Practice nurses need better diabetes education to meet service and individual needs

Anne Phillips, from the iDEAL advisory group, highlights the need for constant evidence-based educational opportunities to be available and accessible, via a variety of means, to ensure practice nurses can keep up to date and deliver evidence-based diabetes care

The iDEAL Group is an independent multi-disciplinary panel of diabetes experts and includes people living with diabetes. iDEAL aims to improve diabetes care outcomes across the UK. iDEAL recognises the need for responsive and effective health professional education, coupled with educated health professionals, to meet the increasing needs for diversity, specialism, cultural competence, advancing practice and person-centredness in diabetes care delivery. The recently published position statement from iDEAL, *Diabetes Health Professional Education to meet Service and Individualised Needs* (Phillips et al, 2019), highlights the need for constant evidence-based educational opportunities to be available and accessible, via a variety of means, to ensure health professionals can keep up to date and deliver evidence-based diabetes care wherever they practice. This follows on from the White Paper published by iDEAL in 2018 (Grumitt et al, 2018). This article provides an overview of the key points made in the position statement.

Why is education needed?

Self management of diabetes can be challenging and psychologically demanding. It requires informed choices, knowledge, personal application and health literacy. There is a need for ongoing education based on individualism, confidence, motivation and potential behavioural change to maintain optimum diabetes self management for every person with diabetes (Swanson and Maltinsky, 2019). At the same time, diabetes care is becoming increasingly complex, with health professionals sub-specialising in their knowledge and care delivery, in order to meet the intensifying complex and diverse requirements of people with diabetes (Riordan et al, 2019).

Practice nurses and allied health professionals are rapidly developing their roles and removing traditional role boundaries. King et al (2019) recognise that each professional will bring a different perspective to their role in diabetes care; however, there are no recognised distinctions between health professionals from different professional backgrounds nor are there clear differences in their scope of practice.

The increasing reliance on unregistered health professionals, especially in primary care, requires clear core proficiency and competency frameworks for safety and access to informed education (Royal College of Nursing (RCN), 2019; TREND UK, 2019). Over-reliance on unregistered health professionals with little or no access to ongoing diabetes education raises concerns around the safety and quality of care for people with diabetes.

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Access to CPD

Building strong networks of engaged, active health professionals participating

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in continuing professional development (CPD) across the health service lies at the heart of educational practice. However, restricted study leave and reliance on health professionals using their annual leave for CPD presents challenges. Greatbatch (2016) on behalf of the Council of Deans of Health suggested that despite the NHS Five Year Forward View (NHS England, 2014) announcing the need for an educated workforce to deliver optimum care, this cannot become a reality without access to CPD to create the right skills, values and behaviours to deliver effective care. Not investing in CPD stops best practice being delivered for people with diabetes.

Person-centred care and respecting choice

An educated health professional can facilitate the development of colleagues to deliver excellent, informed individualised diabetes care. This can make a real difference to individual experiences and develops the abilities of health professionals, enabling practitioners to grow within their roles, supported by access to CPD.

Historically, preparation of educators focused more on teaching them the facts about diabetes rather than emphasising the principles of person-centredness and choice (Dickinson et al, 2019). Greenhalgh and Heath (2010) reported on the unique value of the therapeutic relationship, especially between practice nurses and people with diabetes receiving care.

The evolution of the practice nurse's role in diabetes care has been fundamental, as practice nurses work with most people with type 2 diabetes and some with type 1. The distinctiveness and responsibilities of the role of practice nurses must be acknowledged.

MacDonald et al (2013) undertook an ethnographic survey of practice nurse consultations with people with type 2 diabetes. Their results illustrated that inexperienced practice nurses have a tendency to be checklist-driven to meet all the criteria required within a diabetes consultation. More experienced practice nurses can more readily apply discernment and intuitive self-reflectivity into their practice, which changes the focus of the consultation. Furthermore, people with diabetes reported that the approach to promote self management and discuss their diabetes trajectory was very different and very welcome, as opposed to the usual problem-solving medical model (Silverman et al, 2013).

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Sharing good practice and evidence can motivate health professionals. However, it is important to recognise the needs of health professionals who are isolated or who cannot attend CPD or diabetes updates. Digital access to online communities and education solutions can be useful in these situations.

Role diversity

Diabetes teams are interdisciplinary, which Engel and Prentice (2013) indicated can cause challenges to the delivery of person-centred care. Even though each health professional in the team might wholeheartedly agree with the concept of person-centeredness; it calls back to an ethical narrative that is created by both the health professional and the person with diabetes. Reeves (2012) suggested that the aims of care between health professionals and people with diabetes, might create difficulties if 'common ground' (Stewart et al, 2013; Brown et al, 2011) and choice are not key in the care equation. This can cause misunderstandings about the complexity of diabetes treatment and can lead to people with the most need not accessing the right care at the right time to promote their diabetes knowledge and self-management skills.

Delivery of individualised care and respecting the 'whole person' assumes that people with diabetes are generally autonomous, and therefore are equally capable of making their own decisions. Reaching out to ensure diabetes care meets the needs of people with diabetes and learning disabilities (Smith and Phillips, 2018), those living with severe mental ill health (Taylor et al, 2019) and those who are experiencing social isolation or deprivation (Everest and Phillips, 2015) is essential.

Enabling a learning environment

Health professionals in diabetes care can stimulate peer and student learner engagement in order to succession plan (Christenson et al, 2012). Pre-registration education for all health professionals is key to establishing person-centred diabetes care approaches, as this is where initial knowledge, attitude and education about diabetes is established.

Giving the most current, effective, efficacious and appropriate advice to people with diabetes enables the optimum delivery of diabetes care. Dowell et al (2018) highlighted that the use of language to promote understanding differed between inexperienced and experienced health professionals, with checklist and technical language being applied far more frequently by inexperienced health professionals. Health professionals who follow checklist type diabetes care may miss the nuances and potential needs of each individual. As such, treatment choices offered can be limited by inexperience, usual prescribing habit, pharmaceutical influence or familiarity of the practitioner. Krautscheid (2014) suggested that health professionals must be held to account if failure to maintain current practice affects the delivery of optimum care to people with diabetes.

There is wide variation in accessibility to ongoing education and CPD for practitioners within diabetes care. Up-to-date information is paramount to escalate care accordingly and help prevent complications occurring unnecessarily.

The cost of avoidable complications to the NHS is considerable, with 80% of all funding for diabetes allocated to treat avoidable complications (Hex et al, 2012; Baxter et al, 2016). The cost savings for modest improvements in risk factor reduction are substantial. When we have an NHS, which is experiencing acute financial

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pressures, any financial savings from timely interventions seems practical. Accessible education for practice nurses and other health professionals to enable them to deliver fiscally responsible care to meet individual needs is essential.

Cultural competence

Fourteen percent of the UK population are identified as being from a minority background (Goff, 2019). Self-management education and engagement with health professionals can be less effective in people with diabetes from non-white ethnic backgrounds (Creamer et al, 2016). This is often attributed to a lack of cultural competency among health professionals and a failure to account for cultural beliefs and practices in generic education. Culturally tailored advice and education programmes that are respectful of and responsive to the health beliefs, practices, linguistic needs and culture of people with diabetes from diverse communities are required (Creamer et al, 2016). Furthermore, Attridge et al (2014) suggested that diabetes care for people with diabetes, that has been culturally tailored or is culturally appropriate, can bring significantly greater improvements in risk factor reduction, diabetes knowledge and self-efficacy.

Summary

Growth in accessible diabetes health professional education for both generalist and specialist practice is vital. Educated health professionals, including practice nurses, enable knowledgeable people with diabetes. iDEAL recommend that all health professionals at every level working in all areas of clinical practice should have a competency/proficiency education programme from induction that is recorded and can be evidenced for annual performance and revalidation purposes. The aim of this is to reduce variation in care delivery and raise standards of care for people with diabetes.

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