

## Care of a Resident with Diabetes Policy

### Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

#### Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

#### Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

#### Infection prevention and control

We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

#### How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

#### Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

#### Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

#### Person-centred care

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

#### Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

## Scope

EFH believes that every individual has the right to the highest possible quality of care in the management of their health needs. This document is intended to set out the values, principles and policies underpinning this home's approach to the care of people who use services with diabetes.

This policy is designed to be compliant with the Diabetes National Service Framework (NSF).

EFH that diabetes is a long-term condition in which the amount of glucose (sugar) in the blood is too high because the body does not produce enough insulin to be able to use it properly.

The home recognises that there are two main types of diabetes.

Term	Definition
Type 1 diabetes.	type 1 diabetes is usually treated by insulin injections and changes to the diet
Type 2 diabetes	type 2 diabetes is treated with lifestyle changes such as a healthier diet, weight loss and increased physical activity, and medication and/or insulin to restore normal blood glucose levels.

## Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

## Policy Statement

This policy needs to be read, understood and followed by all members of staff delivering care and their managers.

## The Policy

EFH understands that a key component of the Diabetes NSF is the empowerment of people with diabetes to look after themselves as far as is possible. This is a vital element in enabling those in residential care to live with dignity, self-determination and independence.

This policy, therefore, encourages people who use services to retain control over their diabetes wherever this is clinically safe.

## Assessment

In this home, all diabetic residents should be assessed on admission for their capability in being able to self-care and to determine what support they require.

Where a person develops diabetes during their residency, an assessment will be conducted in partnership with their GP and with any specialist diabetes care services involved.

The initial assessment should be designed to elicit exactly how much support the person will need in coping with their diabetes and to identify who should do what in providing care. The results of the assessment should be entered into their plan of care.

The assessment should identify one of the following typical patterns of care people who use services who:

- may safely maintain control of their diabetes from admission
- may be able to take partial control over some aspects of their diabetes care and who will need support and monitoring by care staff

- may need support on a temporary basis but who will be able to resume control as soon as possible
- are unable to take full control of their diabetes and for whom arrangements will need to be made for support and care to be provided by the home or from specialist diabetes care services.

An effective handover consists of three steps:

1. Preparation by the outgoing personnel for handover.
2. Performing the handover in which the outgoing and incoming personnel communicate to exchange relevant information.
3. Cross-checking of information by the incoming personnel as they assume responsibility.

#### Care Protocol for the Person with Diabetes

In this home, each person with diabetes can expect:

- to be encouraged to play an active role in their own care relative to their overall level of independence
- to have an individualised care plan which they themselves have played a key part in developing along with any members of their family and/or advocates that they wish to be involved
- to have an individualised dietary and nutritional plan agreed with them
- to have an annual review involving their GP and other essential members of the community health team and care home staff
- to have support and assistance from a named member of care staff who will act as a key worker for their diabetic care management, assisting the person in monitoring their diabetes and in managing their medication as required and in compliance with the care home policy on medication administration
- care home staff to work closely with local healthcare teams and provide access to local specialist diabetes nurses for advice, support and educational material, including access to community health professionals such as a community dietician, podiatrist and an optometrist
- access to consultant specialist care by direct referral from the GP or by an agreed community health professional
- assistance from the home in attending specialist hospital outpatients or clinics or receiving a domiciliary assessment.
- To ensure that high quality diabetic care is provided for all people who use services, this home will:
- ensure that care staff have received appropriate training and education in the management of people with diabetes within care home settings — including training in the management of hypoglycaemia, the importance of good glycaemic control, foot and eye care and ensuring that nutritional assessment, guidance and dietary reviews are in place
- provide facilities, resources and support to carry out glucose monitoring where necessary
- provide a suitable room to act as a basic treatment and assessment area in order for annual reviews to be conducted effectively
- ensure that at least one member of the catering or kitchen staff is familiar with the key principles of dietary planning for people with diabetes
- ensure that an agreed protocol of diabetes care is in place which is agreed in partnership with local community nursing and dietetic staff, with community diabetes specialists, and with local GPs
- ensure that a mechanism is in place to collect diabetes-related health data and clinical diabetes audit information
- ensure that one or more members of staff are trained in the administration of insulin therapy
- provide educational information on diabetes for both people who use services and families
- ensure that all new people to the services are screened on admission, conducted in partnership with the person's GP, and fully assessed for diabetic needs, the needs assessment providing the basis of each person's care plan
- ensure that people who do not have diabetes are regularly screened for diabetes by their GP according to health service guidelines.

## Diabetes Care Planning

- In this home, each person with diabetes should have an individual care plan agreed between the person (or relative), GP and home care staff. The plan should include input from specialist agencies involved in the care of the person where necessary. The plan should include the following.
- The identification of a designated and appropriately trained member of care staff to function as a key worker.
- The identification of a designated doctor (usually the GP) to take overall medical responsibility for the diabetes care.
- A specific dietary plan (including a weight assessment) designed by a community dietician.
- A full list of medications and diabetic treatment, including dosage and frequency information — and arrangements for the administration of the medication (ie whether self-administered or administered by care staff).
- Arrangements for an annual review.
- Measures to minimise the risk of both long-term and short-term complications, including hypoglycaemia and arrangements to screen regularly for diabetes-related complications, eg diabetic foot ulcers outside the procedure for annual reviews.
- An agreed set of metabolic targets (eg blood pressure, glycaemic control) and an agreement on the level and intensity of blood glucose monitoring required.
- A series of outcome measures which can be used to measure the adequacy of the diabetes care provided by the home.
- In this home, all care plans for diabetic people must include details of exactly how episodes of hypoglycaemia should be managed. They should also include details of how the person should be managed if they are unwell and unable to eat.
- Most people who use services with diabetes take blood glucose levels at varying frequencies. The person will have their own blood glucose testing machine and test strips prescribed by their GP and should be given support in conducting their own tests at a frequency stated in their plan of care. People who use services should be encouraged to maintain records of their blood glucose results and these should be monitored by care home staff during reviews.
- In this home, all care plans for people with diabetes must include details of exactly how episodes of hypoglycaemia should be managed. They should also include details of how the person should be managed if they are unwell and unable to eat.
- For people with diabetes, monitoring blood glucose is important when unwell, as diabetes can have an additional effect on the illness and the illness can impact on their diabetes. Blood glucose can rise quickly during illness, particularly in older people who are dehydrated. Extra monitoring and medication or adjustment to insulin doses may be prescribed, and additional support and monitoring needed.
- Most people with diabetes take blood glucose levels at varying frequencies. The person will have his or her own blood glucose testing machine and test strips prescribed by their GP and should be given support in conducting their own tests at a frequency stated in their plan of care. People should be encouraged to maintain records of their blood glucose results and these should be monitored by care home staff during reviews.
- New monitoring devices enable people to check their blood glucose without the need for finger pricks, called Flash Glucose Monitoring or Freestyle Libre.
- A monitor is placed on the upper arm which uses a small needle as part of the sensor application process, however no needle is left in the site during the 14-day wear. Results can be obtained via a compatible smartphone, where the app can be downloaded and used to scan the sensor to see obtain readings. A small device called a reader is also available to purchase for those who do not have a smartphone.
- It has been found this may help older people with diabetes and memory loss more easily monitor and manage their blood glucose.
- People with type 1 diabetes can get the FreeStyle Libre free of charge on the NHS and those with type 2 diabetes, if they suffer recurrent or severe hypoglycaemia or have impaired hypoglycaemia awareness.

## Diabetes Annual Review

In this home, every person with diabetes will have an annual review which will include:

- a full clinical examination

- a check of height and weight in order to calculate body mass index
- lying and standing blood pressure
- urinalysis for protein
- appropriate fasting blood tests
- the examination of feet and lower limbs for deformity, infection and ulceration.

People who use services in this home will also have a regular review of their medication and their dietary plan. The appropriateness of their care plan will be regularly reviewed, and reviewed in the light of any major changes in their condition.

### Training

- Care staff are provided with training regarding Diabetes at all suitable stages of their employment from induction onwards.
- This home believes that the education and training of care home staff in modern diabetic care is fundamental for the provision of high-quality care services, for the prevention of diabetic complications and early identification of problems, and for effective diabetic care.
- All new staff should be encouraged to read this policy on diabetic care as part of their induction process as well as any associated policies and care protocols. Existing staff will be offered additional training covering diabetes care, foot care, eye care, wound care management and infection control.
- Nursing staff will be offered appropriate skills training or refresher courses in modern evidence-based practice as identified in appraisal or learning plans and as dictated by their need for continuous professional development.
- Catering staff will be offered necessary training in diabetic diet and menu planning.
- Homes will identify where practicably possible a champion for Diabetes.

### Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of resident care where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

### References

Review date	Next Review Date
May 2024	May 2027