“More time, better quality”: Nurses perceptions of the Diabetes Get Checked Programme – Summary of Results

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Abstract

Aim: The overall goal of this study was to determine what impact the Diabetes Get Checked (DGC) programme had on the practice of nurses, identify those factors that nurses consider contributed to the success or failure of the programme in their work setting, and identify nurses’ suggestions for improved management and outcomes for people with diabetes in the future.

Background: Recent research into the DGC programme has found the programme has not systematically resulted in improved management or outcomes for people with diabetes. Other work however, reports a number of successful outcomes other than clinical indicators including anecdotal evidence that the programme has enabled the development of nursing practice, an area requiring further research.

Methods: An observational study utilising an online survey was undertaken. A total of 748 people completed the survey – the majority nurses. Data were analysed descriptively.

Findings and discussion: The DGC programme had a substantial impact on the practice of nurses, enabling the development of new models of nursing care, improved educational levels among nurses (and doctors), improved confidence in the management of diabetes, and increased satisfaction in their work. Difficulties with the programme included inconsistency in the way it was implemented in differing workplaces, inconsistent levels of education of providers and therefore inconsistent information passed onto people with diabetes, a lack of time to effectively implement
the programme, and in the clinical judgement of nurse respondents, a belief that an annual appointment did not appear on its own to have a significant impact on outcomes – where nurses and the wider multidisciplinary team worked collaboratively, outcomes did appear to improve. Positive aspects of the programme included the ability to build a therapeutic relationship with a person with diabetes, the focused time that was offered, the development of a multi-disciplinary approach to care and the development of systems and models of care that would not have otherwise occurred. Most considered the programme a success or a partial success. Suggestions for how future management and outcomes for people with diabetes can be improved included the implementation of a wrap-around approach, enhanced case management and self-management, implementing direct funding for nurse-led services, and improving population-based approaches such as policy changes and improving population-based education.

**Conclusion:** Future programmes must take into account the impact of funding on outcomes for people with diabetes as well as the outcomes associated with systems and workforce development.

**Introduction**

With the re-distribution of funding for diabetes care away from the Diabetes Get Checked (DGC) programme following the results of recent research into the outcomes of the programme (Kenealy, Orr-Walker, Cutfield et al., 2011), the New Zealand Nurses Organisation and College of Nurses Aotearoa undertook a joint piece of research into the impact of the Diabetes Get Checked programme (also known as the diabetes annual review) on nurses. The purpose of the study was to determine what impact the programme had on the practice of nurses, identify those factors that nurses consider contributed to the success or failure of the programme in their work setting, and identify nurses’ suggestions for improved management and outcomes for people with diabetes in the future.

**Background**

The Ministry of Health invests significant funding into the prevention and management of diabetes and associated complications. This included the Diabetes Get Checked programme that for the past 11 years provided people diagnosed with diabetes a free annual health check at a cost of approximately 8 million dollars annually. Recent research into the programme found it has not systematically resulted in improved management or outcomes for people with diabetes (Kenealy et al., 2011; Ministry of Health, 2011), and as a result the Minister of Health has chosen to wind up the programme. Other research into the Get Checked programme however, reports a number of successful outcomes other than clinical indicators. These include allowing time for the health provider to focus on management of a single complex condition, more consistent care to people with diabetes, and enhanced educational opportunities for health practitioners (McClanaghan, et al., 2007). The Office of the Auditor General (2007) noted the programme improved monitoring of people with diabetes, offered better guidance to GPs on diabetes treatment and referral, and
removed barriers for some people accessing diabetes care. Further anecdotal reports from nurses suggest the programme has given nurses significant opportunities to build effective relationships with people experiencing diabetes, and improved relationships between primary and secondary providers (Diabetes Nurse Specialist Section, NZNO, 2011). Despite the winding up of the Get Checked programme, the Minister has committed to continuing investment into diabetes primary care in New Zealand (Ryall, 2011). This study enabled the perspectives of nurses to be explored more widely and identified those aspects of the Get Checked programme that nurses found effective, and those that were ineffective. The findings provide useful data for the Ministry of Health as it develops future interventions for diabetes prevention and care.

Method

An observational study utilising an online survey was undertaken. The survey was pretested with a small number of primary health care nurses. Some minor amendments were subsequently made before sending the full survey out. Regulated nurse members of NZNO (registered nurses, enrolled nurses, and nurse practitioners) identified as working in primary health care settings, and all members of the College of Nurses Aotearoa were sent an email inviting them to complete the online survey. The approximate sample was around 4000 (a specific sample was not able to be determined as participants were also invited to forward the email invite onto others who may be interested in completing the survey). A total of 748 people completed the survey. Data were analysed descriptively.

Expedited ethical approval to undertake the study was obtained from the Chairperson of the Multi-region ethics committee. Approval number MEC/11/EXP/120.

Findings

Demographics

The majority of respondents were registered nurses (N=669), followed by managers (N=55), and Nurse practitioners (N=20). Nine enrolled nurses completed the survey and one general practitioner. The majority of respondents were female (97.7%) and aged between 30 and 55 years of age (62%). The number of men completing the survey was 17, the majority of whom were registered nurses (N=12). The majority of respondents were NZ European (78.4%), Māori (11.5%), other European (6.6%) or of Pacific descent (3.7%). Respondents had a range of entry qualifications to nursing with nearly 50% hospital trained (N=365). The remainder were split evenly between a Diploma of Nursing (N=178) and a Bachelor of Nursing (N=166). Many respondents also had post registration qualifications, the most common a post graduate certificate in nursing. The majority of respondents worked in general practice settings (68.2%), followed by Māori/Iwi health (6.4%) and PHOs (5.2%).
Registered nurses were the most common practitioner to undertake the DGC checks followed by general practitioners.

**The diabetes check**
Respondents undertaking the DGC programme undertook a number of specific interventions as part of the check and noted including retinopathy screening, foot checks, dietary advice, green prescriptions, and other diabetes specific interventions. Respondents were also asked what types of concurrent interventions they undertook in the context of the DGC programme. Respondents frequently undertook concurrent cardiovascular risk assessments, made arrangements for follow up care, undertook a full health assessment, and implemented quit smoking. Referral to social service provider was least likely of the concurrent interventions to take place. Free text comments also reflected a range of other opportunistic interventions undertaken by practitioners. These included family violence screening, alcohol use screening, assessment of social situation, and interventions specific to the spiritual needs of the individual/whānau. Several nurses noted concern that when a general practitioner undertook a DGC check this was, at times, done within a normal 10-15 minute appointment and therefore a full assessment and other interventions were unlikely to occur when compared to the interventions that could be undertaken in a 30-45 minute nurse appointment.

**Preparation for implementation of the Get Checked programme**
Most nurses (88.5%) had received some education on diabetes before implementing the Get Checked programme. Of these, the most common type of course was a short course of between 2 and 5 days duration and/or on the job training. Those nurses who had received some education were more likely to consider the programme a success than those who had received no education prior to implementation however it is unlikely there is any significance to this finding given the small numbers.

**Knowledge of Diabetes Knowledge and Skills Framework**
Less than half of respondents (42.8%) were aware of the National Diabetes Knowledge and Skills Framework and only 27.6% used the framework in their workplace to validate the knowledge and skills of nurses working with people with diabetes. Although the majority of nurses were either not aware of the Framework or were uncertain of it, most nurses (N=571) were able to self-categorise their practice based on the descriptions given in the survey at some point on the Framework.

**Diabetes Get Checked and nursing practice**
Respondents were asked to consider the impact that implementing the Get Checked programme had on their nursing practice. In summary, implementation of the Get Checked programme had some impact on relationships with other practitioners but more impact on the work they undertook with people with diabetes, noting that on the whole the programme allowed them to work more closely with at risk clients, build a professional relationship with that person, and enabled them to spend more time with people who had diabetes. 78.1% of respondents indicated that implementing the DGC programme had increased their confidence with diabetes management. Respondents also
had a wide range of free text comments to make regarding the impact that offering the DGC programme had on their practice as a nurse. Many of these comments revolved around the impact on the patient as well as the impact on their own practice. Of note is the wide range of differing practice across the sector with some areas taking full advantage of the scope of nursing practice with others offering checks solely by the general practitioner with no nurse involvement at all and a range of examples in between. Where those nurses were able to practice to the full extent of their scope, satisfaction with practice appears to be higher although further research into this needs to be done.

It was the Get checked programme which led to our clinic becoming autonomous in nurse led clinics, currently we don’t refer patients to second care they are managed entirely by the nurses with virtual access to secondary care, our service has been endorsed by secondary care and are very happy with what we are doing to help the load of secondary services. It has also shown our GP’s that nurses are competent to manage these areas and we now have great relationships which include respect and trust from the GP’s it has led the way to us starting asthma/CVD clinics where the nurses are entirely responsible for these patients. It has motivated our nurses into post graduate study and two have chosen to start the NP route. It is empowering for both staff and patients, who get more time, more education and more empowerment to take responsibility for their conditions.

Diabetes Get Checked and the nurses perspective on the impact on the patient
We were interested to know nurses opinions on how often they noticed (if ever) improvements in a range of self-management tasks in people who took part in the DGC programme. Nurses were more likely to notice improvements in a person’s knowledge of and confidence in self-management than actual implementation of self-management. Uptake of lifestyle programmes was less likely to be observed. The limitations to this measure are of course that they are self-reported observations by nurses rather than acknowledgement by a person with diabetes that change had taken place.

Implementing a DGC Programme in the workplace
Respondents were asked what factors enabled and what barriers existed in the implementation of DGC in their workplaces. We were interested to see what factors were important for implementation and what lessons can be learnt. Having good support from nurse colleagues and time allocated to do the checks were the most important enabling factors for implementation of a DGC programme in a workplace. This was followed closely by good support from doctors.

The most common barriers to implementation included a lack of time allocated to implementing the programme and a lack of knowledge and understanding of diabetes. The most common ‘other’ comments were a lack of space to undertake the checks and people not attending pre-set appointments.

Respondents were also asked to comment on the positive and negative aspects of providing the DGC programme in their workplace. Positive aspects included:

- Enabling regular contact with people who have diabetes
- Providing an opportunity to build a relationship with the person with diabetes
- Building understanding and improving outcomes for people with diabetes
- Enabling focused time to discuss diabetes with people
- Increased knowledge of staff
- Development of a multi-disciplinary approach to diabetes care
- The development of systems and models of care to manage diabetes
- Professional reward from seeing improvements in people with diabetes
- Reduction in barriers to access
- Financial benefits to the practice.

While a substantial number of respondents indicated they could see no negative aspects to the Get Checked programme, others had a range of comments that provide useful information on things to avoid in future programme implementation. Negative aspects included:

- Insufficient time to effectively implement the programme. This appeared to be particularly so for workplaces that attempted to implement the programme on top of existing workloads and made no allowance for the extra time involved in not only providing the checks but also the systems that need to exist around the programme to ensure its success e.g. time to arrange recalls, follow up on lab tests etc.
- Significant frustration around both the difficulty of getting people to attend appointments and for those who did, the lack of observable behavioural change. A large number of respondents indicated that the biggest issue was that an annual check did not offer sufficient time to make any progress with people.
- The lack of access to appropriate and affordable follow up resources was also noted as an issue. Although the nurse or other provider could identify what type of supports the person needed, access to these was not always readily available.
- There was a distinct impression from some respondents that many thought the DGC programme was a tick box exercise and that many providers were going through the motions without having the education, inclination or time to undertake the checks in the most effective way.

Was implementation of DGC a success?
Respondents were also asked to rank whether they thought implementation of the DGC programme in their workplace was a success, partial success or not a success. Over 50% of respondents considered implementation of the programme a success.

Suggestions for improved management and outcomes for people with diabetes
The Diabetes Get Checked programme is not going to continue in its current form, therefore we were interested to know nurses’ suggestions for how they see management and outcomes for people with diabetes could be improved. Many respondents supported continuation of the DGC programme and were critical of the evaluation of it. Many had useful comments regarding improving the programme which revolved particularly around the need for more time and more money to undertake the programme effectively. Others had more explicit examples of how diabetes management and outcomes could be improved including:

- the importance of ensuring that both nurses and doctors had access to appropriate and consistent education as a base level and that continuous upskilling of both practitioners
occurred. There was a belief among respondents that education and knowledge amongst both sets of practitioners was inconsistent and this occasionally resulted in people with diabetes receiving inconsistent messages.

- There was support for more nurses to be prescribing, particular support for more training in self-management strategies e.g. Flinders type courses, and support for courses in initiating insulin in general practice.

- There was strong support for a multi-disciplinary wrap-around approach to diabetes care including easy (funded) access to podiatry, dieticians, social workers, retinopathy screening, and pharmacy services. However, this also extended to the importance of addressing continuity of care and the importance of ensuring links between primary, secondary and tertiary care were seamless and integrated.

- There was also strong support for extending diabetes services further into the community including home visits, utilising community support workers and providing marae and church based services.

- Individually focussed interventions remained the most popular suggestions from respondents as a means of addressing the management of people with diabetes. This included substantial support for self-management approaches, more regular monitoring and visits, increased education, case management and follow up telephone support.

- One of most common comments made by respondents was the desire for more funding and more time to undertake the checks and provide the follow-up care required. An annual check was considered insufficient to provide appropriate care, and more time and money needed to be allocated to achieve an appropriate standard of care – in particular to motivate and support people to make significant lifestyle changes.

- Many respondents identified broader interventions that are required to address diabetes in the community. These suggestions included the need for policy change, early intervention, targeted resourcing, advertising/population education and addressing the social determinants of health.

- Respondents identified a range of ways that nurses specifically could respond to improving management and outcomes for people with diabetes including targeted funding for nurses and the establishment of more nurse-led clinics.

- Respondents noted that successful diabetes care revolved around the establishment of an effective therapeutic relationship with the person diagnosed with diabetes. Respondents thought that the DGC programme facilitated the development of this relationship, enabling more sustainable outcomes and that any programme to replace DGC must facilitate the establishment and maintenance of that relationship.

- Respondents had a number of recommendations for how improved IT systems could enhance care of people with diabetes. These included shared clinical records, development of a national database, improvements to the Get Checked template, patient held records, a universal, evidence based website suitable for patient access, and improved ICD codes.
Summary

The DGC programme had a substantial impact on the practice of nurses, enabling the development of new models of nursing care, improved educational levels among nurses (and doctors), improved confidence in the management of diabetes, and increased satisfaction in their work. Most believed the programme led to improved levels of understanding of diabetes among people with the condition but that this did not necessarily result in discernible behavioural change. Difficulties with the programme included inconsistency in the way it was implemented in differing workplaces, inconsistent levels of education of providers and therefore inconsistent information passed onto people with diabetes, a lack of time to effectively implement the programme, and in the clinical judgement of nurse respondents, a belief that an annual appointment did not appear on its own to have a significant impact on outcomes – where nurses and the wider multidisciplinary team worked collaboratively, outcomes did appear to improve. Positive aspects of the programme included the ability to build a therapeutic relationship with a person with diabetes, the focused time that was offered, the development of a multi-disciplinary approach to care and the development of systems and models of care that would not have otherwise occurred. Most considered the programme a success or a partial success. Suggestions for how future management and outcomes for people with diabetes can be improved included the implementation of a wrap-around approach, enhanced case management and self-management, implementing direct funding for nurse-led services, and improving population-based approaches such as policy changes and improving population-based education.

Recommendations

The following recommendations are based on the findings from the research and provide possible future directions for the care of people with diabetes:

1. Future programmes should be structured in a manner that allows for consistent implementation across the sector.
2. Future programmes should ensure sufficient funding is included to ensure initial, ongoing and consistent education of practitioners.
3. Future programmes should encompass culturally appropriate wrap-around services that enable home visits, marae and church-based programme implementation, and more effective use of community health workers.
4. Broader population-based strategies including policy change, population-based education and marketing, and school-based programmes should be implemented contiguously with practice-level interventions.
5. People with diabetes should be given the opportunity to contribute to the discussion around how future programmes should be developed and implemented to meet their chronic condition needs.
6. Nurses should be enabled (through the provision of appropriate education and funding) to practice at the full extent of their scope of practice and take a lead role in the provision of care to people with diabetes across the sector.
Conclusion

Although the Diabetes Get Checked programme has had little clinical impact on people with diabetes as evidenced by Kenealy et al. (2011), there is clear evidence that the programme resulted in improved systems and models of care for managing people with diabetes as well as significant development of health workforce capacity across the sector. Future programmes must take into account the impact of funding on outcomes for people with diabetes as well as the outcomes associated with systems and workforce development.

A draft copy of the full report is available on request from Jill Clendon at jillc@nzno.org.nz
References


