Diabetes and Homelessness Quality Improvement Project

Homeless and Inclusion Health Nurses

Instructions

Clinical audit

Undertake a clinical audit of all or a selection of the patients you have with diabetes (10 maximum). You can either do this totally by yourself, or ask a member of your team to get involved e.g. you can audit 5 each. You can use the prepared Excel spreadsheet to record relevant clinical care markers for each patient (which are also listed in full below).

Patient discussion forms

In addition, undertake some patient care discussions (up to 5) with people experiencing homelessness with diabetes during consultations. A form is provided to direct these discussions. Undertake both processes so you can get both clinical audit data and patient feedback to inform your project.

Interpreting the results

Once the project has been undertaken discuss the results with your wider team.

- What have you learned as a result of undertaking the audit and patient discussions?
- Are there any areas in which care could be improved?
- What could be your action plan for Quality Improvement going forwards?
- What could you share with the wider group of nurses about what you have learned from the process?

Write up for your service

Once you have completed the project, share your action plan with your manager or programme lead. You might also want to write the work up with anonymised data as a formal clinical audit and quality improvement piece for your own organisation.

If you do this, things to write in the introduction to give context to your project would be:

- What is your job title / the nature of your role?
- What health setting do you work in?
- What is the geographical area that you currently serve?
- How many patients do you see in an average week?
- How big is your staff team?
- Why are you concerned about people experiencing homelessness with diabetes specifically?
- How many patients experiencing homelessness with diabetes do you currently have?

Pathway Homeless & Inclusion Health
Faculty For Homeless & Inclusion Health
Burdett Trust for Nursing
Qni The Queen's Nursing Institute

Clinical Audit

First start by understanding your full population.
Undertake a search:

- What is the size of your caseload /service population
- How many people with Type 1, Type 2 or other types of diabetes do you have
- Calculate your prevalence

Now decide on a method for identifying clients for your audit using a time period (e.g. the last 3 months, 6 month or a year) and a reasonably random record selection method e.g.

- Most recent 10 patients seen
- Every other patient
- 2 for all clinicians within the service

Then record the following audit markers for all the patients you audit using the Excel spreadsheet.

Audit Markers

Demographics

- Age
- Ethnicity
- Diabetes type 1 / 2 / 3c
- Year diagnosed (if known)
- Current housing status
- Mental health diagnosis? Y/N
- Alcohol misuse? Y/N
- Drug misuse? Y/N
- Intravenous Drug User Y/N
- Concerns about brain injury / cognition? Y/N
- Eating disorder?
- Smoker Y/N
- Chaos index or similar marker that gives an indicator of stability

Service Usage

- How many times has this person been seen by you or your service in the last 6 months?
- How many of these contacts have been assertive outreach contacts? (if this information is available)
- How many missed contacts or DNAs have there been (if this information is available)
- Has this person attended A&E or been admitted to hospital in the last year? Y/N
- Number of A&E attendances
- Number of admissions

Clinical Markers

- Last HbA1c (date and recording)
- Last cholesterol (date and recording)
- Last urine ACR (albumin to creatinine ratio) (date and recording)
- Last other renal tests if ACR not done (date and recording)
- Weight (date and recording)
- Blood pressure (date and recording)
- Nutrition screening score (date and recording)

Clinical Management

- Currently prescribed diabetes medication? Y/N
- Level of concordance – full, partial, very limited, none

- Diabetes health promotion session given by your service Y/N
- Date of last session
- Total number of sessions in last 6 months (if available)

- Discussion re diabetic diet / nutrition at your service Y/N
- Date of last session
- Total number of sessions in last 6 months (if available)

- Referred for eye check? Y/N
- Attended eye check? Y/N
- Date of last eye check
- If not seen, have appointments been DNA'd Y/N

- Referred for foot check? Y/N
- Attended foot check? Y/N
- Date of last foot check
- If not seen, have appointments been DNA'd Y/N

- Would this person benefit from specialist diabetes review? Y/N
- Have they been referred for specialist diabetes review? Y/N
- Have they been seen by a specialist diabetes practitioner? Y/N
- Date last seen
- If not seen, have appointments been DNA'd Y/N

- Would this person benefit from a dietician?
- Have they been referred to a dietician?
- Have they been seen by a dietician?
- Date last seen
- If not seen, have appointments been DNA'd Y/N

- Would this person benefit from a peer advocate? Y/N
- Is there a peer advocate service to refer to (either in homelessness or diabetes services) Y/N
- Have they been referred to a peer advocate? Y/N
- Have they been seen by a peer advocate? Y/N
- Date last seen
- If not seen, have appointments been DNA'd Y/N

- Does this person have a wound?
- Have they been referred to a tissue viability service?
- Have they been seen by a tissue viability specialist?
- Date last seen
- If not seen, have appointments been DNA'd Y/N

- Does this person have psychological needs?
- Have they been referred to a Psychologist?
- Have they been seen by a Psychologist?
- Date last seen
- If not seen, have appointments been DNA'd Y/N

- Self-neglect safeguarding concerns? Y/N
- Referred to safeguarding Y/N
- Under safeguarding Y/N

- End of life concerns (you wouldn't be surprised if they died in the next six months)?
- Referred to palliative care Y/N
- Under palliative care Y/N

- Has there been a Case Conference in the last 6 months? Y/N
- If not, is one needed? Y/N

- Could any improvements be made to this person's care? Y/N
- Free text action points

Additional Actions
(if you have time!)

Do you have / use accessible information leaflets?

- What leaflets do you use / have available?
- Do leaflets meet NHS accessibility standards? (font, typeface, images etc)
- Are the leaflets always available / and or are there any barriers to using them (like e.g. printing access?)

- *Are there any improvements that can be made to leaflet provision?*
- *Are there any good leaflets that you would like to tell others about?*
- *Is there any good practice you could to share?*

Do you use / have translated leaflets?

- What leaflets do you use / have available?
- Are any languages missing?

- *Are there any improvements that can be made to leaflet provision?*
- *Are there any good leaflets that you would like to tell others about?*
- *Is there any good practice you could share?*

Do you have access to / routinely use interpreting services?

- How easy is it to get interpreting services?
- Are they ever not used when they should be?

- Are there any improvements that can be made to interpreting provision?
- Is there any good practice you could to share?

What engagement does your service have with service users (e.g. feedback, Experts by Experience)?

- How do you get feedback from service users?
- How do you get feedback from vulnerable groups?
- Do you have any service user input in developing services?

- Are there any improvements that could be made to service user feedback?
- Is there any good practice you could to share?