‘Don’t tell us off’:

Examining Ways to Improve the Health Care of People Experiencing Homelessness with Diabetes

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Burdett Trust for Nursing

Pathway Homeless & Inclusion Health

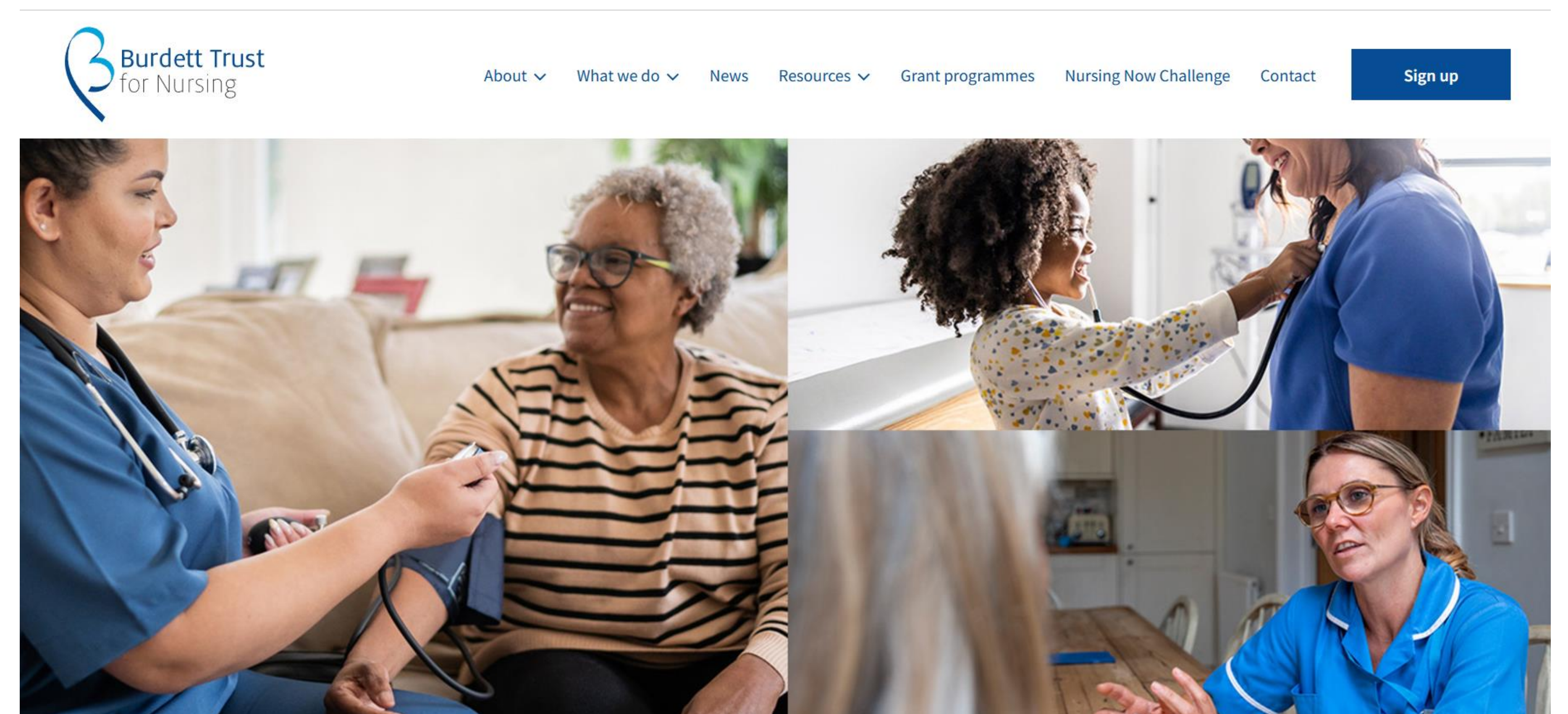
Working with Crisis Together we will end homelessness

Faculty For Homeless & Inclusion Health

Burdett Trust for Nursing

- Quality improvement / research grants for nurses
- Practical projects – relevant to practitioners and patients
- Yearly cohorts – in this case diabetes

- Light touch approach
- Also give one off grants



Project was prompted by…

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HOME / EXPLORE QNI / COMMUNITY NURSING INNOVATION PROGRAMME / CASE STUDIES / PARTNERSHIP WORKING AROUND THE IDENTIFICATION AND MANAGEMENT OF PEOPLE WITH DIABETES

Partnership Working around the Identification and Management of People with Diabetes

This case study describes a quality improvement project to improve the identification and management of diabetes in people experiencing homelessness in Bolton.

In August 2020, a meeting was held with Joanne Dickinson (Advanced Clinical Practitioner) and Rebecca Lace (Registered Nurse) from the Homeless and Vulnerable Adult Team (HVA), Bolton FT, to identify existing gaps in the management of diabetes in adults experiencing homelessness (within Bolton).

The initial discussion covered:

- Estimated number at risk of diabetes, and what screening was being carried out
- Numbers of existing clients with Type 1 and Type 2 Diabetes and whether they were accessing the 9 diabetes care processes annually

Information

Key person
Lynne Bromley

National SAR Analysis

2019-2023 – 652 cases

- Mental Health (70%)
- **60% feature self-neglect - self-neglect the most frequent type of abuse or neglect reviewed**
- 216 cases involved substance misuse, mainly alcohol-dependence (33%)
- **Diabetes (14%)**
- 88 reviews focus on homelessness (13%)

Aim of project:

To bring together 10 diabetes specialist nurses, 10 homeless and inclusion health nurses 4 Experts by Experience and the wider MDT to look at ways of improving care for people experiencing homelessness with diabetes.

Good mix of nurses who were already doing QI work, and those who had not yet done any

Good geographical cover – England and Scotland

Diabetes & homelessness project April 2023 – July 2024

- Literature review (published with article summaries)
- Review of 5 Safeguarding Adult Reviews
- 2 open access online workshops – on challenges and best practice 50+ attendees
- Visits to 4 areas of good practice – visits to Bolton, Liverpool, St Helens, Plymouth
- 13 practice-based nurse led quality improvement projects in a variety of localities across England and Scotland (QI process was designed on project) – visits to Edinburgh, Leeds and Bournemouth
- Diabetes and inclusion health survey – 104 respondents
- 3 Expert Patient interviews. Development of video / audio content with 2.
- 1 face to face event in London sharing the nurse led improvement projects - April 2024
- Creation of training resources

ose who walked so we could run
so our children soar
RE HALL

Background literature review

34 papers 2000 - 2024, mostly USA and Canada, one from China

- The prevalence of diabetes in homelessness populations is unclear – 6%-22%
- **Homelessness poses numerous barriers to managing diabetes**
- **Poor blood sugar control and serious complications are common**
- Gaps in practitioner knowledge are known to exist
- Published QI projects from other countries in this area
- Innovative, multi-disciplinary, multi-agency approaches are needed
- **Experts by Experience provide important insights on service design**
- Peer support can be successful and positive

Analysis of 5 Safeguarding Adult Reviews

- Important to understand where things had gone wrong
- Not easy reading

- **Josh, Jasmine, Jonathan, Sophie and James**

- **https://nationalnetwork.org.uk/**

https://museumofhomelessness.org/dhp

- **1 was 18**
- **2 in their 20s**
- **1 in their 30s**
- **1 was 46**

Key issues identified

- Very high clinical risks related to diabetes and alcohol / substance misuse and mental health
- Multiple A&E attendances / admissions and self-discharges with a lack of coordinated responses
- A lack of understanding of self-neglect, and related failures in safeguarding
- A lack of clear identification of communication and cognition difficulties
- A lack of ability of practitioners to assess mental capacity effectively in complex scenarios
- A need for more robust multidisciplinary team processes, with robust risk management and identified leadership
- A lack of understanding of the risks of homelessness within hospital staff
- A need for 'easy read' materials on diabetes
- A need for trauma informed care
- A failure or lack of transition services for young people leaving care
- Specific risks related to diabetes – e.g. overdoses of insulin and co-concurrent eating disorder

Survey – 104 responses

Respondents: 1/3 diabetic specialist nurses, 1/3 inclusion health nurses, 1/3 support workers / hostel staff

- Diabetes requiring insulin was more common in this population - estimated to be 33% - chimes with practice findings about prevalence of Type 3
- Diabetes care outcomes for people experiencing homelessness were perceived to be substandard - 57% poor or very poor
- Practitioners find diabetes management for PEH to be challenging - 73% challenging or very challenging
- Diabetes related complications occur more often amongst people experiencing homelessness than in the general population - 66% more often, or a lot more often

‘Staff are trying very hard, but the wider context is difficult – challenges with other staff, challenges with accommodation, and their personal challenges with addictions etc’

‘It's easy to 'blame' hospitals for all this and certainly primary care can probably do more. But some of it is the changeable, transient and precarious nature of patients’ lives. It is sometimes very frustrating, and I think reflects the nature of the work but also, the hard lives of those experiencing homelessness’

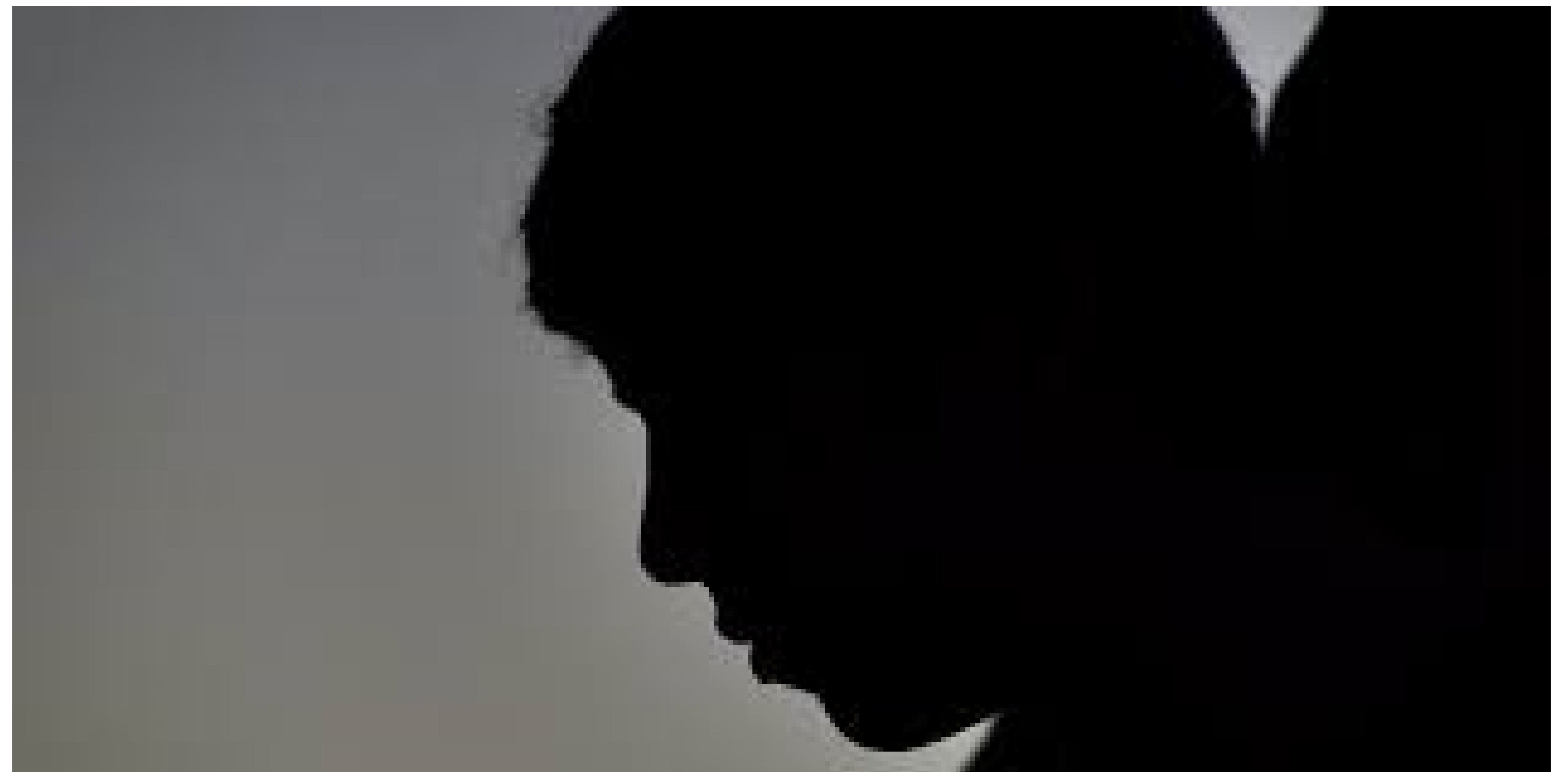
Expert patient - 1

- Late 20s
- Type 1 diabetes
- Attended A&E over 150 times
- Adverse childhood experiences, mental health issues – very high anxiety, impulsive behaviour
- Cannabis and benzodiazepine use
- Mild learning issues, differences of opinion on mental capacity

- DOLS followed by 11-month admission
- Discharged into temporary accommodation with full time care. Deemed not to have capacity to manage his diabetes

Patient feedback on the Deprivation of Liberty Safeguards progress

'I'm glad that happened. I needed someone to take control'



But because of poor management has residual:

- Eye problems
- Foot problems
- Skin issues
- Cognitive issues

The diabetes nurse fought to get the DOLS, and met huge barriers along the way…

Question:

- Are there times when a DOLS could / should be used but this is not happening?
- Nobody would suggest a DOLS should be used every time you can't prove that someone has mental capacity, are we always using it when we could.

Expert patient - 2

- Early 40s
- Serious gastric issues after bowel abscess with stoma
- Type 3 diabetes for 10 years post pancreatic failure secondary to sepsis (unable to absorb food without Creon)
- Past head injury
- Past intravenous drug use
- Adverse childhood experiences and complex trauma, impulsive behaviour
- 10-month admission discharged into Housing First

Post discharge

- Difficulty taking medications / engaging with services
- Chose to have a ‘private’ carer in her home
- 15kg weight lost in 3 months (back to under 40kg) – not picked up by services
- When picked up - huge difficulty sitting in A&E, and then on open wards
- 7 self discharges, viewed to have mental capacity, but impact of complex trauma on decision making underlined by specialist mental health practitioner in the community
- Then admitted to a side room, after which she stayed

- Repeatedly told her inability to engage was not a safeguarding issue (was taken on by safeguarding when she got cuckooed during that admission – due to her son)

Questions:

- Is this a safeguarding issue? If not, why not? If yes, what is the role of safeguarding?

- This person stopped self-discharging as soon as she was given a side room, and admitted directly into it, and then stayed for over a month. What constitutes reasonable adjustments and whose job is it to advocate for these?

EbE and Expert Patient insights

- **'Don't tell me off'** - language, approach and delivery really matter in terms of engagement Language Matters Diabetes

- **'Don't tell me to do something I can't do'** – patients need support to understand e.g. healthy eating, and how to prepare and store food without a kitchen. Cooking without a Cooker

- **'Don't just give me a leaflet' –** diabetes really isn't that simple. Patients need more time, and more accessible education.

THESE THINGS HAVE CAUSED DISENGAGEMENT AFTER ACCESSING SERVICES!

Expert patient input – hugely valuable, completely changed the nature of the project

Pathway Homeless & Inclusion Health
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What can a good safeguarding process look like?

Mary Kadzirange

RMN, BIA, BSc (Hons), LLB(hons), LLM(Mental Health Law), Mental Capacity Act Lead, Leeds

Mary Kadzirange

- Male, in his 50s, living in Temporary Accommodation
- Diabetes, mental health issues and addictions
- Often unwilling to take medications despite highly personalised package of care
- Difficulties understanding the concept of healthy food and preparing it
- Issues with self care
- HbA1c very high, multiple complications
- No family

Subsequent process

- Safeguarding professionals meeting – 42.1
- Need for safeguarding process discussed with patient
- Speech and language therapist – Easy Read, large print and video resources on diabetes, long term effects, and medication choices with diabetes services, and also did a cognitive assessment
- Longitudinal MCA – by SLT and Inclusion Health Nurse with support from Mary on understanding of consequences of non concordance with medication. Used collateral information from multiple sources. Two formal assessment days flanked by multiple other sessions promoting understanding.
- On balance felt not to have capacity (process took 4 months)
- Best interest realist options discussed – essentially no action, covert medication, various types accommodation

Result

- Bespoke older persons sheltered accommodation with onsite health care and support

- Has been considered previously but felt not to meet the criteria

- **Process clearly demonstrated his vulnerabilities and need for support, and got a good result**

Bolton

- Partnership approach between Diabetes Specialist Nurse and Homeless Team
- 51% insulin treated Type 1, Type 3
- 28 current patients - 82% have had 9 Key Care Processes completed
- Routine screening for diabetes in place in hostels and A&E
- Hostel staff trained with Sanofi Eden diabetes programme
- Successful diabetes champions programme in place
- 6 patients on CGM
- Improvements in all clinical markers and reduction in attendances and admissions

Lead: Lynne Wooff

Clinical insights – examples…

- Identification and clinical management of Type 3c diabetes
- Potential benefits of using Continuous Glucose Monitoring in this group
- Adaptions to insulin regimes for people with addictions
- Identification and responses to mental health issues associated with diabetes e.g. eating disorders and overdose risks
- The need for nutritional and food security screening, vitamin and mineral supplementation, and possible supervised supplementation of nutrition supplements and training around buying food and food prep
- Commonality of missed eye screening and responses to this
- The need to promote undertaking of foot checks in primary care and on admission to hospital NG19
- Safeguarding insights

Outputs – AVAILABLE NOW!

- Pathway project report
- E-learning module on the Fairhealth website. Covers safeguarding, nutrition, eye health, foot health as well as direct diabetes content, and ‘how to’ guides.
- Queen’s Nursing Institute Homeless and Inclusion Health Programme clinical guidance resource
- New information leaflets on diabetes and managing it from homeless charity Groundswell
- Eye care leaflet
- **Audit resources**
- **Top tips**

Relevant sections written by experts including Mary

Patient discussion form

Developed with EbEs to sit alongside clinical audit

Patient discussion form: diabetes care

1. How well do you feel you understand your diabetes diagnosis?

"I do not understand my diabetes at all" — *"I understand my diabetes diagnosis really well"*

2. How worried do you feel about your diabetes diagnosis?

"I worry about my diabetes all the time" — *"I don't worry about my diabetes at all"*

3. To what extend have health care practitioners helped you to understand and manage your diabetes?

"Health care practitioners have helped me very little with my diabetes" — *"Health care practitioners have helped me a lot with my diabetes"*

Possible future research areas?

- Understanding client attitudes to and understanding of DOLS?
- Understanding patient perceptions of 'lifestyle choice'
- Formally evaluating the benefits of specialist clinical outreach in meeting the needs of vulnerable populations
- Understanding what works to support health eating for single homeless individuals
- Understanding the prevalence and effectiveness of management of Type 3 diabetes in homelessness populations

Get in touch

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