COMMUNITY WELLBEING SERVICES

'Feeling Well' Diabetes Project

Project Manager: Joseph McGoldrick
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Project Reference: HIPA 15

Name of Client: Diabetes Health Inequalities

Aim:

1. To raise awareness, improve knowledge, and upskill residential care home staff the prevention, treatment and care of diabetes in the care/nursing home setting through a collaborative developed training package.
2. To work with the homeless community and support organisations in Chester to provide education and diabetes support built around the specific needs and situations of homeless individuals

Introduction

Throughout the 12-month activity schedule, the 'Feeling Well' Diabetes Project has evolved to become a fundamental part of positively developing diabetes awareness and education for care home managers, staff; people experiencing unstable housing, the organisations who support them; and the wider Chester community.

As this population is generally unable to access conventional group diabetes education and support; training and support for individuals and organisations has provided invaluable resources and contributions to work towards the ICP standards of quality and safety.

The overall aim of the project was to improve diabetes related health outcomes for people living with diabetes in care homes and experiencing unstable housing, whilst achieving community sustainability.

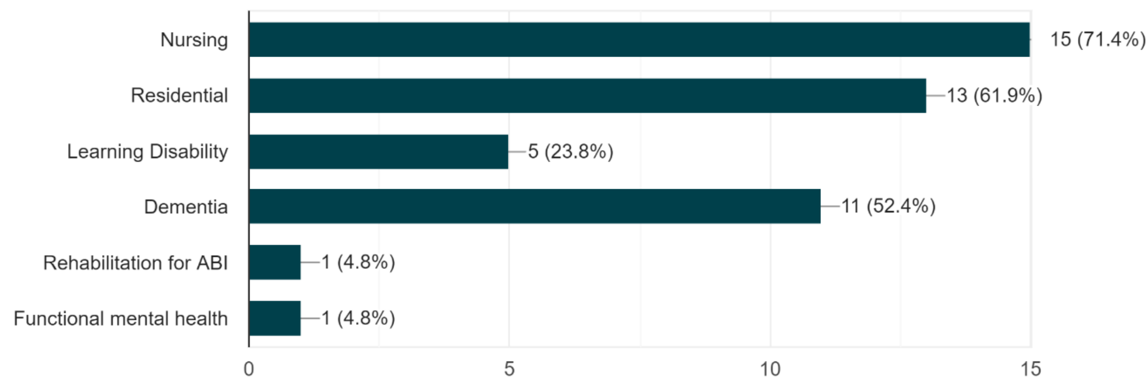
Scoping – Care Homes

Based on our previous experience delivering training in care homes we decided to run a consultation with managers and senior staff enabling them to identify and select their priorities around diabetes education and training. The idea behind a scoping and collaborative approach allowed the care homes to 'own' the project and receive the intervention and support that most meets their needs.

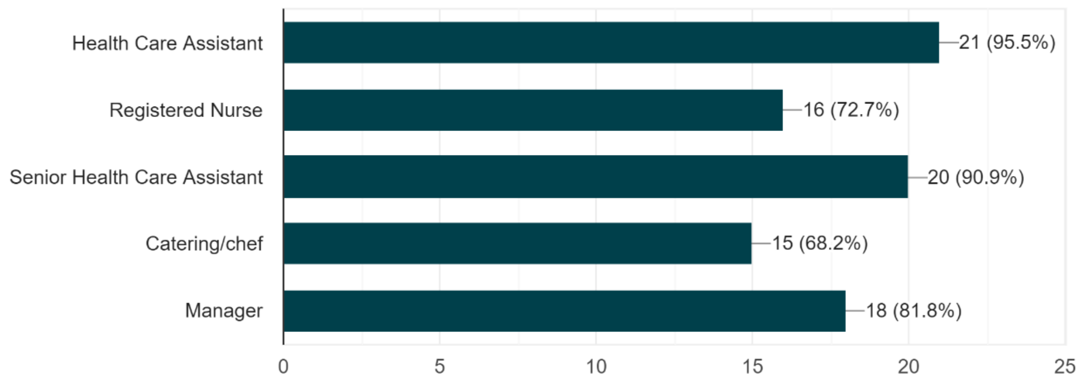
Engagement with care homes – this was achieved through a collaborative approach with the Fountains Integrated Care Home (FICHS) team. Once the FICHS onboarding of the 22 care homes was complete, initial contact was made with individual care home managers via email to invite them to 'have their say', however initial uptake was slow and time consuming. Plan B involved creating a promotional video (https://vimeo.com/558955983 - open link in chrome) to showcase the project and what we aimed to achieve, which realised a little more traction, although still limited commitment. Ultimately, the strategy that proved to optimise engagement, involved shadowing each GP on their ward round at individual care homes and introducing myself and the project to managers.

The scoping element sought to understand what types of care, homes provided in order to offer appropriate training. Care homes were asked to complete a questionnaire in order to offer a bespoke training and support package (https://forms.gle/v9XUqdTGv3EqXKT19 - open link in chrome)

See breakdown of the key results below.



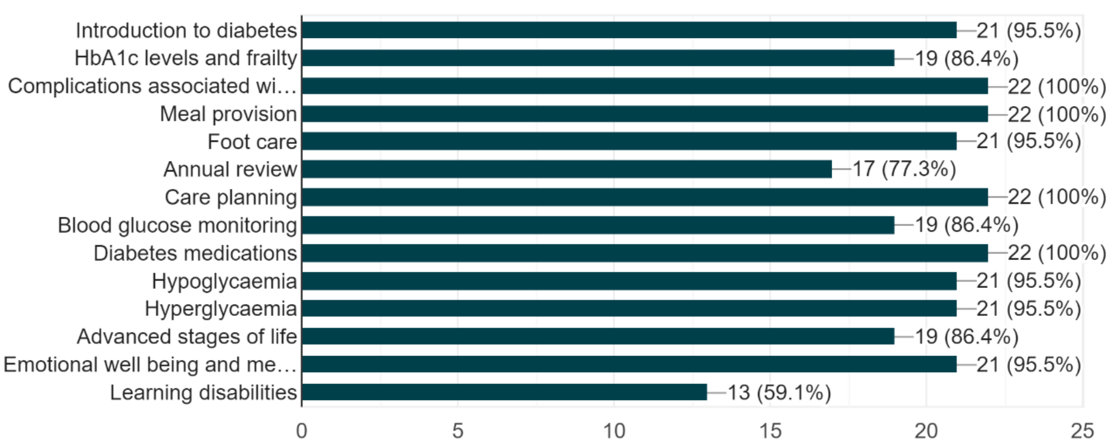
Graph illustrating the breakdown of care provision in FICHS. This demonstrated that the training package would need to incorporate a wide-ranging approach to ensure staff in each of these disciplines had targeted training to best support the residents in their care.



Graph above illustrates the breakdown of staff care home managers wanted to be involved in the training - The package needed to incorporate appropriate material for each of the

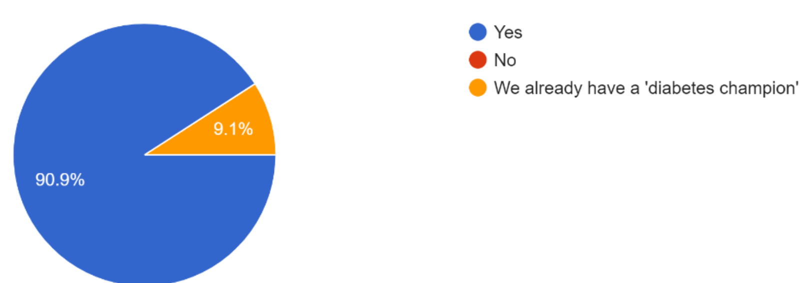
professions without diluting key information. Some of the verbal feedback I received from managers highlighted some staff believed certain elements and modules were not appropriate for healthcare assistants or nursing staff and vice versa. However, having reviewed the material following this feedback it proved very difficult to include/exclude elements of the training without diluting or indeed developing separate training for specific staff groups, which was not efficient or practical, which managers understood and agreed

What areas of diabetes education would you like to see in the training package (choose all that apply)?
22 responses

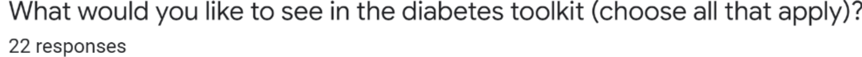


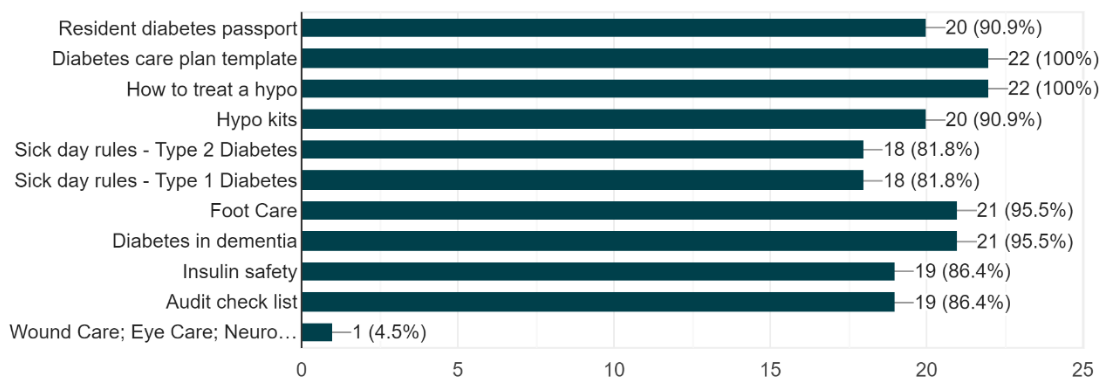
Graph illustrating what topics care home managers would like to see in the training package - This showed that most care providers wanted to see the majority of the suggested modules in the training package, with the exception of learning disabilities, therefore it was decided that a separate training session and content would be developed and dedicated to this cohort of staff within the FICHS.

Would you agree to designating a key member of staff as 'diabetes champion?
22 responses



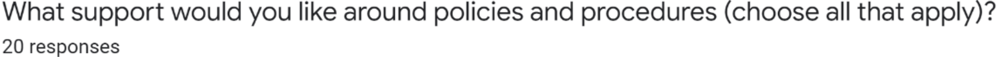
Graph illustrating the breakdown of care homes willing to designate a key member of staff as diabetes champion - To provide sustainability to the project, it was agreed that care homes would be asked to designate a dedicated member of staff to ensure key information was disseminated to staff on a regular basis as further training or updates were provided. Managers were unanimously in agreement to the concept of a diabetes champion, however most raised the reservation that the staff turnover is extremely high in the care home environment and that it would be a challenge to offer cohesiveness to the delivery and ongoing development of this.

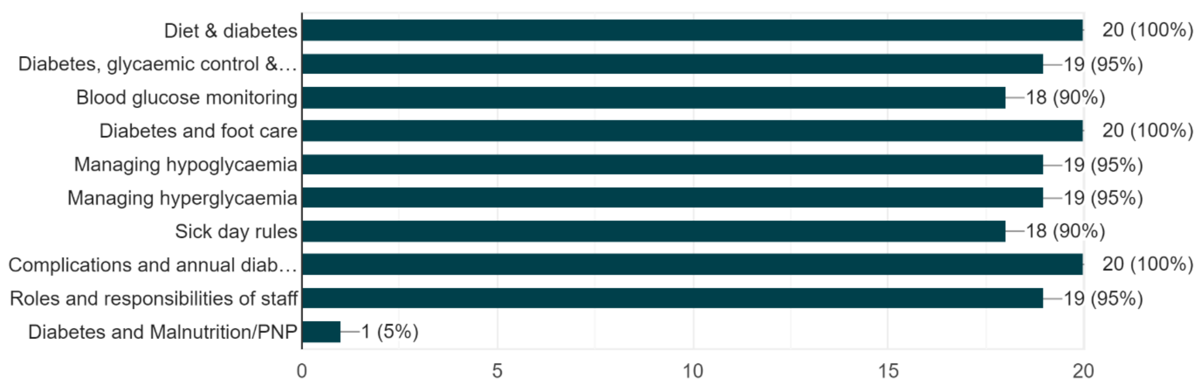




Graph illustrating the key information care providers would like to see in the diabetes toolkit – Again this was to allow for sustainability and provide care staff with a resource to tap into following the face-to-face training, in order to consolidate and support knowledge. The feedback showed most managers were keen to have a diverse and resourceful toolkit to support staff in the ongoing management and care of diabetes residents. Although, most

didn't believe wound care etc was appropriate for staff, as staff already receive training in this regard, therefore this was omitted from the toolkit.



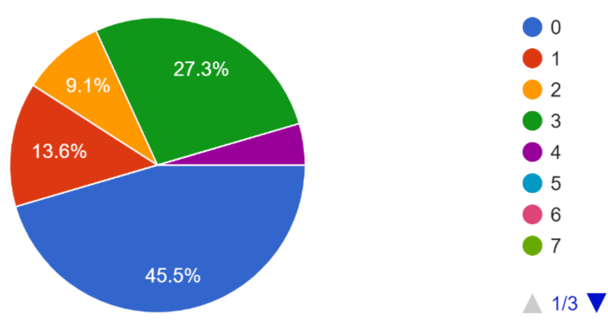


Graph illustrating the key information care providers would like to see in the diabetes training manual – As above, this was to allow for sustainability and provide care staff with a resource to tap into in tandem with and following the face-to-face training, in order to consolidate and support knowledge. The feedback showed most managers were keen to have a diverse and resourceful training manual to support staff in the ongoing management and care of diabetes residents. Although, most didn't believe diabetes and malnutrition was appropriate for staff, as staff already receive training from Countess of Chester Dietitians. I made it clear to managers that some food fortification/first advice was a little different for residents experiencing malnutrition and diabetes and it would be important to focus some education on key information for staff to ensure safe management of residents.

Pre-Training Audit – Care Homes

How many residents do you have living with type 1 diabetes?

22 responses



Pie chart illustrating the breakdown of homes with residents living with type 1 diabetes.

45.5% – 0 residents

27.3% - 3 residents

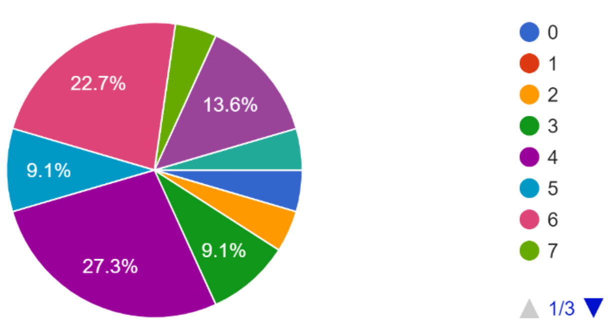
13.6% – 1 resident

9.1% - 2 residents

This showed evidence that the development of training and resources should have some focus on type 1 diabetes and its management

How many residents do you have living with type 2 diabetes?

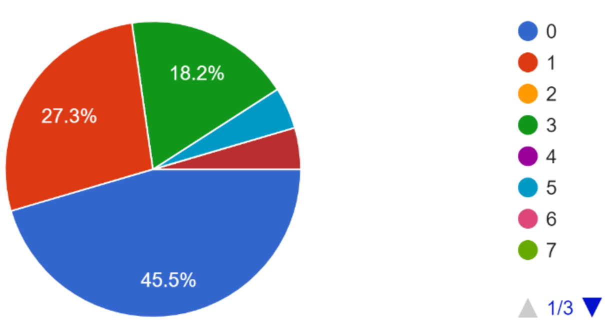
22 responses



Residents living with type 2 diabetes

1 home – 0 residents

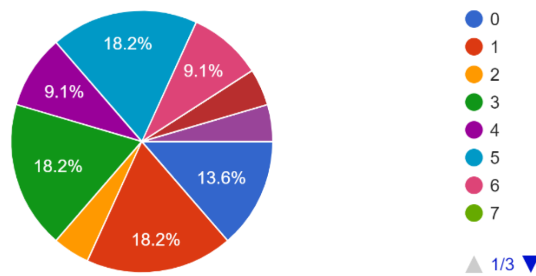
1 home – 2 residents
6 homes – 4 residents
2 homes – 5 residents
5 homes – 6 residents
1 home – 7 residents
3 homes – 10 residents
1 home – 11 residents
Total residents in FICHS living with diabetes = 45



10 homes – 0 residents
6 homes – 1 resident
4 homes – 3 residents
1 home – 5 residents
1 home – 8 residents
Total residents prescribed insulin to manage diabetes = 17

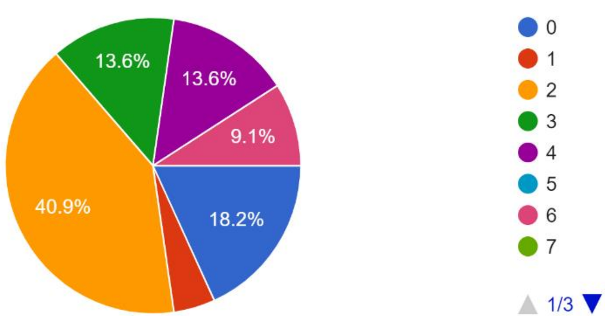
Data revealed evidence that the development of training and resources should have some focus on insulin, even in care homes with zero residents, as they may have an insulin dependent resident admitted at any time.

How many residents are controlled with oral medications?
22 responses



3 homes – 0 residents
4 homes – 1 resident
1 home – 2 residents
4 homes – 3 residents
2 homes – 4 residents
4 homes – 5 residents
2 homes – 6 residents
1 home – 8 residents
1 home – 10 residents
Total residents' diabetes controlled by oral medications = 39

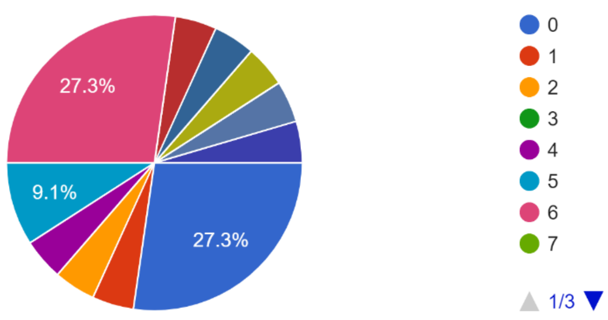
How many residents are controlled by diet/lifestyle alone?
22 responses



4 homes – 0 residents
1 home – 1 resident
9 homes – 2 residents
3 homes – 3 residents
3 homes – 4 residents
2 homes – 6 residents

In your care home, on average how many staff are signed off as competent to monitor blood glucose levels?

22 responses

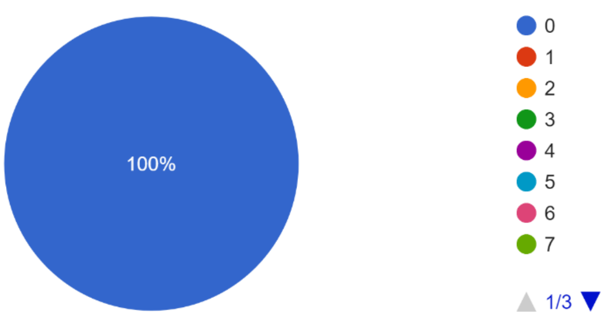


0
1
2
3
4
5
6
7
1/3

8 homes – 0 staff
1 home – 4 staff
5 homes – 5 staff
3 homes – 6 staff
1 home – 7 staff
2 homes – 8 staff
1 home – 12 staff
1 home – 19 staff
Total staff signed off as competent to monitor blood glucose levels = 61

Within the last three months in your care home, how many times has prescribed insulin been delayed for residents with diabetes?

22 responses

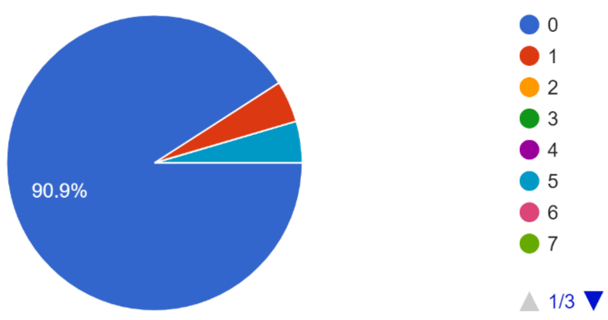


0
1
2
3
4
5
6
7
1/3

Out of the 22 care homes. 100% reported that there had been zero delays in the administration of insulin.

During the last three months how many diabetes medication errors have occurred within your Care Home?

22 responses



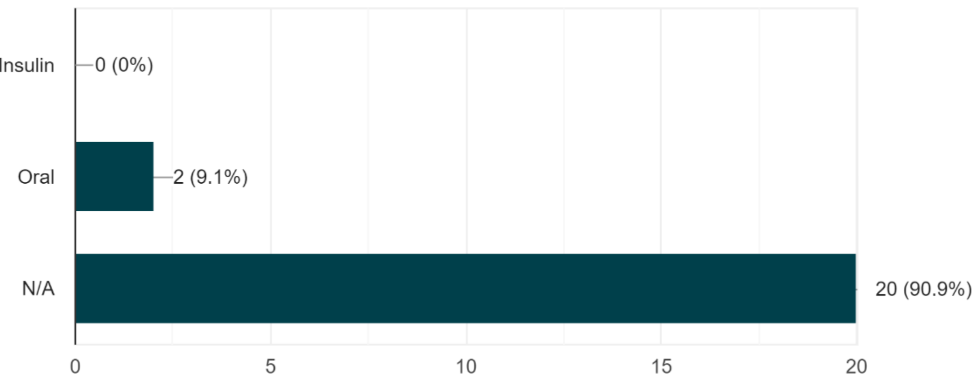
20 homes – 0 errors

1 home – 1 error

1 home – 5 errors

What type of diabetes medication was involved in the error(s)?

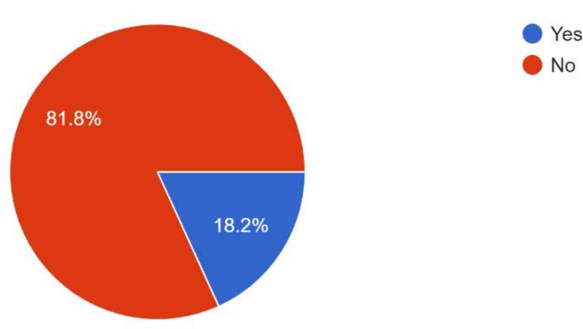
22 responses



Graph illustrating the breakdown of medication errors. Both homes reported errors were oral medications.

Do you have a hypo box on site within your care home?

22 responses



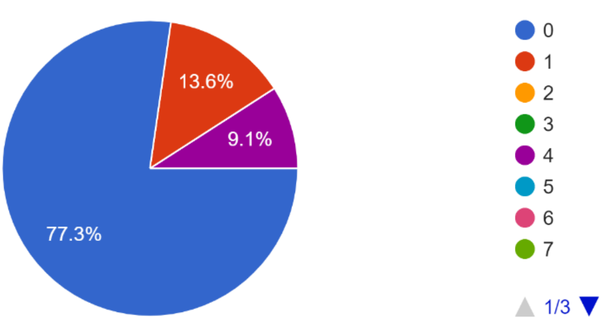
18 homes – no

4 homes – yes

This pie chart illustrated the importance of education on the provision of onsite hypo box's and their use.

Within the last three months, how many times has a GP or ambulance been called out for a diabetes related problem?

22 responses

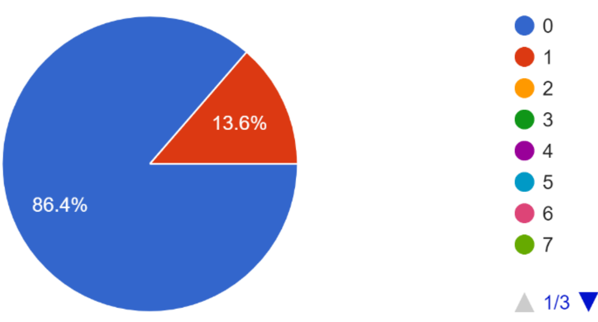


17 homes – 0 call outs

3 homes – 1 call out

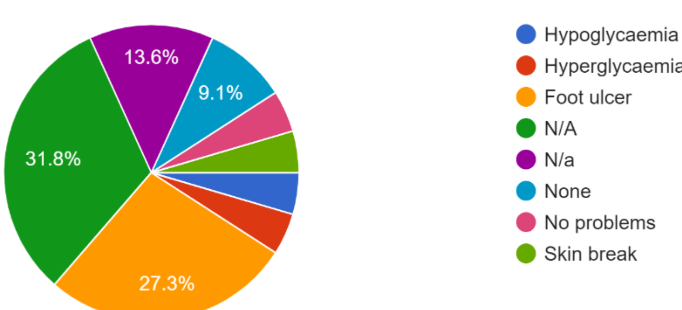
2 homes – 4 call outs

Within the last three months, how many diabetes related hospital admissions have occurred?
22 responses



19 homes – 0 admissions
3 homes – 1 admission

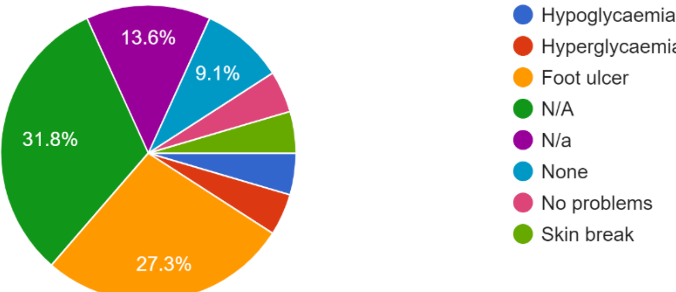
Please indicate the diabetes related problem(s) for the GP/ambulance call outs or hospital admissions
22 responses



12 homes – N/a
1 home – skin break
1 home – hypoglycaemia
1 home – hyperglycaemia
6 homes – foot ulcer

Please indicate the diabetes related problem(s) for the GP/ambulance call outs or hospital admissions

22 responses



Training package development – Care Homes

The training package was built around the supporting evidence above and knowledge for their CQC care standards, making the value of committing staff time to the training valuable to the FICHS workforce

Following the initial scoping process and engagement with care homes, the next step was to develop a training package which included:

- Diabetes manual/ guidelines (see link below)

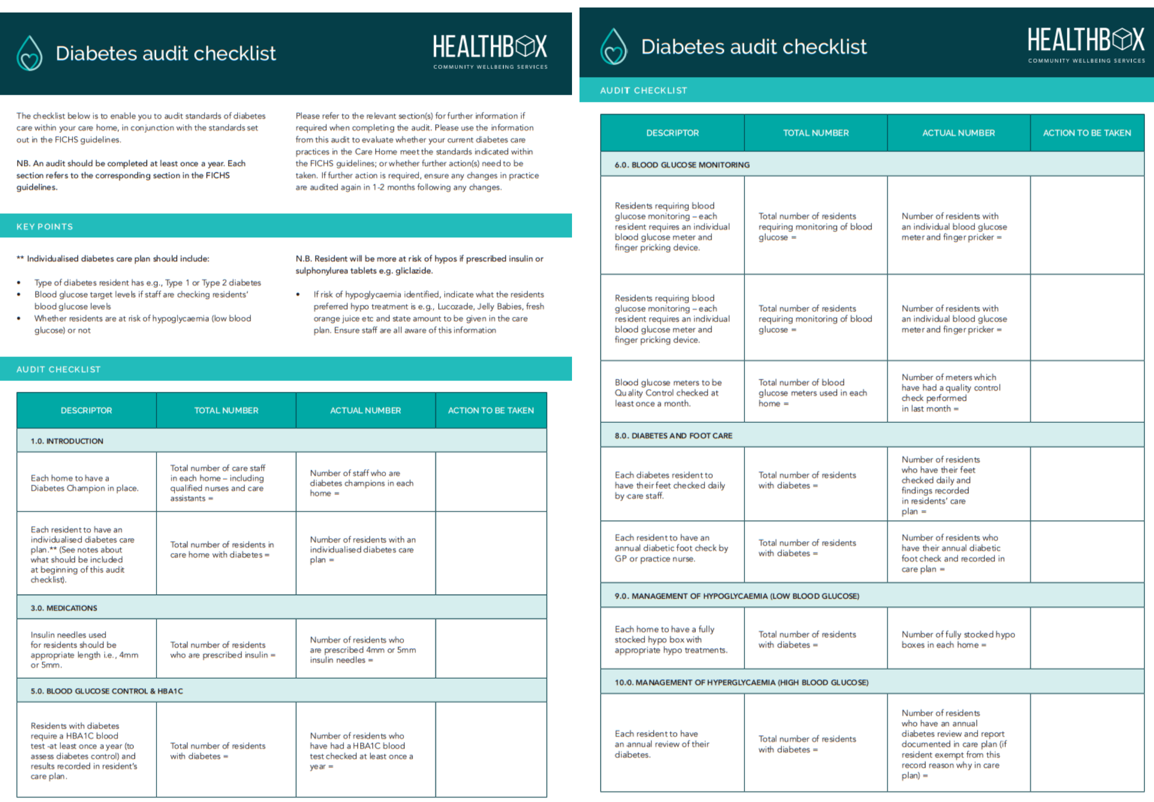
https://drive.google.com/file/d/1W2sIDBpo2Iuo6gwvYLWC2ivRsI-XMJMp/view?usp=sharing

Password: HBCIC-Diabetes

- Diabetes toolkit/info graphics as easy go to guides – see below.

NB. All toolkits were adapted from EDEN CARES programme

1. Diabetes audit checklist



Diabetes audit checklist

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The checklist below is to enable you to audit standards of diabetes care within your care home, in conjunction with the standards set out in the FICHS guidelines.

NB. An audit should be completed at least once a year. Each section refers to the corresponding section in the FICHS guidelines.

Please refer to the relevant section(s) for further information if required when completing the audit. Please use the information from this audit to evaluate whether your current diabetes care practices in the Care Home meet the standards indicated within the FICHS guidelines; or whether further action(s) need to be taken. If further action is required, ensure any changes in practice are audited again in 1-2 months following any changes.

KEY POINTS

** Individualised diabetes care plan should include:

- Type of diabetes resident has e.g., Type 1 or Type 2 diabetes
- Blood glucose target levels if staff are checking residents' blood glucose levels
- Whether residents are at risk of hypoglycaemia (low blood glucose) or not

N.B. Resident will be more at risk of hypos if prescribed insulin or sulphonylurea tablets e.g. gliclazide.

- If risk of hypoglycaemia identified, indicate what the residents preferred hypo treatment is e.g., Lucozade, Jelly Babies, fresh orange juice etc and state amount to be given in the care plan. Ensure staff are all aware of this information

AUDIT CHECKLIST

DESCRIPTOR	TOTAL NUMBER	ACTUAL NUMBER	ACTION TO BE TAKEN
1.0. INTRODUCTION			
Each home to have a Diabetes Champion in place.	Total number of care staff in each home – including qualified nurses and care assistants =	Number of staff who are diabetes champions in each home =	
Each resident to have an individualised diabetes care plan.** (See notes about what should be included at beginning of this audit checklist).	Total number of residents in care home with diabetes =	Number of residents with an individualised diabetes care plan =	
3.0. MEDICATIONS			
Insulin needles used for residents should be appropriate length i.e., 4mm or 5mm.	Total number of residents who are prescribed insulin =	Number of residents who are prescribed 4mm or 5mm insulin needles =	
5.0. BLOOD GLUCOSE CONTROL & HBA1C			
Residents with diabetes require a HBA1C blood test -at least once a year (to assess diabetes control) and results recorded in resident's care plan.	Total number of residents with diabetes =	Number of residents who have had a HBA1C blood test checked at least once a year =	

Diabetes audit checklist

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COMMUNITY WELLBEING SERVICES

AUDIT CHECKLIST

DESCRIPTOR	TOTAL NUMBER	ACTUAL NUMBER	ACTION TO BE TAKEN
6.0. BLOOD GLUCOSE MONITORING			
Residents requiring blood glucose monitoring – each resident requires an individual blood glucose meter and finger pricking device.	Total number of residents requiring monitoring of blood glucose =	Number of residents with an individual blood glucose meter and finger pricker =	
Residents requiring blood glucose monitoring – each resident requires an individual blood glucose meter and finger pricking device.	Total number of residents requiring monitoring of blood glucose =	Number of residents with an individual blood glucose meter and finger pricker =	
Blood glucose meters to be Quality Control checked at least once a month.	Total number of blood glucose meters used in each home =	Number of meters which have had a quality control check performed in last month =	
8.0. DIABETES AND FOOT CARE			
Each diabetes resident to have their feet checked daily by care staff.	Total number of residents with diabetes =	Number of residents who have their feet checked daily and findings recorded in residents' care plan =	
Each resident to have an annual diabetic foot check by GP or practice nurse.	Total number of residents with diabetes =	Number of residents who have their annual diabetic foot check and recorded in care plan =	
9.0. MANAGEMENT OF HYPOGLYCAEMIA (LOW BLOOD GLUCOSE)			
Each home to have a fully stocked hypo box with appropriate hypo treatments.	Total number of residents with diabetes =	Number of fully stocked hypo boxes in each home =	
10.0. MANAGEMENT OF HYPERGLYCAEMIA (HIGH BLOOD GLUCOSE)			
Each resident to have an annual review of their diabetes.	Total number of residents with diabetes =	Number of residents who have an annual diabetes review and report documented in care plan (if resident exempt from this record reason why in care plan) =	

2. How to treat a hypo

How to treat a hypo

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NOTE: DO NOT OMIT INSULIN IF DUE & REVIEW MEDICATION, TO PREVENT RECURRENCE

If blood glucose <4.0mmol/l TREAT

Conscious and able to swallow.
Give **15-20g** quick acting carbohydrate.

150-200ml natural juice.

x5 jelly babies.

x1.5-2 glucose gel tubes in between the teeth and gums.

x5-7 glucose tablets.

Suitable treatments are:

- 100ml of LucozadeTM
- Small NON-DIET fizzy drink (approx. 150ml)
- 200ml (a small carton) of smooth fresh orange juice, NOT orange cordial or diluted squash drinks
- Five or six dextrose tablets
- Four large jelly babies
- Seven to eight large jelly beans
- One to two tubes of glucose gel (Glucogel), usually prescribed by GP recommended

Wait **15 minutes.** Then **recheck.**

<4.0mmol/l

Repeat treatment
If treatment repeated **3** times ring **999.**

>4.0mmol/l

Give long acting **carbohydrate.**

Or a meal consisting of **carbohydrate.**

Unconscious or unable to **swallow.**

Ring **999.**

Give **1g** glucagon injection.

Glucose gel **not** be given.

If fully conscious and able to **swallow.**

3. Insulin administration

Prime, dose, inject, dispose

THINGS TO CHECK FOR INSULIN SAFETY

PRIME

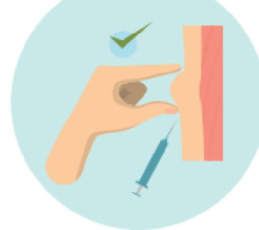
- Check the insulin pen is in date
- For cloudy insulin, roll the pen
- 10 times and move it up and down a further 10 times
- Ensure a new insulin needle is attached
- Perform a 2 unit 'air shot'
- A few drops of insulin should come out of the needle
- Perform further 'air shots' until drops appear

EDEN TOP TIP
Ensure the insulin pen in use is stored at room temperature for one month, and spare pens are stored in the fridge.

DOSE

- Review previous blood glucose levels
- Consider if the insulin dose needs to be changed
- Check the person can see the unit

EDEN TOP TIP
Ensure blood glucose levels are checked before injecting insulin.



INJECT

- Ensure the person has good dexterity to use the insulin pen
- Check the person can see where they are going to inject
- Look at injection sites (avoid lumps, bumps & bruises)
- Injection sites need to be rotated each time
- Put the needle close to the skin and smoothly insert
- Fully press down slowly, wait 10 seconds, then remove

EDEN TOP TIP
If a person requires support, please prescribe and demonstrate insulin safety needles to their care giver.

DISPOSE

- Do not re-sheath the needle
- Unscrew the needle from the insulin pen
- Place the needle into the sharps box
- Avoid shutting the sharps box lid until filled to the marker line

EDEN TOP TIP
Check the person has a sharps box on prescription with the appropriate type and size.

Check our website, educational modules for all HCP's involved in caring for people living with diabetes.

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info@healthboxcic.com

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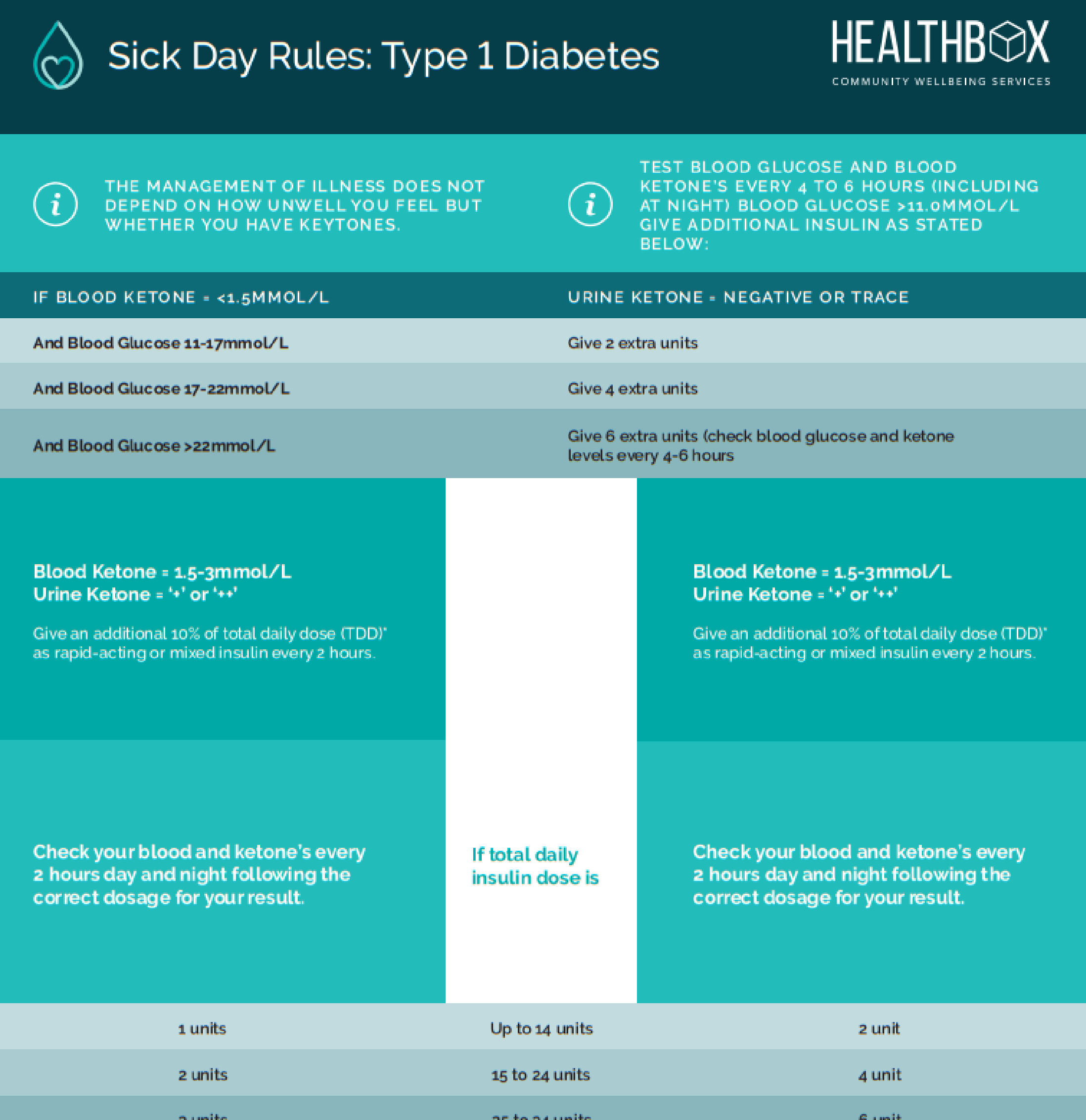
4. Type 1 sick day rules



Sick Day Rules: Type 1 Diabetes

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THE MANAGEMENT OF ILLNESS DOES NOT DEPEND ON HOW UNWELL YOU FEEL BUT WHETHER YOU HAVE KEYTONES.

TEST BLOOD GLUCOSE AND BLOOD KETONE'S EVERY 4 TO 6 HOURS (INCLUDING AT NIGHT) BLOOD GLUCOSE >11.0MMOL/L GIVE ADDITIONAL INSULIN AS STATED BELOW:

IF BLOOD KETONE = <1.5MMOL/L	URINE KETONE = NEGATIVE OR TRACE
And Blood Glucose 11-17mmol/L	Give 2 extra units
And Blood Glucose 17-22mmol/L	Give 4 extra units
And Blood Glucose >22mmol/L	Give 6 extra units (check blood glucose and ketone levels every 4-6 hours

Blood Ketone = 1.5-3mmol/L **Urine Ketone = '+' or '++'** Give an additional 10% of total daily dose (TDD)* as rapid-acting or mixed insulin every 2 hours. **Check your blood and ketone's every 2 hours day and night following the correct dosage for your result.**	**If total daily insulin dose is**	**Blood Ketone = 1.5-3mmol/L** **Urine Ketone = '+' or '++'** Give an additional 10% of total daily dose (TDD)* as rapid-acting or mixed insulin every 2 hours. **Check your blood and ketone's every 2 hours day and night following the correct dosage for your result.**
1 units	Up to 14 units	2 unit
2 units	15 to 24 units	4 unit
3 units	25 to 34 units	6 unit
4 units	35 to 44 units	8 units
5 units	45 to 54 units	10 units

*TDD = Add together all of your doses of insulin for a normal day
Basal/long acting – 18 units AM + 20 units PM = 38 units
Rapid acting – Breakfast 4, Lunch 4, Dinner 6 = 14
TDD = 52 Units

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5. Type 2 sick day rules

Sick Day Rules: Type 2 Diabetes

TEST BLOOD GLUCOSE LEVELS EVERY 4 TO 6 HOURS (INCLUDING AT NIGHT) BLOOD GLUCOSE >11.0MMOL/L GIVE ADDITIONAL INSULIN AS STATED BELOW:

ON INSULIN		NOT ON INSULIN	
11-17mmol/L	2 extra units	Oral diabetic therapies or GLP-1	2 extra units
17-22mmol/L	4 extra units	Oral diabetic therapies which help to produce more insulin in the body (i.e. SU)	• Consider increasing the dose • Consider initiating insulin whilst unwell • Gradually reduce adjustments as the illness improves
>22mmol/L	6 extra units		

ADVICE

Rest
Avoid strenuous exercise

Hydration
Drinking sugar free fluids at least 100 to 200ml per hour

Symptom control
For example painkillers for a high temperature

Treat infection
Use of antibiotics may be required

NUTRITIONAL ADVICE

Eating
Aim for small regular meal/snacks that contain carbohydrates

- Fruit juice (100ml)
- Milk (100ml)

- Plain vanilla ice-cream (1 large scoop)
- Tomato soup (200 grams)

- Yoghurt (150 grams)
- 2 rich tea or malted milk biscuits

SEEK

Urgent medical attention if any of the following present

Vomiting, diarrhoea or acute abdominal pain (stop Metformin SGLT-2 GLP-1)

Not held down any food or drink for more than 6 hours

Unable to control glucose or ketone levels

DO NOT STOP TAKING YOUR INSULIN BLOOD GLUCOSE LEVELS <4 MMOL/L REDUCE INSULIN DOSE BY 10%. ADAPTED FROM LEICESTER DIABETES.

Adapted from Leicester Diabetes Centre, 2018. Trend UK, 2018.

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6. Diabetes passport/care plan

Resident's diabetes passports
CARE PLAN

HEALTHBOX COMMUNITY WELLBEING SERVICES

Note: A copy of this document should go with me to any hospital appointments, or if I am admitted to hospital. This should be updated at least annually.

KEY PEOPLE IN MY DIABETES CARE TEAM — Date / /

Name | Known as
Address | Date of birth / /
| Tel no

The person at my care home who makes sure that my diabetes is reviewed is:

Name | Tel no

The GP responsible for my diabetes care is:

Name | Tel no

Other HCP contacts (consultant/DSN/podiatrist/dietician):

Name | Tel no
Name | Tel no
Name | Tel no

MY BLOOD GLUCOSE TARGET RANGE

Between | mmol/l and | mmol/l

My hypo signs are:

IF BLOOD GLUCOSE IS BELOW: | mmol/l | Actions

My hyper signs:

IF BLOOD GLUCOSE IS ABOVE: | mmol/l | Actions

BLOOD GLUCOSE TESTS: | When should this be done? | Who should do this?

Meter and strip:

Resident's diabetes passports
CARE PLAN

HEALTHBOX COMMUNITY WELLBEING SERVICES

MY FOOD CHOICES

The goals for my personal diet are:

Likes/dislikes:

Food allergies/intolerance:

Other eating difficulties:

Target weight:

BMI target:

PHYSICAL ACTIVITY

WALKING ABILITY: Walking unaided | Uses walking aid | Chair bound | Bed bound

BALANCE: Sits, stands and turns unaided | Prevent a fall

BATHING AND DRESSING: One carer support for bathing | Dress unaided

MEALS AND NUTRITION: Eat independently | Requires assistance | Fully dependent

Physical activity targets:

Physical activity plan:

MY DIABETES MEDICATION — HBA1C target:

Name of medication:

When to take it: | How to take it:

Name of medication:

When to take it: | How to take it:

FOR BLOOD PRESSURE: BP target: | FOR CHOLESTEROL: Chol target:

Other medication:

Resident's diabetes passports
CARE PLAN

HEALTHBOX COMMUNITY WELLBEING SERVICES

MY INSULIN

The person to contact for advice about my insulin, and before making changes to my treatment is:

Name:

Location: | Telephone:

Name of insulin? | WHEN IS IT GIVEN? | Units @
Units @
Units @
Units @

Device used? | Injection sites preferred?

Who gives insulin?

MY MENTAL/EMOTIONALWELLBEING

Things that would improve my mental/emotional health and wellbeing (eg hobbies, leisure activities, family visits):

Comments:

Resident's diabetes passports
CARE PLAN

HEALTHBOX COMMUNITY WELLBEING SERVICES

MY MEASUREMENTS — Date / /

ASSESSMENT OF MY MEMORY:

Use of Mini-Cog? | Yes | No | Commet/Plan

ASSESSMENT OF MY MY MOOD SCORE:

Use of depression screening? | Yes | No | Commet/Plan

My weight today in kg: | BMI (body mass index):

MUST score: | Blood pressure today:

Visual acuity date checked: | Tick if not undertaken

Retinal screening date: | Tick if not undertaken

Issues with my eyes:

MY FOOT RISK: Low | Moderate | High* | Active*

MY LAB TESTS: HBA1C | Cholesterol | HDL | LDL
Trigs | eGFR | Creatinine | ACR

HYPO FREQUENCY:

IMMUNISATIONS:

Pneumovax | Date / /

Flu jab | Date / /

SMOKING: Yes | No | Cessation advice given? Yes | No | N/A

*High/Active should have 'Red card' foot attack prevention card in notes (available from Diabetes UK).

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info@healthboxcic.com

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7. Foot care

Taking care of your feet in diabetes

1

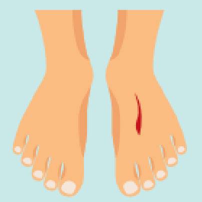
Wash your feet daily with lukewarm water and soap.

2

Dry your feet well epecially between the toes.

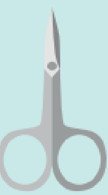
3

Apply moisturising lotion, but do not apply between the toes.



4

Check your feet for blister, cuts, redness, etc. If present, consult your doctor.

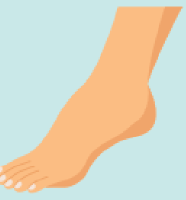


5

Trim your nails straight across and file the edge with a nail file.

6

Change socks daily; avoid dirty and tight socks.



7

Never walk barefoot either indoors or outdoors.

8

Examine your shoes daily for cracks, stones, nails which may irritate feet.

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Training

- The presentation was developed on PREZI (presentation software) and followed the format of the training manual – a video version of the training can be seen below.
- An online and remote version of the training was also developed to make sure all avenues were explored to engage staff in training, especially during COVID-19. (See link - open in chrome): https://prezi.com/v/lseia 4sdwe6z/
- Video animation production for sustainability (example link below – open in chrome). Total of 14 short videos created for community sustainability of the project which will be published to Healthbox online platforms 'The Bubble' and shared with Social Prescribing Link Workers for community dissemination

1. What is Diabetes
2. HBA1c blood test
3. Alcohol
4. Weight management
5. Food labelling
6. Meal patterns and snacking
7. Hydration and fluids
8. Fats and oils
9. Dairy
10. Glycaemic Index
11. Portion sizes
12. Protein
13. Eatwell guide
14. Carbohydrates

Click on link – open in chrome: Watch my Powtoon: Vegetables

Invitation to training

When all the resources were developed, the next phase was to invite care home staff to training and ask them to book via online booking form (example below)

https://forms.gle/dFseteCFuy6nomqE8 - open in chrome

The invitation to training element proved to be another significant hurdle to overcome, which was compounded by fresh restrictions due to COVID-19 and the Omicron variant. Care homes were struggling to release staff, due to shortages and sickness for training. In addition, when staff were booked onto training the DNA rate was significant. One particular training course had a full booking of 20 delegates and only 4 attended training.

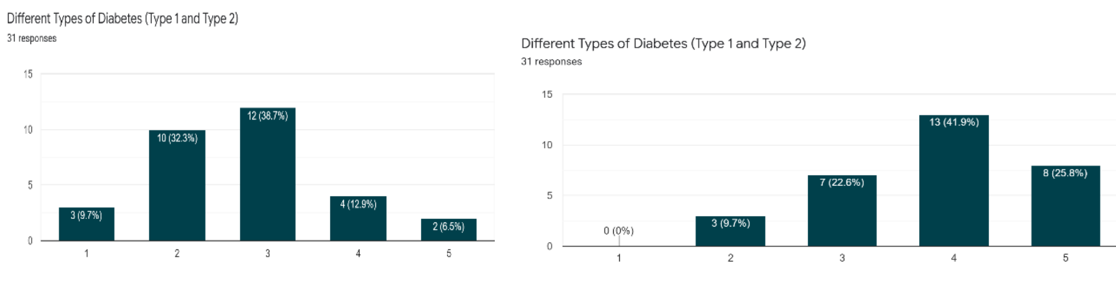
In total 42 (however we only received 31 of the feedback forms) staff attended with a total of 6 out of 22 homes engaging in the face-to-face training. Delegates were asked to complete a number of forms to measure:

- Knowledge and confidence – same questionnaire pre and post training to evaluate effects of training. See format of questions for scales in the links below.
  Pre - https://forms.gle/q6Q2gHNmxGV4HJoc6
  Post - https://forms.gle/NbmDq3YSNL5pHM8V8
- Evaluation of training - https://forms.gle/Hrg9yL8ki4zERh9q9

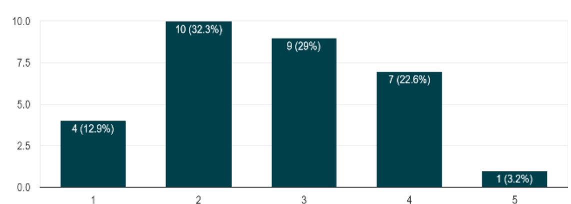
The difficulties presented with Omicron variant and the, meant we came up with a 'Plan B' option to invite care homes to participate in a virtual training sessions; however, after several attempts to engage homes and multiple emails and telephone calls, ultimately managers were finding it too difficult to release staff for any form of training during what proved to be a very challenging time for the indudtry

Knowledge and confidence results

- Left graphs – Pre training
- Right graphs – Post training



Recognising Signs and Symptoms of Diabetes
31 responses



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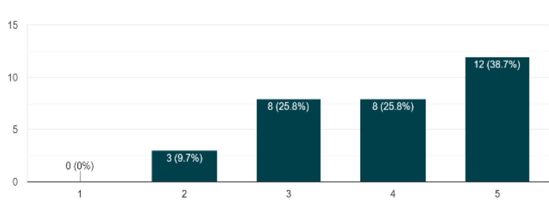
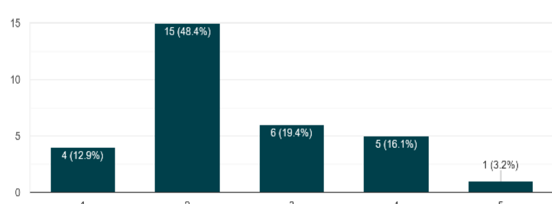
31 responses



Diabetes Related Complications (e.g. Neuropathy, Retinopathy, Nephropathy, Cardiovascular Disease)
31 responses



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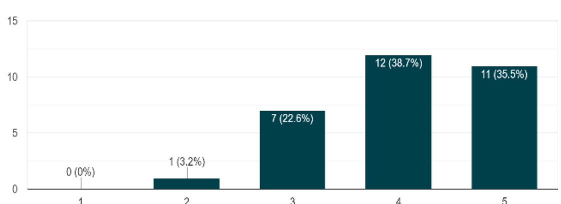
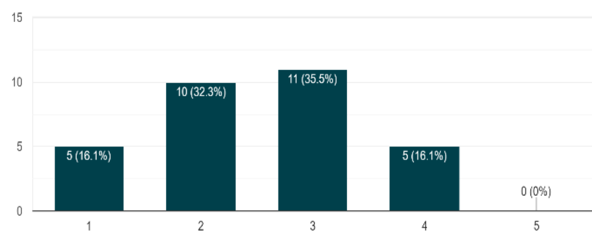
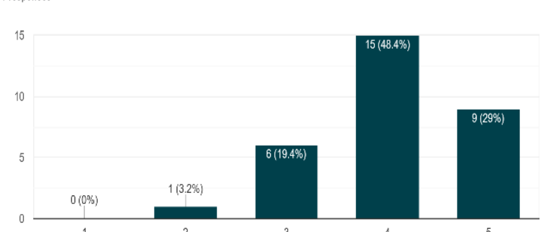


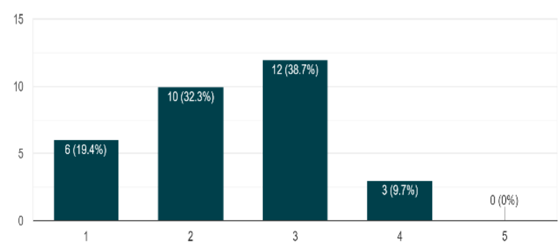
Foot Care for People with Diabetes
31 responses



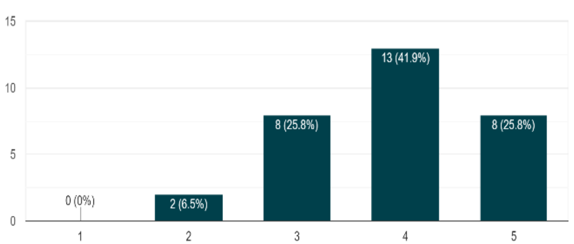
Foot Care for People with Diabetes
31 responses



Annual Review and Diabetes Health Screening
31 responses

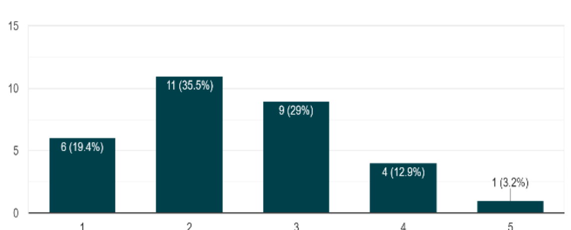


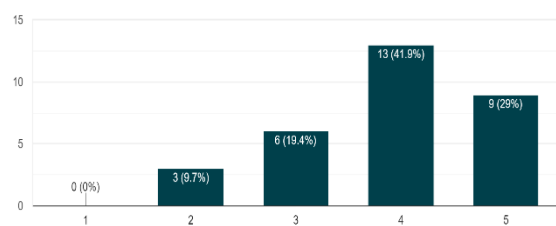
Annual Review and Diabetes Health Screening
31 responses

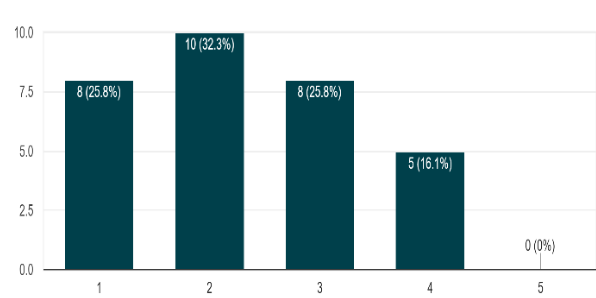


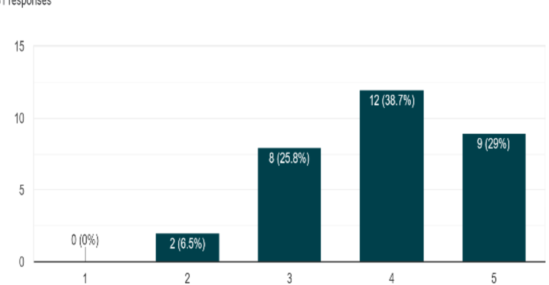
HEALTHBOX

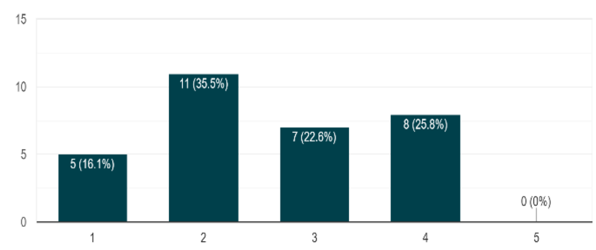
COMMUNITY WELLBEING SERVICES

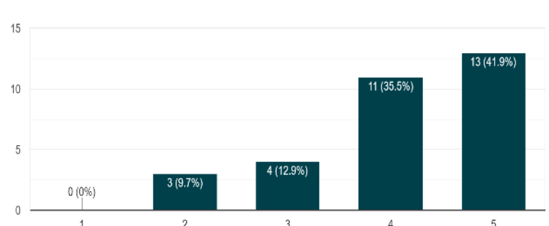


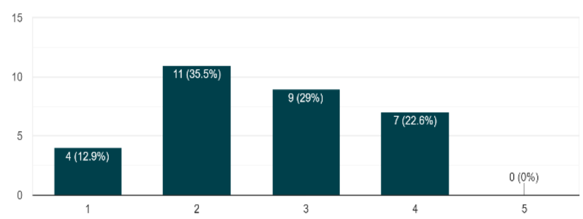


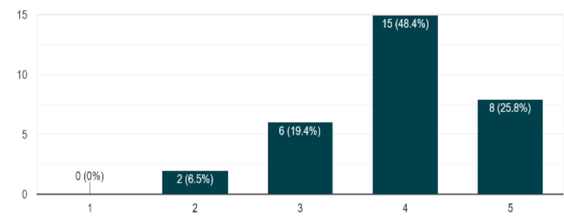


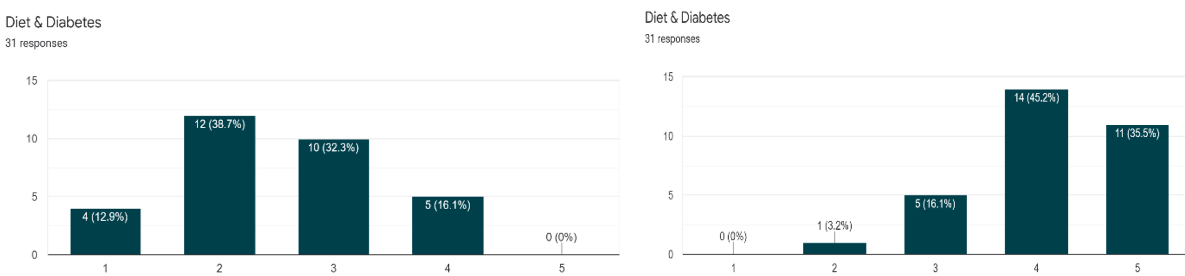


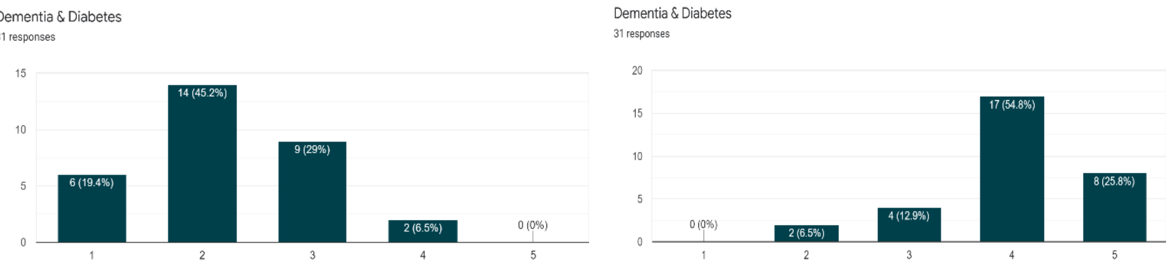








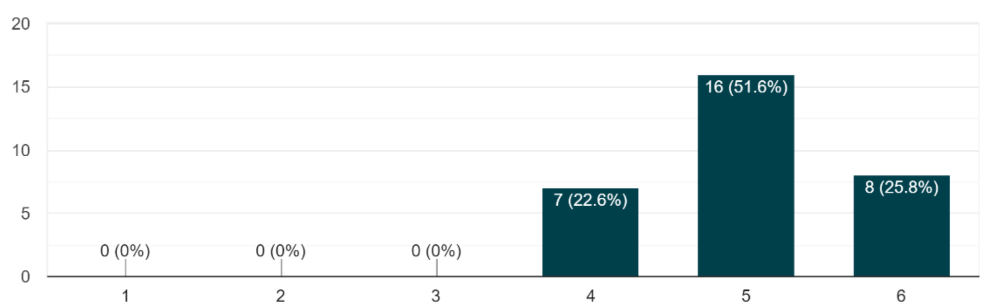




Evaluation of training

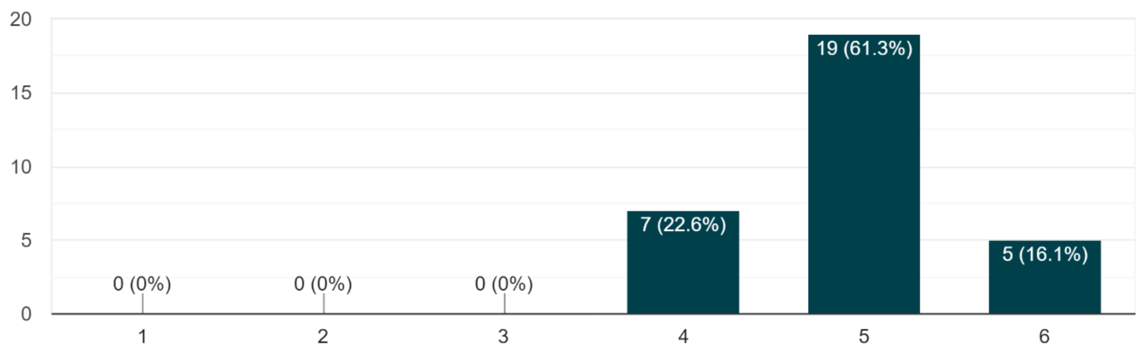
The overall quality of the training was

31 responses



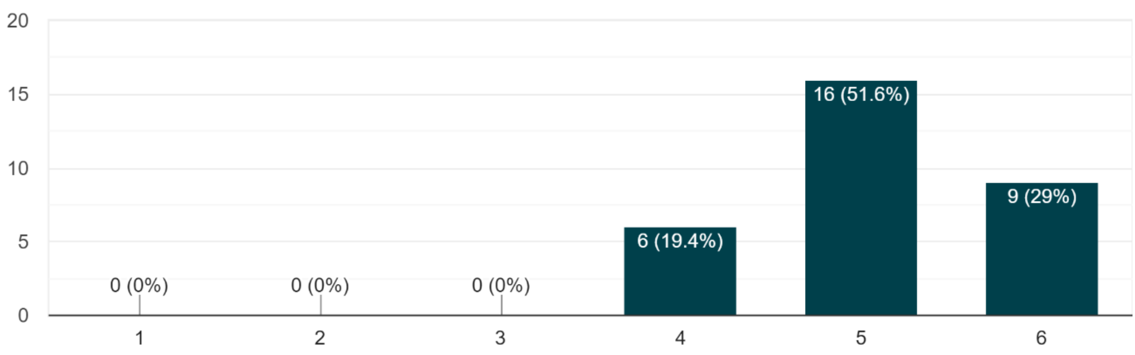
The content of the training was

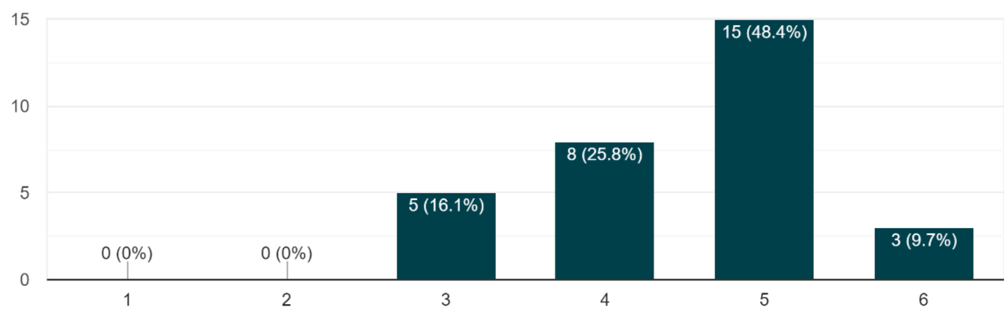
31 responses

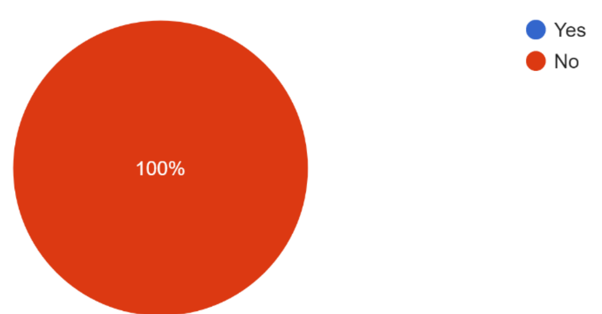


The delivery of the training was

31 responses







Results Summary

The total number of completed returned questionnaires was 31 out of 41 delegates from 6 out of 22 care homes. When compared, results revealed a significant increase in knowledge and confidence across all categories, from an average of 32% pre-training to 68% post-training, an improvement of 34%.

The evaluation feedback forms showed staff believed the training fell between the good to excellent across most categories, the exception being the length of the training, with a portion of the delegates suggesting that training was too long in duration and that it was difficult to maintain concentration over a 3-hour period and perhaps this may have been more valuable split over 2 sessions.

Designated 'Diabetes Champions'

This was a key performance indicator for the project, and although all care homes had agreed to put this in place, when followed up, unfortunately no care homes had designated a diabetes champion in the interest of sustainability. The main reasons for this were a lack of staff and high staff turnover to facilitate this during what was a very challenging time for the care home industry.

Outstanding outcomes

- ***Reduced Hypoglycaemia/Hyperglycaemia adverse events***
- ***HbA1c changes***
- ***Improvements in annual review data – care homes + homeless***
- ***Improvements in diabetes screening – care homes + homeless***

Unfortunately, due to the difficulties getting feedback data from key stakeholders, we have no data to support any changes in any of the above categories. Although, in hindsight, it is important to note, that it was extremely optimistic to expect any significant changes in the above during a project lasting 1 year. To see any meaningful improvements, I believe the project would need a minimum of 2-3 years to yield these results.

‘Feeling Well’ – Homelessness and Diabetes

Introduction

The diabetic homeless population face multiple inequalities and compounded difficulties in awareness, mental wellbeing and resources to enable management and care for diabetes. Issues range from food availability, access to medication to monitoring their blood sugar levels. A recent study states that often individuals experiencing homelessness will:

- experience a higher incidence of diabetes related adverse outcomes
- have poorer access to medical care
- experience financial barriers to medications and dietary control
- Have a lack of trust in healthcare providers
- potentially experience significantly poorer outcomes due to the lack of tailored interventions and diabetes care targeted to their specific needs and challenges

The project aimed to tackle some of these issues in partnership with the range of VCSE organisations that support the needs of individuals experiencing homelessness.

The initiative aimed to provide diabetes prevention and management education to homeless individuals alongside the venues and groups that provide access to food and housing, such as identifying signs and symptoms as well as managing diagnosed diabetes. Part included an element of ‘learning as we go’ to provide the support that will aid these patients to improve their self-management and encourage regular GP/medical monitoring of their condition.

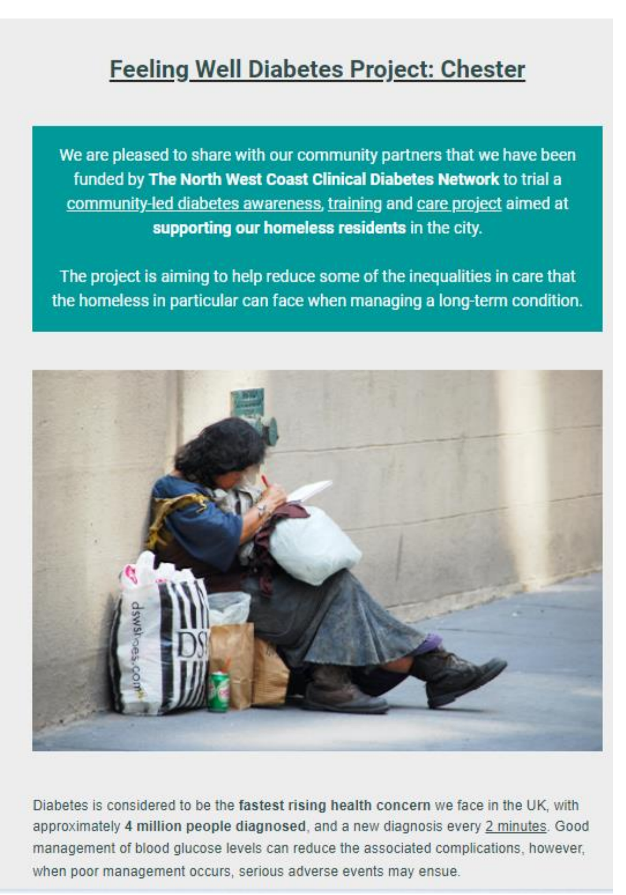
As a CIC we always aim to provide a community input that can be made sustainable or benefit our community partners. Enabling people to make healthier lifestyle choices is part of our key mission and this element was developed and delivered in conjunction with our Social Prescribing team and online wellbeing portal: The Bubble. See videos developed in care home section. This initiative endeavours to have a wider input through providing education and diabetes support through the Social Prescribing service.

This aimed to include where possible: practical cookery (via videos during COVID restrictions) benefits of regular exercise for prevention and management, yoga/relaxation and mindfulness for diabetes as well as linking with a local diabetes buddy system (via ICP contact) and peer support. This component of holistic community-based support, although not targeted at any one population, endeavoured to offer an easy access, open doors approach to patients and carers. We feel has offered the significant aspect of sustainability to the project, in particular to enable people to feel more confident and informed in self-management and to feel connected, as well as providing a service to individuals who may be less likely to contact the GP due to the pandemic. More and more people are being impacted by financial and mental health issues as a result of the pandemic, which could impact on their

overall health and wellbeing making preventative and self-management programmes relevant to the wider community.

Engagement

A newsletter was sent out to all supporting organisations, sample below:



Feeling Well Diabetes Project: Chester

We are pleased to share with our community partners that we have been funded by **The North West Coast Clinical Diabetes Network** to trial a community-led diabetes awareness, training and care project aimed at **supporting our homeless residents** in the city.

The project is aiming to help reduce some of the inequalities in care that the homeless in particular can face when managing a long-term condition.

Diabetes is considered to be the **fastest rising health concern** we face in the UK, with approximately **4 million people diagnosed**, and a new diagnosis every 2 minutes. Good management of blood glucose levels can reduce the associated complications, however, when poor management occurs, serious adverse events may ensue.

Further engagement was achieved through a social media drive to raise awareness of the project, see sample video for 'Diabetes Day' 2021: https://fb.watch/cNNqMX0LEf/

The engagement aimed to work alongside the community homeless organisations, including 'Inside Out' (30+ organisations/individuals supporting people in unstable housing throughout Cheshire West and Chester), SHARE, Soul Kitchen, food bank and the Welcome Network Meeting Places (funded via Cheshire West and Chester Council as part of their dedication to reducing food inequality and poverty across the borough). The Cheshire West and Chester Poverty Truth Commission are currently exploring the inequalities and issues surrounding emergency food provision for residents with medical conditions and/or learning disabilities and homelessness, therefore we were lucky to work alongside them and offer support around education and appropriate emergency food provision for people living with diabetes. This element offered links between existing networks by including diabetes education within their broader scope.

To enable sustainable outcomes, we have worked with our local social prescribing schemes providing resources for link workers aimed around raising awareness of diabetes and preventative behaviour change in our local communities. Healthbox Link Workers currently provide online weight management groups which could include prevention and self-management of newly diagnosed type 2 patients. Through our close links with our PCNs patients facing health inequalities, patients were encouraged to be referred into the project if they require a more personalised approach to management and self-care. However, due to data protection and the limitations of the data-sharing agreement, we were unable to reach out to individual diabetic patients to invite them for support, therefore no one availed of this service.

Our Public Health Dietitian and nutritionists planned several practical group cooking for diabetes sessions, with an aim to provide life skills for patients increasing education and self-management. Although, again due to the Omicron variant, all of these sessions were cancelled and no follow up was arranged, due to time constraints of the project.

Practical Guides

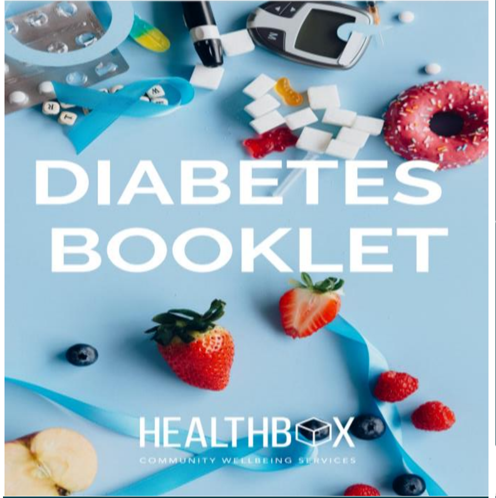
A focus of the intervention was to provide practical support for the people of Chester experiencing unstable housing. These guides are to be disseminated across all supporting organisations, including:

- PCN Social Prescribing Link Workers
- St Werburgh's Practice for the Homeless
- All organisations within 'Outside In' e.g. CATH, SHARE, Soul Kitchen etc.
- Welcome Network
- Cheshire West and Chester Foodbank

Five booklets were developed to support homeless patients and supporting organisations, depending on their individual circumstances, see sample booklet below.

1. Alcohol Dependency
2. Eating at a hostel mission
3. Street Homelessness
4. Cooking Facility Access
5. Food bank

Example Booklet: Reliant on Food bank



MANAGING TYPE 2 DIABETES FOR PEOPLE THAT ARE EATING DONATIONS FROM FOOD BANKS AND CRISIS CENTRES

Whilst eating donations from food banks and crisis centres, it is important to distribute sugar and carbohydrate intake. Save half for later in the day can be beneficial for preventing high blood glucose.

North West Coast Clinical Networks

MEALTIME FOOD : PER MEAL

Options to look out for:

- 1/2 handful portion of cooked rice and 1/2 packet of instant rice (brown rice if possible)
- 1 nest of instant noodles
- 1/4 of a plate of instant pasta, and cooked pasta.
- 2/3 of a can of tinned pulses or beans.
- 1/2 a can of baked beans/ spaghetti. 1 can of soup eg veg/tomato/lentil
- 1 can of tinned meat/fish in sauce

North West Coast Clinical Networks

MEALTIME FOOD : PER MEAL

Options to look out for:

- 1/2 a can of rice pudding or custard
- 1/2 a large bowl, or 1 small bowl of non-sugar-coated cereal.
- Thin spreading of jam/honey on 2 slices of bread (wholemeal/seeded if possible).
- All salad, vegetables, meat, fish, poultry, and vegetarian substitutes are unlimited.

North West Coast Clinical Networks

SNACKS & DRINKS

Options to avoid if possible:

- High sugar snacks eg sweets/chocolate/cake/biscuits/ fudge.
- Canned fruit in syrup and multiple pieces of fruit at once.
- Adding sugar into hot drinks, full sugar fizzy/ energy drinks/ large portions of juice

NHS

North West Coast Clinical Networks

MEALTIME FOOD : PER MEAL

Options to avoid if possible:

- Plates full of carbohydrates eg rice/ pasta/bread/potato.
- Full cans of carbohydrate-rich foods eg baked beans/ spaghetti/ leek and potato soup.
- 2 carbohydrates on the same plate eg bread and pasta.
- Large portions of high sugar cereals.
- Large portions of canned sweet puddings eg rice pudding/custard/ semolina.

NHS

North West Coast Clinical Networks