'Declarations, Recommendations, Resolutions, Action!'

Highlights from the 14th Annual Conference of the Federation of European Nurses in Diabetes (FEND), 25–26 September 2009, Vienna, Austria

The 14th Annual Conference of FEND took place in Vienna, and opened to an audience of over 700 international delegates with a wave of nostalgia and remembrances for the first ever FEND conference (also held in the beautiful city of Vienna in 1996). Opening remarks by the Chair Deirdre Kyne-Grzebalski reflected the need back then to the same need now – a strong, robust, active membership of FEND, which is now free for all nurses. Comments by the President Anne-Marie Felton highlighted the theme of the conference and the crossroads currently faced by Europe with regards to protection of diabetes services in these harsh economic times. The president declared FEND was always prepared to fight to establish equitable health provision for people with diabetes, to work towards improving education for diabetes nurses, and to continue to influence health policy through collaboration. These main themes and aims were clearly evident in the two-day conference programme.

Diabetes care in Austria

Professor Thomas Pieber, Medical University Graz, Austria began the conference with an overview of diabetes in the host country. His talk highlighted problems with strict separation existing between primary and secondary care, and lack of central regulation making it difficult to implement guidelines and treatment pathways. In keeping with many other European countries, type 2 diabetes (T2DM) is treated in the community, whilst type 1 (T1DM) remains a hospital-managed condition. There also exists the concept of a rehabilitation unit for people with diabetes; this costly aspect of diabetes healthcare recently came under scrutiny, but lack of data meant that there was no real way of knowing whether this was an effective educational resource. Despite difficulties of health economics and institutional performance, diabetes management in Austria focuses on a co-ordinated comprehensive continuum programme. The components of this programme include population screening, evidence-based treatment, patient education and empowerment, training for healthcare professionals, evaluating treatment, new information technology, and a quality assurance management system for care pathways.

Need for education and research in diabetes: all patient groups

Hypoglycaemic unawareness

One very specific care pathway was presented by Professor Stephanie Amiel, King's College London School of Medicine, UK. Responses to falling blood glucose levels are mainly due to physiological cues, which make people correct hypoglycaemic events themselves. For example, feeling hungry, sweaty or faint are given side-effects for most people who have lowered blood glucose, and are brought about by certain counter-regulatory mechanisms. In certain people these physiological cues are defective, resulting in 'hypoglycaemic unawareness'. Many will re-establish these cues by monitoring and avoiding low blood glucose. Patient education, the use of insulin pumps, and even transplantation, are therefore all possible ways of counteracting this phenomenon. However, there are still some patients who do not respond to these approaches and who form the basis of continued research. It has been reasoned that such people have no memory of having episodes of very low blood glucose, and hence do not remember feeling bad during the event. Glucose sensors that may assist those patients who do not really recognise the problem whilst addressing brain reaction to hypoglycaemia (which may be preventing a learned response to these events) remain a research priority.

Diabetes in older adults

Older adults with T2DM have different priorities, as presented by Dr Simon Croxson, University Hospital Bristol, UK. In this population group, diabetes prevalence is rising globally, although up to 50% may remain undiagnosed – primarily because fasting plasma glucose is not an effective predictor of diabetes in older people. Glucose tolerance tests, or a post-prandial blood test are required to exclude diabetes, and these are not always performed. Dr Croxson also discussed the risk of hypoglycaemia due to frequent changes made to

an older person's medication, poor nutrition and hospital admissions. Hypoglycaemia usually resulted in falls and prolonged stays in institutional environments for older adults. Healthcare professionals were sometimes responsible – using medication to lower blood glucose levels which were not required. Some medications prescribed also caused weight loss in this population (*eg* metformin, which also doubles the risk of causing low vitamin B12 levels). Antihypertensives also need to be prescribed with care and the blood pressure goal should be a little higher for this age group. Effective hypertension treatment also appears to reduce the incidence of dementia, and an annual memory test may help in monitoring cognitive impairment for this population. Nursing homes came in for particular criticism as being places where patients were likely to have more hypoglycaemic events, and to be lacking in certain nutrients.

The 'challenging patient'

Susan Clever, Hamburg, Germany, discussed the notion of the 'challenging patient' – the person who continues to behave recklessly with regards to their diabetes management despite education and assistance from healthcare professionals. Several psychological barriers to changing lifestyle were highlighted and reluctance to behavioural modification in patients was linked to feelings of helplessness, shame, anger or fear. Such attitudes may also be stressful for healthcare professionals, and understanding patient motivation may help consultations with this challenging population. Nurses, it is suggested, have a contribution to make in helping to break down any barriers to treatment during patient consultations. They should, for instance, sometimes go with the resistance met during the consultation, rather than try to change it. Discussions on what patients really fear about insulin commencement, and finding out reasons for ambivalence to treatment or behavioural change, may bring about the dialogue to make the change.

Screening in younger adults

The emerging trend in T2DM in younger adults was also presented by Professor Tadej Battelino, Slovenia. Young people with T2DM may have a slightly different clinical presentation: there appears to be a strong genetic background; obesity linked with insulin resistance; and impaired beta cell function. Many present with metabolic syndrome, polycystic ovaries syndrome and acanthosis. Should we screen for this problem given that 80% may be asymptomatic? Professor Battelino argued that although there is resistance to a screening approach, there was no denying that these youngsters will suffer complications of diabetes much earlier. Treatment is based around nutritional and lifestyle advice, oral agents and insulin (insulin pumps have also been seen to be effective in reducing insulin resistance). T2DM in younger people is an escalating problem – many are currently undiagnosed, it is a rising burden to public health, and is difficult to treat. More resources are needed, as is more research that is age specific and which traverses social, cultural and ethnic backgrounds.

Patients with retinopathy

A devastating complication of diabetes is blindness due to retinopathy. Professor Roy Taylor, University of Newcastle, UK, said that screening was the key to preventing blindness and he discussed one locality's attempt to screen all of its diabetes population using a mobile camera. Use of mobile cameras and education for screeners who read the film results have helped to realise a decrease in people going blind in Newcastle. Dr Taylor said that it was important to ensure patients get examined every year; that a retinal camera is used, rather than an ophthalmoscope; and to educate retinal examiners to read the pictures and refer immediately if any problems are detected. He emphasised that screening was imperative, as was the need to ensure problems with blood glucose levels and blood pressure were also addressed.

Need for effective alliances

The burdens associated with the treatment of diabetes and the strategy needed for establishing effective alliances was discussed by Dr Ala Alwan, of the World Health Organisation (WHO). He outlined the magnitude of diabetes prevalence and the escalation of diabetes incidence, which have serious implications not just for world health but also for both the social and economic development of many countries. Diabetes is now one of four major NCD causes of death globally (the others being cancer, respiratory conditions and cardiovascular disease). Much of this disease is preventable, and NCD conditions share the same problems – tobacco and alcohol misuse, unhealthy diet and inactivity. Cost-effective, sustainable strategies and policies are needed that will address the world's population with the appropriate intensity, Dr Alwan stressed. Involving whole communities and combining the actions of all sectors is essential – such as collaboration with FEND.

Study on European Nurses in Diabetes (SEND)

Professor Bert Vrijhoef opened one of the main features of this year's conference – the Study on European Nurses in Diabetes

(SEND). This landmark study was commissioned and launched by FEND in 2007 to describe the function of diabetes nurses in eight European countries via a survey of nearly 6000 nurses. A response rate of 2179 questionnaires was able to yield the following information: over half of respondents hold a degree and are very experienced, with 70% having worked in diabetes for more than five years. Although diabetes nurses have large caseloads there was sometimes little understanding of how many patients in that caseload were newly diagnosed. Not many nurses were in management positions and roles differed enormously within countries. Most countries, however, agreed that they collected patient data which mainly concerned clinical outcomes but less often on learning or patient-satisfaction data.

This is the first study describing the function of diabetes nurses in Europe and differences in the structure and process of work of diabetes nurses were highlighted. Findings indicate that the 'diabetes nurse specialist' does not exist in large parts of Europe and this has implications for diabetes healthcare provision. National associations and FEND may now be able to work together to standardise some of these structures and processes.

The masterclasses provided further feedback on the SEND survey. It was agreed that SEND highlighted variable European standards and provided evidence to lobby political systems to improve by demonstrating best diabetes practice – a gold standard for all European nurses. Nurses valued the opportunity to learn from each other, to collaborate, and find information on different quality systems via the SEND study. FEND has been instrumental in this, and the ENDCUP training course and FEND website were identified as ways to raise standards across Europe.

Further master classes were asked to define the scope of practice, standards of practice and professional performance for European Nurses in Diabetes. Discussions from the audience advocated the need for a protected title, which included the term 'nurse'. The job should also include educational requirements and clinical competencies needed to undertake the role. Nurses should be able to advise on behavioural change, monitor clinical outcomes, conduct research and audit, present comprehensive assessments of patients' care needs, and provide structured education to people diagnosed with diabetes. The notion of a model job description was discussed.

Other research in diabetes

The conference also gave focus to a diverse range of oral presentations. Rasmussen (Australia) discussed the identification of life transition issues likely to affect diabetes self-care through qualitative interviews. The life transitions highlighted were moving home, starting employment and impending motherhood. To address these issues people were likely to try to take control of their diabetes management, associate with other people with diabetes, remain positive and organised, and to place diabetes into an appropriate life perspective.

Older adults with diabetes were the focus of two oral presentations by Huber (Switzerland), and Olsen (Sweden). The latter presented a literature overview, which concluded that there was a lack of RCT trials on which to base care guidelines. Huber explored Swiss nurses' perspectives on diabetes healthcare provision in nursing homes via interviews with 23 nurses. Nurses were able to articulate their own perception of diabetes care in nursing homes and their own experiences of fluctuating standards with recommendations for improvement.

Oral presentations on very practical matters concerning diabetes management were also presented. Kreugel (The Netherlands) discussed findings on the use of different needle lengths with regards to glycaemic control and personal preference in obese patients. Morrison and Courtenay (UK) reviewed independent nurse prescribing in the UK. In the first presentation it was proposed that patients were often advised to use longer 8–12 mm needles due to their obesity. The findings from 130 obese patients in the study, however, demonstrated that 5mm needles can still be used safely and effectively. Nurse prescribing in the UK was also presented as being part of a team approach which is safe, reliable and effective. It also contributes to the professional status of nurses and cuts down waiting times for patients.

Two very different needs with regards to diabetes education of patients were discussed. Zeljkovic (Croatia) described the causes of repeated hospitalisations for diabetes ketoacidosis (DKA) in one secondary-care site, and Dunning (Australia) investigated the educational needs of younger adults with T2DM. In the former study those presenting with more than one episode of DKA were likely to be slightly older, male and with a longer diabetes duration. DKA was more likely to be due to treatment mistakes by patients themselves and alcohol consumption, which may indicate educational priorities for the future. Changing educational needs was also the focus of a study enquiry into preferred learning models for people between 25 and 45 years of age with T2DM. Findings suggest that this population prefer

age-specific information which is not too technical, is creditable, and can be found at one source. People were ambivalent about the internet being the source of this information.

Conclusion

The conference concluded with awards to Lopes *et al* (Portugal) for a well designed abstract poster on Quality of Life Evaluation in T1DM; and The Diabetes Education Study Group Award went to Orvik *et al* (Norway) for work on spouses' self-reported need for diabetes education. The chance for FEND executive committee members to reflect over the past years were remarked upon by the FEND Chair, Deirdre Kyne-Grzebalski. FEND was started over 14 years ago with the aims of having an annual conference, of setting up a diabetes course for nurses, and also establishing a European diabetes journal and all have been achieved. This conference was themed around resolutions, recommendations and action. The action of vice president Anne-Marie Felton was applauded and her efforts to date meant FEND was now nearer to having a meaningful alliance with WHO. Mike Felton was also acknowledged for his tremendous effort behind the scenes, as were all the members of the executive committee. In particular, Claudia Leippert highlighted the efforts of German nurses who raised money to pay for insulin in third world countries. In the same manner members of FEND were also asked to keep true to the themes of this year's conference – declare the need to raise standards for diabetes healthcare provision through local evidence-based research; recommend FEND membership to all colleagues; be resolute in the need to inform FEND of local work through abstract and publication submission; and take action by registering for next year's conference.

Gillian Hood
Co-editor