

Holistic assessment and management strategies of diabetes



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This essay will focus on a patient referred to District Nursing (DN) Service via the Trust's Triage Central Booking Service. Patient was referred for the management and support of Blood sugar monitoring and Insulin administration.

The essay will be structured under the following sub-headings of introduction dealing with Patient's demographic and morbidity

The core of the essay will address chief complaints and critically address proposed plans and interventions put in place towards promoting independence post nursing DN assessment.

Also, the essay will highlights types of nursing models used complimentarily during holistic assessment whilst using empowerment and self management of Diabetes model as part of intervention strategies

Conclusion will provide an overview of patient's condition on the journey towards independence and safe-netting

Finally, reference list will be added using Harvard referencing format, as per London South Bank (LSBU) referencing guidelines.

Demographics

The patient is a 67 years old active Gardner named Peter, who lives with Partner and two children in a maisonette (social housing)

Peter is a pseudo name adopted to protect the identity and maintain patient's confidentiality (Nursing and Midwifery Council (NMC), 2018)

District Nursing services are significant part of the National Health Service (NHS) for many people often making the difference between people able to stay at home or moving into residential care settings, and preventing hospital admissions; together with a policy ambition to shift more care out of hospitals into community settings (Ham et al, 2012; Maybin et al, 2016)

Peter was referred to DN Service from hospital (acute setting) for Blood sugar monitoring (BSL) and insulin management/support, as Peter was recently diagnosed with Type 2 Diabetes Mellitus (T2DM) with significant medical history of hypertension (HTN)

Bayliss et al, (2003) affirmed that chronic medical conditions often occur in combination as co-morbidities, rather than an isolated condition

Diabetes Mellitus is a metabolic disorder (endocrine) characterised by chronic hyperglycaemia and hypoglycaemia resulting from insulin insufficiency and resistance (World Health Organization (WHO), 1999)

The National Institute of Care Excellence (NICE), (2018) estimates that, about 90% of adults are currently diagnosed with Diabetes type 2; in 2013, over 3.2 million adults were diagnosed with diabetes, with prevalence in England 6% and Wales 6.7% respectively.

Diabetic care is estimated to account for at least 5% of UK healthcare expenditure, and up to 10% of NHS expenditure (NICE, 2018)

This morbidity (Diabetes Mellitus) is classified as long term condition due to its chronicity, aetiology and its presentations (Kuzuya and Matsuda, 1997)

About 15 million diagnosed sufferers of long term conditions are in England; Long term conditions are diseases which currently there are no cure but, managed with multiple therapies or mono therapy (Kingsfund, 2018)

The prevalence of long term conditions are attributed to the factors of people living longer, large aging population cohort, unhealthy lifestyles, etc (Department of Health(DH), 2006)

Grady and Gough, (2014) state that there is increasing awareness and focus that long term conditions, including its prevention, treatment and management represents public health as well as a clinical issue

It is apt to support Dunning, (2013) that the aims of nursing care among others include: formulating an individual nursing management plan to foster patients' recovery, maintains their independence and quality of life and mitigate or ameliorate any complications of treatment

Peter was visited for initial assessment following local Trust's guidelines which stipulates that, all medications dependent patients referred to DN must be prioritised and seen within pre-set time. The Trust Triage algorithms template is designed to ensure the referrer stipulates the priority needs of the patient

One of Whittington Health (2018) DN local policies states that, prior to Patient initial visit, there is the need to contact patient to establish availability and pre-arranged suitable time slots hence, Peter was contacted

In the initial assessment phase, present was my mentor (Practice teacher) and Peter's Partner but assessment was carried out by me (DN Student) under the supervision of my mentor

Prior to assessment at Peter's abode, DN Team explained to Peter and his Partner about the reasons for DN visit and agenda, consent sought and was gained as per guidelines (NMC, 2018)

Primarily, initial assessment provides platforms to evaluate Peter's care needs, preferences and abilities. Also, it provides DN Team the opportunity to underscore any potential risk to patient and visiting District nursing Team and the need to sign post to Multi-disciplinary Team (MDT) if warranted

In addition, initial assessment involves the holistic assessment of Peter's Health and social care needs as this will help foster individualised patient-centred care

The importance of Patient-centred care was given credence by Innes et al, (2006) that nurses should recognise the need to tailor individualised needs by offering choices, as it promotes independence and autonomy rather than control; involves services that are reliable and flexible chosen by service users

The Roper, Logan and Tierney model (1996) dependence-independence continuum was used in Peter's nursing process of assessment. The model guides the nurses to assess patient's abilities in 12 domains of activities of daily living (O'Connor, 2002)

This model has been criticised for being too medically orientated but its simplicity of use and popularity in the UK have been its allure. O'Connor (2002) states that, the model helps in systematic and logical means of delivery care, encouraging Teams participation and continuity of care

In the initial assessment continuum, the Trust's assessment tool was used to establish the following: skin integrity, Judy Waterlow score tool (it is a tool to estimate patient risk of developing pressure sore) and Malnutrition Universal Screen Tool (MUST) for nutritional needs and the to establish the risk assessment (Whittington Trust, 2018)

Peter is independent of activities of daily living with sound physical and cognitive abilities with no obvious dexterity deficit. I am inclined to use Orem's theories of self care and self-care deficit in identifying Peter's care needs and independence promotion

Importantly, Peter's needs and chief complaints were identified as Blood sugar monitoring (BSL) and Insulin management. During the assessment, Peter willingness to self care was explored with added Partner's support

Grady and Gough (2014) observed that, due to the prevalence of long term conditions; chronic illness management has gained focus and emphasis on symptoms management towards maintaining patience independence and quality of life over longer periods of time has gained significance

The management of Diabetes Mellitus (T2DM) type 2 is central in preventing long term complications and improving quality of life (Pamungkas et al, 2017)

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Critically, it is evident based that to manage diabetes effectively, patient must be able to set their agenda and make decisions that fit their values and lifestyles in the face of multitude of physiological and personal psychosocial factors (Funnel and Anderson, 2004)

The need to empower and promote Peter's independence and his Partner to support in BSL monitoring and insulin administration was part of management and intervention strategies put in place

Using the synergy of empowerment and medical management of diabetes frameworks, Peter and DN Team fostered therapeutic relationship based on mutual respect with predetermined goals of independence and self care

Funnel and Anderson, (2004) defined empowerment as helping patients discover and develop their ability and capacity to be responsible for their own care which involves educational process and setting goals

Orem, (1980) focuses on self care by emphasizing the need for autonomy and promotion's of patient's ability to meet their needs wherever possible

In supporting the need for self care, Department of Health (DoH) (2001) launched the Expert Patient Programme (EPP) with the main objective was to improve self care support in the National Health Service (NHS)

The NICE, (2018) recommended Diabetes structured patient education as part of the management plan towards enablement and self care.

The importance of patient education is important due to the complexity of T2DM, as patient is routinely overwhelmed with plethora of tasks: adherence

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to medications regimen and engage in self-care behaviours including at home blood glucose monitoring , healthy dietary changes and increased physical activities (Pamungkas et al, 2017)

In the management of chronic diseases or provision of nursing care, it is important to identify barriers to self care

Bayliss et al (2003) identified barriers to self care to be the following: lack of knowledge, physical limitations, need for social and emotional/psychological support, aggravation of symptoms or treatment of another condition, and overwhelming effect of dominant individual conditions

DN Student was able to identify the following: psychological, social and lack of knowledge as major barriers in Peter's journey towards independence hence the need to employ the support of Peter's partner.

It is evidence based that, family support has positive effects on patient self management behaviour hence, the need to explain the importance of education to patient and primary carers (NICE, 2009. Pamungkas et al, 2017)

According to Hughes (2013) suggests that nursing process look at the goals of care from dependence to independence; once stability and capacity to make decisions are reached, long terms goals can be jointly set or indicated directly by patient

Patient's independence and autonomy have been described as the ability to achieve, make decisions and initiate actions by oneself (Roy, 1976)

Additionally, i proposed measures with inputs from Peter and Peter's partner in the management of diabetes mellitus (morbidity) was put in place by incorporating SMART framework

A smart framework is an acronym for Specific, Measurable, Achievable, Relevant and Time-bound (SMART) is a statement of intent that a person or group of people signed to help provide direction in pre-determined goals (Handrick, 2017)

The specific within the SMART framework helps to set the stage in identifying what Peter's would like to focus on or achieve.

Thompson, (2018) stated that SMART framework, is a goal setting framework that directs how to initiate goals that will help achieve outcomes

Using the SMART framework DN student acknowledged what specific skill or performance Peter would like to achieve (administration of insulin and Blood Glucose monitoring independently).

Self Management:

Cooper (2001) believes that self management by patients is about the development of confidence and skills to find their own rhythm, pace and resources, which include inner strengths and knowing where and when to ask for help

Based on the above premise of self management paradigm, i initiated intervention plan of coaching techniques to foster self care and family support by using empowerment and self management of diabetes framework

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It is evident that coaching technique can be used to support patients and family members to take control of their health (Hughes, 2013)

Coaching is defined as the skill of questioning, effective listening and giving feedback in a professional relationship to promote learning, self awareness and actions (Hughes, 2013)

It is a process embarked upon by DN by directing patients to examine what they want to take control of; it helps in establishing therapeutic relationship by promoting openness, trust and awareness of skills required for independence in the context of collaborating (Hughes, 2013)

In fostering Peter's and spouse learning and coaching, i explored Adult learning theory in support of my techniques. It is evident based practice that healthcare practitioners and patients enter into a teaching-learning relationship (Russell, 2006)

Knowles, (1970) described the adult learning theory as a process of self directed learning styles with characteristics of motivation, mutual trust and clarifications of mutual expectations

The National service framework (NSF) long term conditions in its 12 standards: aim to enable people with diabetes to exercise personal control over the daily management of their condition and to experience the best possible quality of life. It moves the practitioner's role from one of disease management to that of enabler (Nazarka, 2003)

Medical Intervention strategy

It was agreed with all the parties that, DN to maintain daily visit until desired competency and confidence levels are achieved in blood sugar monitoring and insulin administration

In addition to the above, is for DN Team to send in competent, experienced and confident nurses to help in teaching both Peter and spouse on how to use the Glucometer and insulin Kwik pen

Self management includes injection techniques and subcutaneous injection sites and the need to rotate injection sites

Self-monitoring of blood sugar is considered very important in diabetes management and may improve glycaemia control, especially is often recommended for patients with T2DM that are newly diagnosed (Peel et al, 2004)

Other Empowerment Intervention strategies and safe-netting

Arguably, it is well documented that DN service is poorly designed to effectively treat chronic diseases such as diabetes that require the development of a collaboratively daily self management plan plus the effects of DN huge workloads (Funnel and Anderson, 2004)

Premised on the above, Peter consented to be referred to educational programmes such as DESMOND and other collaborative multi disciplinary team members

DESMOND: is the acronym for Diabetes Education and self Management for ongoing and newly diagnosed T2DM. It is part of a school of patient education for people with diabetes (Diabetes UK, 2018)

Desmond is commissioned by some NHS organisations for free with the mandate to provide education to patients and learn more about T2DM, it provides resource to help manage diabetes related changes with platform to meet and share life experiences with others (Diabetes UK, 2018)

Nutrition

The nutrition therapy: is identified as the use of specific nutrition services to treat ill-health and medical condition. It involves an assessment of the nutritional status of the service user and treatment plans of nutritional therapy, counselling and use of specialist nutrition supplements (Pastors et al, 2002)

The management of nutrition therapy (MNT) and self-management promote patient's involvement and adherence with its huge benefits of knowledge, behaviours, skills, attitudes, etc. (Pastors et al, 2002)

Post consultation, Peter agreed to be referred to Freedom4life a non-governmental organisation (NGO) educational program; Freedom4Life focuses on diet and lifestyle changes in order to improve blood sugar control and improve quality of life for the people who take the course (Diabetes UK, 2018)

The General Practice/Practitioner (GP)

I ensured adequate enlightenment was given to Peter's and spouse, particularly Peter on the role of his GP especially in the management of HbA1c and medication-Injection prescription

HbA1c: It is known as the glycated haemoglobin which is the average blood glucose sugar levels for a defined period. It differs from finger prick which is a snap shot of one's blood sugar at a particular day at a particular time (Diabetes UK, 2018)

Diabetes Team: It is important newly diagnosed patients are on Diabetes Team caseloads to help provide specialist inputs and recommendations when it becomes necessary

Community Matrons

It is evidence based that DN service is saddled with generalist based caseloads Chapman et al, (2009) hence the need to refer Peter to community matrons with intent and purposes of meeting Peter's medical and social needs

Diabetes UK

Is a community of people with diabetes, family members, friends, supporters and carers, offering their own support and first-hand knowledge to each other. It is commissioned to provide support, diabetes education to its members (Diabetes UK, 2018)

Peter was advised on how to get his medications supplies and insulin Kwik pen regularly at one of the local pharmacies

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Conclusion

To conclude, Peter a newly diagnosed T2DM referred to DN service for the management of Blood sugar levels monitoring (BSL) and insulin support was assessed using relevant nursing models of Roper Logan Tierney, Orem's and the DN Wittington Health assessment tools.

The assessment revealed low level of needs in the activities of daily living domains, as patient was deemed cognitively okay, with no impairment, mobilising independently and communicating coherently and not at risk of pressure sores

It was of great significance that Patient needs to be supported on the journey towards independence by the local DN Team whilst enlisting the help of Peter's spouse.

Peter consented to DN care and for his Partner to be involved in his care, as she remains her main carer without the social service inputs

The need to empower Peter whilst engaging Peter's partner on the journey towards independence was premised on the benefits of self management of blood glucose (SMBG).

It is evident based that, patient's journey towards independence helps to gain better understanding about factors that affect their disease and the potential rewards that might accrue (Inzucchi et al, 2015)

Furthermore, Inzucchi et al, (2015) put forward that, self-management of blood glucose improves adherence to pharmacological treatment and motivates patients to make appropriate lifestyle changes

Self monitoring of blood glucose with glucometer device is used as part of resources available to patients with Type Diabetes Mellitus (T2DM). It aims at collecting information on blood glucose levels at different times of the day and it allows for identification of any fluctuations of values as to foster possible actions (Welschen et, al, 2005)

Moreover, DN student collaboratively set up a rolling plan with Peter and his Partner on the panned independence journey specifically on coaching on how to use Glucometer and insulin administration devices by using SMART framework and set up visit plans for the local DN Team as prescribed

Important safe-netting measures put in place consented to by Peter and his spouse include referrals to made to the GP, Dieticians/Diabetes community Teams, Matrons, and to signpost to relevant educational NGO's specifically DESMOND, Diabetes UK, Other local Diabetes support groups, etc.

And, DN student application of robust frameworks in assessing and planning measurable care plans and safe-netting of Peter's roadmap to independence were rooted in the ethos and nursing paradigm below

DN are aware that components of measurable good nursing is based on holistic approach to care with a focus on continued therapeutic relationship, involvement of family and carers, patient education and self management support, and care coordination (Maybin et al, 2016)