Creative partnerships in diabetes nursing: Promoting learning through collaborative practice – a preliminary evaluation

J Sewell, S Da Costa, C Dempsey, A McHoy, E Turner, D Wamae, J Williams*

Abstract

This paper describes the collaborative partnership between two geographically diverse NHS trusts in the UK serving patient populations with very different demographic profiles. A programme of structured exchange has been developed allowing diabetes specialist nurses (DSNs) to visit the partner trust to share and compare clinical practice. The model allows the individuals involved to critically reflect on their own and others' practice and has facilitated networking between the DSNs and service developments within the trusts.

Eur Diabetes Nursing 2006; 3(2): 98–101.

Key words

Collaboration; professional development; structured reflection; networking

Authors

J Sewell,[1] RGN, BSc (Hons), Diabetes Specialist Nurse
S Da Costa,[2] RGN, MBA, Nurse Consultant and Clinical Lead for Diabetes for Worthing and Southlands Hospitals and Adur, Arun and Worthing PCT
C Dempsey,[2] RGN, DipNursing, Primary Care Diabetes Nurse Specialist, employed by Adur, Arun and Worthing PCT
A McHoy,[2] RGN, BSc (Hons), Primary Care Diabetes Nurse Specialist, employed by Adur, Arun and Worthing PCT
E Turner,[1] RGN, MSc, Nurse Consultant
D Wamae[2]**,** RGN, DipNursing, Diabetes Nurse Specialist
J Williams,[2] RGN, BSc (Hons), Senior Diabetes Nurse Specialist

[1]King's Diabetes Centre, King's College Hospital NHS Trust, Denmark Hill, London, SE5 9RS, UK
[2]Worthing and Southlands Hospitals NHS Trust, Lyndhurst Road, Worthing, Sussex, BN11 2DH

***Correspondence to:**
J Sewell, King's Diabetes Centre
King's College Hospital NHS Trust
Denmark Hill, London, SE5 9RS, UK
e-mail: joanne.sewell@kingsch.nhs.uk

Received: 13 January 2006
Accepted in revised form: 27 April 2006

Introduction

This paper describes a preliminary evaluation of a creative partnership between the diabetes nursing teams in two secondary care trusts in the UK: King's College Hospital, NHS Trust in London, and Worthing and Southlands Hospitals NHS Trust, situated on the south coast of England. The aim of the project was to build creative and collaborative partnerships to support learning through practice. Although study days and meetings can challenge and inform practice, it is often observation of, and discussion with, colleagues that promotes critical reflection and encourages a problem-solving approach to clinical and professional dilemmas. Acknowledging this, the teams at King's and Worthing have formalised this collaborative process by developing an educational structure enabling diabetes specialist nurses (DSNs) from both centres to visit the partner trust in order to share initiatives and develop their professional knowledge and skills in diabetes care.

Context

King's College Hospital NHS Trust provides healthcare and emergency services for an ethnically diverse and socially deprived community in south-east London, and serves a population of approximately 400 000, which has the largest black Caribbean and African population in the country. The prevalence of diabetes across the community ranges from 2.84% to 6%, reflecting ethnic diversity.[1]

The higher incidence and prevalence of diabetes within the population brings with it specific issues of management compared to a predominantly white population. Type 2 diabetes tends to develop around 5 years earlier in people from African, Caribbean and Asian backgrounds, and the prevalence of the condition is at least five times higher in these communities.[2] King's is an internationally renowned specialist tertiary referral centre. The Trust has approximately 900 beds and employs around 4500 people.

The ethnic diversity and social deprivation in south-east London imposes specific burdens and management issues when caring for this patient group. Weng *et al* suggest that there is difficulty in the delivery and uptake of care for chronic conditions in large cities. Problems can include high rates of patients changing address, homelessness, unemployment, non-attendance, and the specific needs of large ethnic minority groups.[3] All these issues are very evident at King's.

It is well documented that social and economic deprivation is associated with higher incidence of illness. Ward demonstrated that people from an Afro-Caribbean background tend to live in deprived areas rather than in prosperous ones with a higher incidence of smoking and poor nutrition.[3,4] Philip *et al* believe that the restricted diet in lower socioeconomic groups is due to lower income and lack of appropriate health beliefs.[5]

In comparison, Worthing and Southlands NHS Trust is a district general hospital with 500 beds on two sites. The local population of 300 000 is predominantly white, with one of the highest proportions of elderly people in Western Europe. Meneilly and Tessier point out that as many as 20% of those over 65 years of age have diabetes.[6] Specific issues of management in this ageing population relate to the higher prevalence of type 2 diabetes and age-related morbidity/disability.[7] Considerations when caring for this population include their fragility and the importance of reducing the risk of hypoglycaemia to ensure that iatrogenic falls do not occur. Safety, symptom control and low hypoglycaemic risk are therefore considered to be as important as glycaemic control. Many elderly people have impaired dexterity or visual acuity so choosing an appropriate insulin-administering device is vital to maintain independence. The utilisation of district nurse support also affects treatment options. The National Service Framework for Older People[8] states that health and social care services should treat older people as individuals and enable them to make choices about their own care. This could pose a significant problem for already-overstretched community nurses, who may find an indicative increase in the number of insulin-treated patients requiring help with injections on their caseloads.[9]

A number of elderly people live alone with limited ability to cook and shop, which can impact on dietary habits. The DSN team at Worthing is responsible for exploring each patient's full social background and communicating effectively with district nurses, community matrons and practice nurses to ensure treatment options reflect the patient's individual needs and the services available.

Annual study days are held for nursing-home staff to help improve knowledge and working relations.

Background

Current UK health policy[10] emphasises the need for continuing professional development through an increased focus on (work-based) lifelong learning and a shifting emphasis towards professional and academic accreditation.[11] This political context and the desire to develop diabetes-nursing practice encouraged the teams to seek new strategies in order to achieve these objectives, and were the major drivers for this project.

The model of collaborative working between the trusts emerged as a potentially beneficial method of identifying new ways of working that would help achieve government targets while at the same time allowing the DSNs to develop their skills and expertise without the financial and human resource implications associated with more formal education programmes.

The influential work of Schon established the importance and value of reflection on clinical practice and experiential learning.[12] In the UK, these processes are described as clinical supervision (CS) or structured reflection (SR) and are defined in the literature as a reflective relationship that maintains and improves practice.[13] A designated interaction between two or more practitioners within a safe/supportive environment[14] and a working alliance involving reflection, using formative (developing knowledge and skills), restorative (supporting and re-charging) and normative (demonstrating competence and maintaining standards) means.[15] At its simplest CS/SR can be defined as regular, protected time for facilitated, in-depth reflection on clinical practice.

However, although the value of this approach to professional development is widely acknowledged in the literature,[16–19] it is not commonly mirrored in clinical practice,[19] even though there is now some evidence to support positive outcomes of CS/SR. Cutliffe and Proctor purport that CS/SR can enhance levels of self-awareness, interpersonal, teaching and facilitation skills, patient-focused care and effective team working.[20]

The partnership created between the King's and Worthing teams has resulted in DSNs benefiting from a 'reflective space' where clinical practice and diabetes care can be explored and critically evaluated without the pressures of clinical responsibility. During this opportunity the DSNs are encouraged to utilise a model of structured reflection to enhance their experience (see Figure 1).[21] Structured reflection is encouraged before, during and after the visit to the partner trust.

Structure of collaboration

The collaboration developed following a discussion between the nurse consultants from each trust. Nurse consultants are employed to provide key skills in diabetes nursing and improve patient outcomes and experiences through leadership, research, audit, education and training, service redesign and relocation (often moving services

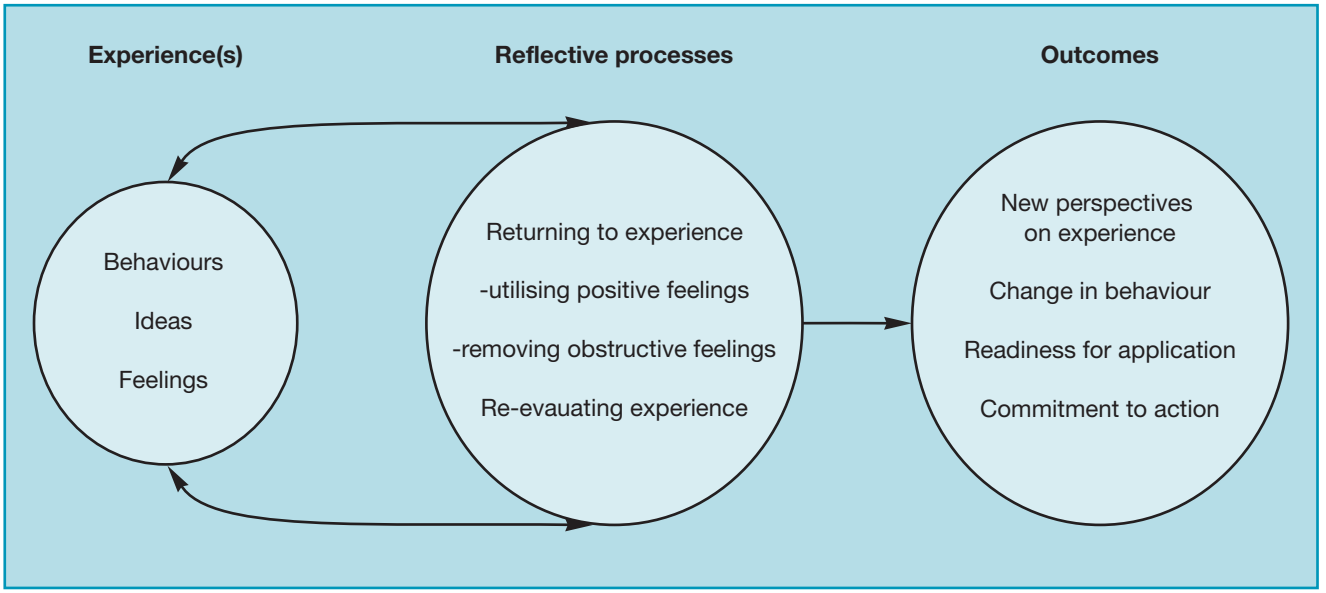

Figure 1. (Boud *et al*: Reflection: turning experience into learning, Routledge Falmer, Copyright Taylor and Francis, 1985)

into primary care) and expert clinical practice. It was acknowledged that individuals and the teams would benefit from the exchanges and collaborative working. Two DSNs from each site have taken part to date. Prior to the networking visit, the DSN contacts the partner trust and, with a nominated mentor, discusses the expectations and learning objectives of the visit. The visits have lasted for one day and initially the consultant nurses acted as mentors. These mentoring skills have since been cascaded to other team members who have taken part in the exchange. Dates for the visits are agreed in advance, allowing teams to cover both study leave for the visitor and mentorship time for the host trust without disrupting clinical services. After each visit, structured reflections by the visitor and the nominated mentor are shared with each other and their respective teams and potential areas for service development are evaluated and discussed. The visits began in an informal manner, but due to their success the intention is to formalise the process to allow evaluation and audit against the learning outcomes.

Discussion

This model of collaboration and networking has facilitated an ethos of critical reflection within the teams, and from these reflections differences and similarities in a number of areas within clinical practice have been identified and reviewed.

For example, a comparison between management guidelines for those with type 2 diabetes converting to insulin therapy found that at King's usual practice is to add bedtime NPH insulin to oral hypoglycaemic agents for patients whose glycaemic control is inadequate on oral agents alone.[22,23] A different method for insulin conversion is used in Worthing. Their research has demonstrated the benefits of a twice-daily insulin regimen in this patient group, with significant increases in patient satisfaction with treatment, minimal weight gain and improved HbA_{1c}.[24]

Both centres use a group format, as well as the traditional one-to-one method, to deliver education and support to those starting insulin. Structured group education has been demonstrated to be at least as, if not more, effective than traditional one-to-one education when starting insulin. It is also more cost effective.[25]

Interestingly, team working in the diabetes antenatal clinic is interpreted differently in both trusts. At King's women have a single appointment where the opportunity to meet all members of the joint obstetric/diabetes team (obstetrician, specialist midwife, diabetologist, DSN and dietitian) on a one-to-one basis, depending on clinical need or patient choice, is given. At Worthing the woman is offered a joint consultation with all members of the specialist obstetric/diabetes team. Although the structure of care is different, both formats achieve patient-focused, collaborative management planning for the pregnancy and the delivery.

The scope of practice of the DSN was discussed in relation to the role and responsibilities of the in-patient DSN (IPDSN). The IPDSN is a fairly new role with responsibility for clinical care and practice development surrounding in-patient standards.[26] The Worthing team shared the results of an audit, which demonstrated how an IPDSN positively

influenced care and reduced length of stay by 1.8 days (unpublished data). Patients seen by the IPDSN had a medication review and the opportunity for education.

A major difference in utilisation of IPDSNs was identified. At King's the IPDSN main clinical focus is insulin transfers with the medical team responsible for medication reviews and 'troubleshooting'. In Worthing the IPDSN follows a patient group directive (PGD) for prescribing insulin and oral hypoglycaemic agents. This allows the IPDSN to review diabetes medication and make changes while patients are on the wards. Insulin can be initiated and doses adjusted in nurse clinics.

The intention at King's is for all DSNs to become independent nurse prescribers. Two members of the team have completed the prescribing course to date.

Both teams undertake extensive education programmes for nursing, medical and professions allied to medicine and the collaboration provided the opportunity to share teaching materials, education methods and evaluation tools.

Conclusions

This collaboration has achieved the primary aim of supporting learning through practice. The importance of regular, critical evaluation of clinical care has been highlighted, and through this process, the significance of the sociocultural context, in terms of care delivery and service development, has become apparent.

Networking between the two nursing teams has identified similarities and differences within the DSN role and promoted the utilisation of structured reflection as a tool for professional development. The project has provided the teams with the opportunity to give and experience constructive feedback, and it is anticipated that, through this ongoing initiative, professional development, underpinned by structured reflection and life-long learning will continue to flourish.

Conflict of interest:
None

References

1. Department of Health. *Quality Management and Analysis System*. London: The Stationery Office, 2005.
2. Osei K, Schuster DP. Metabolic characteristics of African descendants. *Diabetologia* 1995; **38(9):** 1103–1109.
3. Weng C, Coppini DV, Sonsken PH. Geographic and social factors are related to increased morbidity and mortality rates in diabetic patients. *Diabetic Med* 2000; **17**: 612–617.
4. Ward JD. Wealthy means healthy: diabetes and social deprivation. *Diabetic Med* 1994; **11**: 334–335.
5. James WP, Nelson M, Ralph A, *et al.* The contribution of nutrition to inequalities in health. *BMJ* 1997; **314**: 1545–1549.
6. Meneilly GS, Tessier D. Diabetes in the elderly. *Diabetic Med* 1995; **12**: 949–960.
7. Krentz A, Bailey C. *Type 2 Diabetes*. London: Royal Society of Medicine Press, 2001.
8. Department of Health. *National Service Framework for Older People*. London: The Stationery Office, 2001.
9. Richmond J. Diabetes care in older people. *J Diabetes Nursing* 2004; **8**(10): 378–382.
10. Department of Health. *The NHS Plan: A Plan for Investment, a Plan for Reform*. London: The Stationery Office, 2000.
11. Royal College of Nursing Institute. *Changing Patients' Worlds Through Nursing Practice Expertise*. London: Royal College of Nursing, 2005.
12. Schon D. *The Reflective Practitioner: How Professionals Think in Action*. New York: Harper Collins, 1983.
13. Van Ooijen E. *Clinical Supervision: A Practical Guide*. Edinburgh: Churchill Livingstone, 2000.
14. Bishop V. Clinical supervision: what's going on? Results of a questionnaire. *Nursing Times* 1998; **94**(18): 50–53.
15. Proctor B. Supervision: a co-operative exercise in accountability. In: *Enabling and Ensuring: Supervision in Practice*. Marken M, Payne M (eds). Leicester: Council for Education and Training, 1996.
16. Benner P, Hooper-Kyriakidis P. *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-Action Approach*. Philadelphia: W.B. Saunders, 1999.
17. McGill I, Beatty L. *Action Learning: A Guide for Professional, Management and Educational Development*. London: Kogan Page, 2006.
18. Titchen A. Critical companionship: a conceptual framework for developing expertise. In: *Practice Knowledge and Expertise in Health Professionals*. Higgs A, Titchen A (eds). Oxford: Butterworth Heinemann, 2001.
19. Hardy S, Garbett R, Titchen A, *et al.* Exploring nursing expertise: nurses talk nursing. *Nursing Inquiry* 2002; **9**(3): 196–202.
20. Cutliffe J, Proctor B. An alternative training approach to clinical supervision. Parts 1 and 2. *Br J Nursing* **7**(5): 280285, **7(6):** 344–349.
21. Boud D, Keogh R, Walker D (eds). *Reflection: Turning Experience into Learning*. New York: Kogan Page, 1985.
22. Yki-Jarvinen H, Kauppila M, Kujansuu E, *et al.* Comparison of insulin regimes in patients with non-insulin dependent diabetes mellitus. *N Engl J Med* 1992; **327**: 1425–1433.
23. Yki-Jarvinen H, Ryysy L, Nikkila K, *et al.* Comparison of bedtime regimens in patients with type 2 diabetes mellitus. *Ann Intern Med* 1999; **130:** 389–396.
24. Dempsey C. International Nursing Research Conference, 2004.
25. Rickheim P, Weaver TW, Flader JL, *et al.* Assessment of group Vs individual diabetes education. *Diabetes Care* 2002; **25:** 269–274.
26. Department of Health. *National Service Framework for Diabetes: Standards*. London: The Stationery Office, 2006.