Small steps towards a large framework: a workshop approach

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ARTICLE POINTS

1 Empowerment (of the person with diabetes) is mentioned strongly within Standard 3 of the National Service Framework for Diabetes.

2 Effective education is required so that people with diabetes develop the knowledge and understanding to self-manage their condition.

3 The consultation between the healthcare professional and the person with diabetes should be a meeting of equals.

4 There is often a mismatch between what the healthcare professional and the person with diabetes perceive happens during a consultation.

KEY WORDS

- **Empowerment**
- **Effective education**
- **Partnership**
- **Goal setting**

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Introduction

This article follows the progress of a project to support DSNs in meeting Standard 3 of the NSF for Diabetes. The workshop format provided the delegates with the opportunity to discuss shared issues and concerns.

There has been much emphasis placed on nurses to help deliver the standards within the National Service Framework for Diabetes (DoH, 2001), however, little guidance has been offered on how to achieve the outcomes detailed within the document.

With this issue in mind, a group of 13 DSNs from across the Yorkshire, Trent and Northampton regions were brought together by a pharmaceutical company to explore how DSNs could be assisted to achieve the standards. Empowerment (of the person with diabetes) is mentioned strongly within Standard 3 of the National Service Framework for Diabetes. The group of DSNs who organised the meetings identified empowerment as a crucial issue, and wanted to gain an insight into how we could influence and promote strategies to help fulfil Standard 3.

Educational programme on empowerment

An educational programme entitled *Standard 3: Making it work* was developed by the organising DSNs, which addressed components of Standard 3. Two meetings were held in May and October 2003 which followed the same programme. *Figure 1* shows the group at one of the venues.The diversity of diabetes care was addressed by considering which strategies could be used to achieve Standard 3 in the following groups: people with type 2 diabetes and older people with diabetes, people with type 1 diabetes and young people with diabetes and ethnic minority groups.

Over 50 DSNs and PDSNs, who attended and participated in the meetings, were given prereading material and shared the same aims and objectives to achieve on the day of attendance. The meetings were chaired and facilitated by the DSN organising group. Each meeting commenced with a pre-dinner debate about whether empowerment works.

Figure 1. Woodhall hotel meeting

This debate set the scene for the following day. The motion was 'I believe self care and empowerment are essential for people with diabetes'. Pat Clarke argued for the motion and Paul Dromgoole argued against.

Pat Clarke stated that Standard 3 from the NSF for Diabetes centres on patient empowerment and that there should be a partnership in care and decision making. She posed the question 'how long, on average, does a person with diabetes spend with a health professional?' The answer is approximately 3 h per year, which leaves 8757 h of the year for patients to manage their own condition. For this reason, we owe it to our patients to understand and take responsibility if outcomes are to be optimised. Effective education is required, providing information in an acceptable form, so that patients develop the knowledge to self-manage their diabetes. Another issue is compliance leading to concordance, for example, only one in three people with diabetes take all of their tablets; these are decisions which have a major impact on long-term health (Morris, 2002).

Empowerment is a two-way street; the empowerment model of diabetes care and education where the patient becomes the central player is recognised as a good model to help patients successfully manage their diabetes.

Paul argued against the motion that healthcare professionals believe that they can force empowerment even when people do not want to be empowered. Patients have spent many years under a paternalistic medically focused healthcare system and actually go to their healthcare professional for instruction and advice; they do not want to be pushed into decision making (McKinstry, 2000). Empowerment is often talked about in terms of something we do to people, that it is expected of our patients to play an active role without appreciating that some people choose to be passive recipients of information. Empowerment takes time and we need to consider this in our busy clinic systems. The debate generated much discussion but it was agreed that self care and empowerment are essential for people with diabetes.

The following morning began with keynote speaker, Chas Skinner, Health Psychologist, presenting differing views on empowerment.

Empowerment strategies

Chas opened his presentation by putting the concept of empowerment, or the healthcare professionals' view that you can empower, into context:

- Nearly all the decisions that affect outcomes for the individual are made by the individual. They have the responsibility.
- Nearly all the consequences of these decisions rest with the individual with the condition. They have the complications.
- Nearly all the barriers to achieving effective self-management lie in the individual's personal and social world. They have the problems.
- People will make the best decisions for themselves given their perception of the situation they are in. They have a life beyond their condition.

Chas suggested that instead of empowerment being imposed, it should be about checking and exploring people's values about themselves and their real world. It should be about supporting the individual in making an informed choice that matches their understanding and values.

ARCH and SMART

It was considered that health professionals might benefit from the following strategy:

Accept that the consultation is a meeting of equals, with different roles, expertise and responsibilities.

Respect the individual's decision and that the consultation should be about supporting the individual in making a truly informed decision.

Curious. Be curious. Not confrontational or challenging but curious in trying to discover what patients believe to be true, their values or understanding.

Honest. Be honest concerning risk, options for change and consequences of their decisions.

In supporting the individual in their decision making and action planning process, it is important for health professionals to remember some of the principles of goal setting (Bauman et al, 2003). Goals should be:

- **S**pecific
- **M**easurable
- **A**ctionable
- **R**ealistic
- **T**ime-limited

Planning and decision making

Often there is little agreement during consultation as to what was discussed and perhaps agreed. Chas drew on a recent study which considered levels of agreement post-consultation between the nurse or dietitian and the patient (Parkin and Skinner, 2003) After 20% of the consultations there was complete disagreement between the nurse or dietitian and the patient on what issues were discussed. Following 21% of the consultations there was complete disagreement as to decisions made. Complete agreement with what was discussed occurred in only 28% of cases and complete agreement regarding decisions made in only 47%. This study should make us all conscious of mechanisms that might improve clarity of thought between ourselves and our patient during and following consultation.

This was an enlightening presentation and one that allowed the listener to focus on their own attitudes and beliefs, consultational style and methods of agreeing and developing action plans with their patients. Syndicate sessions followed the presentation. Each

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1 To support empowerment it was suggested that a change in the culture and perceptions of health delivery by both the person with diabetes and the healthcare professional was required to allow individual wants and needs to be taken into account.

2 All the delegates in the group for type 1 diabetes/young people agreed that this group is a very difficult group to empower. They have very specific problems not only in relation to their diabetes but also in the transition from childhood to adulthood.

3 We firstly discussed what we mean by empowering people from ethnic minorities. The main points were that we need to be able to understand culture and beliefs.

syndicate group explored how their chosen client/patient group could be empowered and what the difficulties or barriers might be. The groups then presented their findings to the main group in a feedback session.

Feedback from syndicate groups

People with type 2 diabetes and elderly people with diabetes. The discussions in this group highlighted issues that may need to be addressed in relation to this group of patients, such as the paternalistic attitude to healthcare delivery and the way education programmes are delivered, which very often do not take into account the special requirements of the elderly population. To support empowerment it was suggested that a change in the culture and perceptions of health delivery by both the person with diabetes and the healthcare professional was required to allow individual wants and needs to be taken into account. The issue of management plans was highlighted and whether there was the need for generic plans that would need to be adapted to support this particular group of patients.

The use of group education and how this can support empowerment was discussed, but questions were raised regarding the lack of and length of follow up, and whether by supporting more structured follow-up would lead to better outcomes. It was suggested that self-help groups could also facilitate this.

There was a great deal of discussion on whether nurses have the skills to empower patients; it was decided after some debate that nurses have the skills but these are often are used unconsciously. Barriers identified by the group to empowerment included a perceived lack of time and training, the lack of confidence by the professional to let go and in some cases health professional having the 'I know best mentality'.

People with type 1 diabetes and young people with diabetes. All the delegates in the group for type 1 diabetes/young people agreed that this group is a very difficult group to empower. They have very specific problems not only in relation to their diabetes but also in the transition from childhood to adulthood. Some examples of good practice are highlighted here:

- One centre gives all young people attending the clinic a tick list for them to tick what they would like to discuss with the doctor/nurse during the consultation so the clinic is led by the young person, i.e. their agenda not the health professional's.
- Many DSNs are now using other forms of communication to reach their patients, including email and texting.
- Some centres offer social events for young people to meet and discuss issues in an informal environment. These are a common approach.
- Transition clinics for young people, where both paediatric and adult diabetes teams work together are a common approach.

We concluded that there is still further to go and our 'wish list' for the future would be:

- Psychological support present in clinic
- An up and running 'Buddy' scheme which is patient led and nurse facilitated.
- Current and relevant patient information that is designed specifically for the young person, in a format relevant to the group, for example, CD rom.

People from ethnic minorities. The majority of DSNs who chose this group were working with people of south Asian origin. We firstly discussed what we mean by empowering people from ethnic minorities. The main points were that we need to be able to understand culture and beliefs. We also discussed whose agenda empowerment was, and came to the conclusion that not all patients wish to be empowered. Therefore it must be patient choice and we as nurses should respect their wish.

We progressed to discussing what we do well when working with people from ethnic minorities. Health promotion was high on the agenda. As a group we were all able to share ideas of different approaches. We also realised that many of us were working on similar projects, which we hope that we will be able to share with each other so that we are able to implement best practice.

For the future, we discussed the possibility of using the 'expert patient' approach, particularly in a primary care group situation.

On reflection, the group highlighted possible ways in which we may be able to empower people from ethnic minorities in their own diabetes care, such as single sex education sessions, education programmes on local radio stations, multilingual educational leaflets and videos of patients

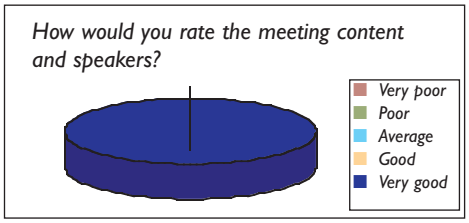

Figure 2. Woodhall meeting results; all participants rated the meeting as very good.

discussing their own experiences of diabetes.

Motivational interviewing

The afternoon session began in a controversial manner with keynote speaker, Dr Yvonne Doherty, Consultant Psychologist, Northumbria Health Care NHS Trust, stating how DSNs should be motivating patients with diabetes. She implied that we were not doing things well, that we could do better and that her way was the expert way. This rapidly unfolded into a ploy for debate amongst the delegates which was followed by an electric interactive session on motivational interviewing of patients with diabetes.

Yvonne offered theoretical and practical advice, highlighting the positives and negatives of putting MI into practice. Small groups were encouraged to form, allowing role-play. Practical suggestions were made, such as tape or video recording of consultations, so that individuals could establish how skilled they are at MI. In essence, this was an exhilarating session filled with enthusiasm. The key benefit of motivational interviewing appears to be the role of the health professional in developing the patients own decision-making strategies and assisting greater self-reliance and self-efficacy. The healthcare professional is directive in helping the patient examine and resolve ambivalence. Health professionals need to accept that patients may not be ready for change or may have made conscious and rational decisions to maintain the status quo. Consultation style is something that all healthcare professionals should be conscious of, particularly in relation to moving away from prescribed advice.

Evaluation

Feedback from the delegates confirmed that the both meetings were well delivered and enjoyed by all (*Figure 2*). Verbal feedback (*Figure 3*) and evaluation forms confirmed that the content was relevant and topical.

DELEGATES' COMMENTS

- Fantastic – well organised
- Excellent venue
- Enjoyed workshops and found them most useful
- Both excellent speakers
- Makes you think about current practice and possible improvement
- Helpful session on empowerment – buzz word
- Good networking
- Good feedback from other groups – very helpful
- Enthusiastic about changes we can make
- Feels like a treat – reflects how Novo Nordisk value DSNs contribution
- Relaxing environment with ready available refreshments

Figure 3. Delegates' comments

Delegates felt that the keynote speakers were excellent and it was appreciated that both speakers welcomed questions and comments during and after their presentations.

Overall it was felt that the groups were well organised and well facilitated, were appropriate in size numbers and that the delegates themselves worked well together. Group sizing (smaller rather than large) featured positively on many of the evaluation forms. Members of the organising group felt that in smaller groups delegates can share their views and make a contribution to groupwork activity, whereas in a larger group one or two more vocal delegates can alter dynamics of group. (We recognise that this can also happen in a smaller group, however, a good facilitator would deal with this appropriately). Feedback from each syndicate group to the main group was given by a nominated delegate.

The format of the meeting also afforded delegates the time to network and exchange good practice and ideas. Most delegates reported that they were able to take back to their workplace something that would make a difference in their workplace. There is overwhelming support and interest in further meetings this year. Throughout the planning and delivery stages of the days, the organising group of DSNs were able to build on their own personal development in areas of chairing and facilitation skills. ■

The organising group of DSNs would like to thank Alan Gourlay, Nicki Copeland and the Region 2 team of Novo Nordisk Limited not only for providing the funding and organisation for these meetings but also for the support they provided the organising group during the whole process.

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