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North of England Commissioning Support

Care Bundle

Adult patients with type 2 diabetes

North of England Commissioning Support
Medicines Optimisation on behalf of Cumbria CCG

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1. Introduction

1.1. What is a care bundle?

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. The measures chosen reflect best practice and are based on NICE quality standards or other national guidance. Care bundles have been used extensively and successfully in Secondary Care, their use in Primary Care is more recent. This care bundle is based on the work of Healthcare Improvement Scotland and the Scottish Patient Safety Programme in Primary Care.

Reliability in health care is a failure-free operation over time. This equates to ensuring patients receive all the evidence-based care they are entitled to receive.

A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. In relation to care bundles, this means ensuring that patients receive optimum care at every contact. The process for achieving reliability is to implement this set of measures (a care bundle). The key measure in a care bundle is the score which measures the level of compliance with all measures for all patients.

The care bundle data collection tool is a way of sampling whether optimum care is being delivered by applying the bundle to a sample of patients. This approach is therefore very different from traditional auditing approaches that are designed to identify whether individual measures are being implemented.

1.2. What makes up a care bundle?

- 4-5 measures
- All or nothing compliance
- Measurement done by a non-clinician if possible
- Spread over patient's journey
- Evidence based
- Creates teamwork and communication
- Multiple functions of care essential for desired outcome

1.2.1. How should a care bundle be used in practice?

A care bundle is a quality improvement tool which can be used in general practice to identify both where care is in line with best practice and where improvements are needed. Some are disease specific and some are medication specific. The latter may also be known as patient safety bundles if they relate to high risk medication.

Bringing about changes in practice is not easy. To be an effective tool the results of the care bundle measurements must be discussed by ALL members of the team involved in the care of the patient. The practice team then need to take ownership of the issues identified and commit to changing the way care is provided, using tools such as the 'Plan, Do, Study, Act (PDSA) cycle.

Principles of successful measurement:

- The support of all members of the practice team should be obtained
- Data should be collected anonymously
- The results should be discussed by every member of the team
- The results should be used to plan and implement improvement initiatives
- Clinician support may be needed initially by the data collector until they are familiar with the measures.

1.3. Records

The care bundle is not a performance tool and so there is no requirement to report the measures achieved. The practice should keep a reflective log of improvements.

1.4. Resources

This care bundle has the following supporting resources:

- A word document data collection form
- An excel spreadsheet data collection form with a graphing function
- A reflective log template

Further information on Care Bundles and Improvement Models can be found at www.healthcareimprovementscotland.org/pspc.aspx

Further advice can be obtained from the Medicines Optimisation team, and specific queries about this care bundle can be directed to the author (details are on the front page).

2. Adult patients with type 2 diabetes

2.1. Search Criteria

Please identify a random sample of up to 20 adult patients a month in your practice with a diagnosis of Type 2 Diabetes. Use the data collection form to record the answer to each measure and transfer this to the spreadsheet. This should be repeated over a period of time, and the results discussed by the clinical team at regular intervals. Use of the spreadsheet will enable changes in practice to be monitored and compliance with the care bundle to be measured.

2.2. Measures

01

Measure	**Has patient attended a structured education programme (e.g. DESMOND) since diagnosis?**
Rationale	People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education delivered by trained staff. A healthcare professional should check every year whether the person would find further diabetes education useful and diabetes education should continue to be available. When first diagnosed with type 2 diabetes, or soon after, the patient should be offered the opportunity to learn about diabetes in a structured education programme. This usually involves going to group sessions run by people who have been specially trained to do this. If the patient can't or doesn't want to attend as part of a group, they should be offered an alternative individual programme.
Source	NICE Quality Standard QS6: Diabetes in adults. March 2011. Updated August 2015 Statement 1. https://www.nice.org.uk/guidance/qs6/chapter/Quality-statement-1-Structured-education NICE clinical guidelines [NG28] Type 2 diabetes in adults: management. Published date: December 2015 Last updated: July 2016 https://www.nice.org.uk/guidance/ng28

02

Measure	**Has the patient participated in annual care planning to develop an individualised self-management plan?**
Rationale	People with diabetes should be involved in annual planning for their own care which includes agreeing the best way to manage their diabetes and setting personal goals. Management of diabetes typically involves a considerable element of self-care and advice should, therefore, be aligned with the perceived needs and preferences of people with diabetes, and carers. People with type 2 diabetes should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

	People with diabetes should be given advice on diet and exercise from a trained healthcare professional or as part of their diabetes education course. Taking care with diet is an important part of managing diabetes, and the patient should be offered ongoing and personalised nutritional advice from someone with specific expertise. This should cover the best timing of meals and snacks for them, their carbohydrate intake and advice on alcohol. General healthy eating is also important, and an nutrition expert should encourage them to: • eat carbohydrate from fruit, vegetables, whole grains and pulses • eat low-fat dairy products and oily fish • control their intake of foods containing saturated fats and trans fatty acids. Dietary advice should be integrated into a personalised diabetes management plan which includes other aspects of lifestyle modification such as increasing physical activity and losing weight. Overweight patients should be encouraged to lose weight and agree a target weight loss of 5-10% initially, whilst recognising that any weight loss will help and a larger weight loss will have an advantageous metabolic impact. People with diabetes agree with their healthcare professional a documented personalised HbA_{1c} target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia. HbA_{1c} should be measured every 2 to 6 months until it is stable and the patient is settled on a particular medication (if needed). When this has happened, they should have an HbA_{1c} blood test every 6 months.
Source	NICE Quality Standard QS6: Diabetes in adults. March 2011. Updated August 2015 Statement 3. https://www.nice.org.uk/guidance/qs6/chapter/Quality-statement-3-Care-planning NICE clinical guidelines [NG28] Type 2 diabetes in adults: management. Published date: December 2015 Last updated: July 2016 https://www.nice.org.uk/guidance/ng28

03

Measure	**Has the patient had an annual assessment for the risk & presence of complications of diabetes?**
Rationale	Type 2 diabetes is commonly associated with raised blood pressure, a disturbance of blood lipid levels and a tendency to develop thrombosis. It is notable for the increased cardiovascular risk that it carries: coronary artery disease (leading to heart attacks, angina); peripheral artery disease (leg claudication, gangrene); and carotid artery disease (strokes, dementia). The specific ('microvascular') complications of diabetes include eye damage (blindness), kidney damage (sometimes requiring dialysis or transplantation) and nerve damage (resulting in amputation, painful symptoms, erectile dysfunction etc.). Annual review should include an assessment for the risk and presence of the complications and additional health problems associated with diabetes. Any risks or problems identified should be properly managed

Source	NICE Quality Standard QS6: Diabetes in adults. March 2011. Updated August 2015 Statement 8. https://www.nice.org.uk/guidance/qs6/chapter/Quality-statement-8-Complications NICE clinical guidelines [NG28] Type 2 diabetes in adults: management. Published date: December 2015 Last updated: July 2016 https://www.nice.org.uk/guidance/ng28

04

Measure	**Has the patient had a medication review in the past 12 months to start, review & stop medications to lower blood glucose, blood pressure & blood lipids in accordance with NICE guidance?**
Rationale	People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidelines.
Source	NICE Quality Standard QS6: Diabetes in adults. March 2011. Updated August 2015 Statement 5. https://www.nice.org.uk/guidance/qs6/chapter/Quality-statement-5-Medication

05

Measure	**Has the patient received advice on appropriate frequency of self-monitoring of blood glucose?**
Rationale	Patients, who have just been diagnosed with type 2 diabetes, should have monitoring of blood glucose levels (self-monitoring) discussed as part of their structured education programme. The programme should cover how to check their blood glucose and how to interpret and use the results. 1. Do not routinely offer self-monitoring of blood glucose (SMBG) levels for adults with type 2 diabetes unless: o the person is on insulin or o there is evidence of hypoglycaemic episodes or o the person is on oral medication that may increase their risk of hypoglycaemia while driving or operating machinery or the person is pregnant, or is planning to become pregnant. For more information, see the NICE guideline on diabetes in pregnancy. 2. Consider short-term self-monitoring of blood glucose levels in adults with type 2 diabetes (and review treatment as necessary): o when starting treatment with oral or intravenous corticosteroids or o to confirm suspected hypoglycaemia. 3. Be aware that adults with type 2 diabetes who have acute intercurrent illness are at risk of worsening hyperglycaemia. Review treatment as necessary. 4. If adults with type 2 diabetes are self-monitoring their blood glucose levels, carry out a structured assessment at least annually. The assessment should include: o the person's self-monitoring skills o the quality and frequency of testing

	○ checking that the person knows how to interpret the blood glucose results and what action to take ○ the impact on the person's quality of life ○ the continued benefit to the person ○ the equipment used At least once a year, the doctor or nurse should check the continuing need and the way the patient is self-monitoring and using the results and the equipment, so they continue to get accurate and helpful results.
Source	NICE clinical guidelines [NG28] Type 2 diabetes in adults: management. Published date: December 2015 Last updated: July 2016 https://www.nice.org.uk/guidance/ng28 https://www.nice.org.uk/guidance/ng3

Appendix One: Abbreviations

Abbreviation	Definitions
NICE	National Institute for Health and Care Excellence
SPC	Summary of Product Characteristics
NICE CG	NICE Clinical Guideline
NICE QS	NICE Quality Statement
SMBG	Self-monitoring of blood glucose