This summer, I worked on an educational CD-ROM for nurses who provide care for patients with diabetes in the hospital setting. In preparation for this project, I became immersed in the medical and nursing literature addressing the care of hospitalized patients. This forced me to take a hard look at the delivery of diabetes care and confront the reality that inpatient diabetes management has often failed to meet the standard of care seen in outpatient settings.

Thirteen years ago, I worked as a clinical nurse specialist in diabetes in a major hospital. The problems in the management of diabetes that I confronted at that time are the very same problems that persist to this day: poor timing of meals and insulin doses, varying methods for treating hyperglycemia with few standard protocols, performance of glucose monitoring hours before insulin dosage decisions are made, inappropriate nutrition substitutions for medically necessary dietary adjustment, removal of insulin pumps before surgery . . . and the list goes on.

In the years since I worked at that hospital, the results of landmark diabetes research studies such as the Diabetes Control and Complications Trial, the U. K. Prospective Diabetes Study, and the Diabetes Prevention Program have sculpted and refined the goals for diabetes control and management. These studies have had a major impact on clinical practice and were responsible for the present-day mantra that glucose control must be achieved to prevent chronic complications.

Those of us who work in the field of diabetes scramble every day to find innovative ways to help our patients not only reach target glucose goals, but also maintain them long term. We arm them with knowledge, urge them to test their glucose levels and be proactive in their own care, and give them our phone numbers to call whenever they need support, information, or assistance in diabetes self-management. And then the day comes when they are admitted to the hospital . . . .

My patients describe it as being sent to a foreign country where no one speaks their language. Insulin regimens are rewritten because the hospital formulary “does not carry that type of insulin.” Food trays appear loaded with carbohydrate. Glucose testing occurs at 6:00 A.M., 2 hours before breakfast is served. And “running a little high” is seen as safer than being in “too tight control.” Needless to say, the stress of all this contributes to the anxiety and fear that patients already feel from being hospitalized.

A technical review by Clement et al.1 on diabetes care in hospitalized patients was published in Diabetes Care in February 2004 and has clarified the need for diabetes control. Its authors set target goals for glucose levels and cited the supporting research showing that hyperglycemia affects mortality rates, lengths of hospital stay, nursing home referrals, and rates of infection.

I realize that the hospital setting I left 13 years ago has changed. Patient acuity levels are higher, lengths of stay are shorter, and providing care has become more complicated, demanding, and technology-centered. However, diabetes as a primary or secondary diagnosis for hospitalized patients has increased, and the need to update and improve care standards must keep pace. Given that our knowledge of how to better manage diabetes during illness has improved (e.g., insulin drip methods, basal coverage with aggressive supplemental insulin algorithms), there must be translation to the hospital setting for the sake of those with diabetes. There are no excuses.

And so I come to the title of this editorial, “Crusaders for the Cause.” We, the practitioners in the field of diabetes, can no longer simply shake our heads in wonder or raise our fist in anger at the “foreign-ness” of the hospital care received by our patients. This is a call to action that I am addressing to all who provide care for people with diabetes—a call to help the hospital systems make the changes necessary for the provision of diabetes care that meets the standards outlined by Clement et al. and supported by the American Diabetes Association.

What can we do?

• Prepare our patients for hospitalization. Encourage them to insist on being heard as part of the care team and to ask questions about insulin, diet, and glucose monitoring.

• Make sure someone from our patients’ outpatient diabetes care team is aware of their hospital admission and will follow their progress and advocate, as well as educate, when necessary.

• Volunteer to do inservice programs for our local hospitals’ nursing staffs. Staff development departments frequently look for speakers who will donate time for continuing education programs.

This is a call to action that I am making to the medical and nursing literature. People with diabetes—a call to help them achieve and maintain long-term control. This is a call to action that I am making to those of us who work in the field of diabetes. We are the crusaders for the cause.
• Contact the diabetes educators or clinical nurse specialists at our local hospitals and offer assistance in serving on a task force to improve hospital care for people with diabetes.
• Donate a subscription to local hospitals’ nursing/medical libraries for one of the diabetes specialty journals.

If we truly believe in the importance of the continuum of care, then those of us who consider diabetes our field of expertise must act to improve our weakest link. We all fly the banner stating “Glucose Control Matters,” and now we must be willing to lift up and support those in our ranks who are endeavoring to improve care for hospitalized patients with diabetes. In the war on diabetes, we must move forward, crusading for the cause and helping one another.

Reference

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