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Extended Abstract

Standard and tight protocol by the trained nursing care and good glycaemic control when adding insulin to oral hypoglycaemic agents.

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Abstract

Background: Diabetes is being more headache in India day by day when patients are prone to micro or macro vascular complications with glycaemic uncontrol stage (more than 9.5 HbA1C value. To understand why patients could not always attain the Treat to Target in Type 2 Diabetes. HbA1c ≤6.5 % glycaemic target when adding insulin to oral glucose lowering therapy. The term diabetes mellitus includes several different metabolic disorders that all, if left untreated, result in abnormally high concentration of a sugar called glucose in the blood. Diabetes mellitus type 1 results when the pancreas no longer produces significant amounts of the hormone insulin, usually owing to the autoimmune destruction of the insulin-producing beta cells of the pancreas. A GI value for the test food is then calculated for each person by dividing their glucose AUC for the test food by their glucose AUC for the reference food. The final GI value for the test food is the average GI value for the 10 people. Good glycaemic control, as measured by A1C, reduces the risk of diabetes complications. For most people with diabetes, the A1C goal should be <7%. However, it is important to individualize A1C goals when needed.

Methods: Observational study of 12 weeks with 345 patients and 322 health professionals, recruited from reputed clinical centres. Most patients were committed to taking insulin as recommended by trained nursing staff with standard protocol. Although initially anxious about injections, patients were 'insulin receptive' rather than 'psychologically insulin resistant'.

Results: Most patients were committed to taking insulin as recommended by trained nursing staff with standard protocol. Although initially anxious about injections, patients were 'insulin receptive' rather than 'psychologically insulin resistant'. This was due to experiences of deteriorating blood glucose control and perceptions that oral glucose lowering agents were no longer working. To avoid hypoglycaemia, patients occasionally altered or skipped insulin doses, sometimes in consultation with staff. Staff felt that automated insulin dose adjustment algorithm increased their confidence to prescribe larger insulin doses than in routine clinical practice but all described situations where they did not follow recommendations. Application of a 'one size fits all' glycaemic target was seen as contrary to clinical experience. Staff also expressed concerns that 'tight' glycaemic control might impose an unacceptably high risk of hypoglycaemia that could compromise trust and safety, especially amongst older patients. Patients were usually unaware of the glycaemic targets. Positive staff feedback led some to believe they had been 'successful' trial participants even when their HbA1c exceeded 6.5%.

Conclusions: To understand tight glycaemic outcomes it is necessary to move beyond the patient and consider the broader context, including the difficulties staff encountered in balancing and reconciling their 'clinical' and 'research' roles and responsibilities.