours collaborative thinking and shared decision making. The patient is recognised as the expert they often are and their views and priorities are now put at the forefront. Nursing practice has consequently changed from the being prescriptive to delivering a more holistic type of care that strives to understand the complexities of the individual and their life.