

# Exploring Diabetes Home Nursing Care: A Pilot Study

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## A B S T R A C T

### OBJECTIVE

To explore the experiences and perspectives of nurses who provide diabetes care to homebound clients.

### METHODS

The first phase of this qualitative study consisted of observing 12 home nursing visits with clients who had diabetes. In the second phase, 3 focus groups were conducted with a total of 17 community nurses involved in diabetes care.

### FINDINGS

Observations from the field visits demonstrated the complexity of managing the medical, social and emotional needs of home care clients. Focus-group findings highlighted the unique role nurses play in delivering care in clients' private homes; the challenges and rewards of autonomous practice; and nurses' efforts to advocate for client services within a system of limited resources.

### IMPLICATIONS

Findings called for the development of diabetes tools specific to the needs of home care clients, new models of diabetes home care provision and diabetes prevention strategies in the community.

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## R É S U M É

### OBJECTIF

Explorer les expériences et les points de vue d'infirmières qui donnent des soins à des patients diabétiques confinés à domicile.

### MÉTHODES

La première phase de cette étude qualitative consistait à observer 12 visites à domicile de patients atteints de diabète. La seconde phase consistait en trois séances de discussion ayant regroupé un total de 17 infirmières communautaires qui intervenaient dans le traitement du diabète.

### CONSTATATIONS

Les visites ont révélé la complexité de la prise en charge des besoins médicaux, sociaux et émotionnels des patients qui reçoivent des soins à domicile. Les séances de discussion ont fait ressortir le rôle unique que jouent les infirmières dans les soins à domicile, les défis et les récompenses liés à l'exercice autonome et les efforts des infirmières pour plaider en faveur des services à offrir aux patients au sein d'un système dont les ressources sont limitées.

### CONCLUSIONS

D'après les constatations, il faudrait mettre au point des outils particuliers aux besoins des patients diabétiques qui reçoivent un traitement à domicile, de nouveaux modèles pour la prestation de soins à domicile aux patients diabétiques et des stratégies de prévention du diabète dans la collectivité.

## INTRODUCTION

The growing prevalence of diabetes in Canada, combined with the trend toward providing chronic disease management in the community, has resulted in increasing numbers of people with diabetes receiving care in their homes. Although diabetes has been identified as a priority health issue in Canada (1), the particular challenges facing front-line diabetes home care providers have received relatively little attention in the diabetes care literature. Research in the United States and Sweden has explored the level of diabetes knowledge of nursing personnel in home care agencies (2,3); the impact of a diabetes educator on home care agencies (4); the benefits of dietitian visits to home care clients with diabetes (5); and the diabetes education infrastructure in home care agencies (6). Collectively, this research suggests the need for enhanced knowledge of diabetes among home care nursing personnel and greater interdisciplinary collaboration. Furthermore, Adams and Cook (4) showed that nurses working in agencies that had diabetes educators demonstrated significantly more diabetes knowledge and provided a significantly higher standard of care than their counterparts in agencies without a diabetes educator (4). The practices, experiences and perspectives of nurses who provide diabetes home care in Canada have yet to be addressed. The purpose of this pilot study was to explore the challenges and needs of front-line nurses providing diabetes care in the home setting within an urban community in Ontario, Canada.

## BACKGROUND

The Diabetes Local Improvement Network in the Community (LINC) is a network of 20 community organizations that provide diabetes care and/or related services in north Toronto. Members include local hospitals, diabetes education centres, community health centres, family practice units, rehabilitation hospitals, community care access centres (CCACs), community nursing agencies, Lifeline Systems Canada Inc. and the Toronto chapter of the Canadian Diabetes Association. The purpose of the network is to share resources and collaborate across sectors to improve diabetes care in this catchment area. Members meet regularly on a volunteer basis to explore opportunities and address gaps in care provision.

### Catchment area

The community stretches across a distance of approximately 140 km<sup>2</sup> in the north end of Metropolitan Toronto. It is home to a population of over 655 000 people, 15.5% being 65 years of age or older (7). More than half of the population (56.0%) was born outside Canada; of this number, 45.6% came to Canada after 1991 (7). It is estimated that more than 100 different languages are spoken in the community, and over 90 ethnocultural groups are represented (8). The area is also economically diverse: 22.6% of households were considered low-income in 2001, while over 21% had an annual income of \$100 000 or more (8).

In 2001, the Diabetes LINC conducted a general assessment of the diabetes care issues in this community. In addition to reviewing community demographics and public health data, each member organization shared internal reports and needs analyses with the network, allowing common issues to be identified. A growing demand for enhanced support of front-line nurses to provide diabetes care in the home setting was emphasized by multiple stakeholders. (While current data on the incidence and prevalence of diabetes among home care clients in Canada is not available, we estimate that at least 5% of the home care clients in our catchment area receive diabetes-related services.) In response, the LINC developed and implemented a workshop on diabetes management techniques for front-line registered nurses (RNs) and registered practical nurses (RPNs). However, during this workshop, it became evident that the needs of participants were much broader in scope than the half-day session could address. We conducted this pilot study to investigate these needs further.

### Home care in Ontario

In Canada, service-delivery models for the provision of home care vary from province to province (9). In Ontario, where this study took place, the provision of publicly funded home care services is governed primarily by the *Community Care Access Corporations Act* (10) and the *Long-Term Care Act* (11). Services are coordinated by 42 CCACs, community boards accountable through service agreements to the Ontario Ministry of Health and Long-Term Care (12). The CCACs coordinate access to homemaking, nursing, therapy and other services to people at home, and provide long-term care facility placement and community information to family caregivers (12). Within the CCACs, case managers assess client needs and eligibility for services, and they develop, monitor and adjust service plans (12). Based on case managers' assessments, appropriate home support, nursing and other professional healthcare services, such as physiotherapy and dietetics, are purchased from local for-profit and not-for-profit health service agencies (12). The Caplan Report (13) recently reviewed the competitive bidding process used by Ontario's CCACs and made 70 recommendations for improving the home care system. While these recommendations have far-reaching implications for how all services are managed and how nursing care is delivered in general, none deals specifically with diabetes care. Our research team worked with 2 CCACs and 2 nursing agencies within the LINC to explore the specific needs of nurses who provide diabetes home care services.

## METHODS

The project was guided by an advisory committee that consisted of a manager from each of the 2 participating CCACs, as well as a nursing supervisor and 2 nurse educators from

each of the participating nursing agencies. It was reviewed and approved by the Research Ethics Committee at Sunnybrook and Women's College Health Sciences Centre and by administration.

This pilot study was intended to be the first phase of a comprehensive assessment of the needs of a wide range of home care personnel involved in diabetes care in our catchment area. While many clients received care from a variety of personnel, including dietitians, social workers, occupational therapists, physiotherapists and RPNs, most were visited by RNs at some point in their care. We therefore began our exploration by looking at the perspectives and experiences of front-line RNs who worked for the agencies contracted by the CCACs to deliver home care services.

Due to the exploratory nature of the inquiry, qualitative methods were used (14). Specifically, we collected data through field observation of nursing visits and focus groups with community agency nurses. The objectives were as follows: to improve our understanding of the context in which home diabetes nursing services are provided; to identify community nursing needs with respect to the provision of effective diabetes home care; and to identify structural issues that influence the provision of home diabetes nursing care.

### Phase 1: Field observation

In order to appreciate the challenges nurses faced in their day-to-day practice, it was important to obtain a better understanding of the context in which they worked. Field observation methods were used to gather this contextual information. This approach places a strong emphasis on exploring the nature of social phenomena rather than on testing hypotheses about them, working primarily with unstructured data, interpreting a small number of cases in detail and analyzing data in a way that interprets the meaning of human actions (15). By attending nursing visits and observing nurses providing care, we sought to appreciate the nature of the tasks they performed, the relationships they built and the challenges and rewards they faced.

We worked with 1 nursing agency that provided contracted nursing services to both of the CCACs in our catchment area to identify nurses who would agree to be observed during their visits with clients with diabetes. Nurses who typically encountered clients with diabetes as part of their regular caseload were identified and asked to consider participating. Five nurses agreed, and all signed consent forms after being provided with information about the study. The participating nurses received a small honorarium to acknowledge time away from direct client care that might be imposed by the study (e.g. time spent after visits speaking with the research assistant).

A research assistant accompanied the 5 nurses on 12 visits over a 3-week period. Clients and/or family members were contacted prior to each visit by the nurse, who explained the study and purpose of the observation and

obtained verbal consent. Written consent was obtained at the beginning of each nursing visit. Following the visit, the research assistant met privately with the nurse, usually in her car on the way to the next appointment, to clarify observations and ask questions. An observation template, based on Spradley's guidelines for descriptive observations (16), was developed by the project advisory team in order to document observations in a systematic way. This template included notes about each client's medical and social situation; a description of the events of the encounter; a description of the surroundings; comments made by both the nurse and the client; and questions and issues discussed with the nurse after the visit. Observations were summarized and shared with the project advisory committee. From the observations and discussion that ensued, the committee then identified several themes to be explored further during the focus group sessions.

### Phase 2: Focus groups

In the second phase of the study, nurses from 2 agencies in our catchment area were recruited to participate in focus group interviews. Focus groups can provide a vehicle for posing specific questions to knowledgeable informants after considerable research has been completed (17). The focus groups allowed us to share our observations from the home visits with other nurses who do the same kind of work and to gather additional input.

Nursing supervisors at the 2 agencies were provided with information about the study and asked to invite any nurses who provided diabetes care within our catchment area to attend a focus group session. Nurses who had not participated in the observation phase of the study and who had been practising in home care for at least 1 year were encouraged to attend. We recruited nurses who had not participated in the observation phase in order to involve a wider range of personnel and to share our perceptions of the field visits with a different group of nurses who performed the same work in the same geographic area.

The focus group sessions were held at the nursing agency offices to facilitate attendance. Two sessions were held at 1 agency and 1 at the other. Seventeen nurses in total participated in the 3 sessions. Nurses were given a small honorarium to acknowledge their time. The fact that all of the participating nurses had considerable experience working in home care (4 to 22 years) was noted.

Each focus group session began with a general overview of the study, signing of consent forms and an introduction to the format and procedures for the discussion. Specific pre-determined questions were posed to the entire group. Periodically, the facilitator asked each person in the group to respond in sequence to ensure that each participant had an opportunity to voice opinions. The questions posed fell into 4 categories: information about the nurses and the nature of their experiences with diabetes; major challenges and con-

cerns in providing diabetes home care; exploration of the field observation themes; and suggestions for improving diabetes care. The focus groups were audiotaped and transcribed verbatim. In addition, a research assistant took notes during the sessions and then provided a written summary of the discussion. After each group session, the facilitator and research assistant recorded general impressions of the group and the responses received.

Summaries of data generated from both the focus groups and the home visits were presented to the advisory committee for discussion, and recommendations for further action were developed.

## FINDINGS

The findings of this study are presented in 3 sections. First, a general description of the field observations is provided. Second, the themes identified through our observational experiences accompanying nurses on home visits are explored using feedback from the focus group sessions. Finally, we describe additional issues raised by the nurses during the focus groups and offer suggestions for change.

### Field observations

Our goal in accompanying nurses on home visits was to better understand the context in which they provide diabetes care in the home setting. It became readily apparent that when nurses visited clients for diabetes care or education purposes, they were dealing not only with diabetes but also with a multitude of medical, psychological and social concerns. Many clients receiving home care services have impaired mobility, cognitive disorders or other health conditions that challenge their ability to access care outside of their home (in most cases, a person must be homebound or unable to access treatment in the community to be eligible for CCAC services in our catchment area). During our 12 visits with clients with diabetes, we noted that the nurses also needed to take into account the following medical conditions: Alzheimer's disease; visual and hearing impairments; arthritis; cardiovascular disease; foot ulcers; osteoporosis; dermatological disease; renal disease; Parkinson's disease; dysphagia; and mental health issues, such as depression and schizophrenia. The nurses also encountered language barriers due to cultural diversity; family issues, including elder abuse; and living conditions in which clients lacked adequate food, heating and clothing. They addressed personal care and hygiene issues, and they identified severe loneliness and social isolation as concerns for 7 of the 12 people visited.

In some cases, diabetes was listed as the primary diagnosis and the reason for the home care referral. This was the situation for 1 client, who was a frail elderly woman with a poor memory living on her own. This woman had experienced frequent severe hypoglycemia because she sometimes forgot that she had administered her insulin and repeated the injection. Her physician had referred a home care nurse to

assess her safety in managing her diabetes and to administer her insulin so that the amount given could be controlled.

Some clients were referred to the CCACs for reasons other than diabetes but typically related to the disease. For example, 4 of the 12 visits were to provide wound care to clients with diabetic foot ulcers. During these visits, in addition to dressing the wounds, the nurses also tested blood glucose levels and addressed eating concerns. One client had no food in his fridge or cupboards, had no money and was unable to go out to shop because of his foot ulcer. The nurse went out and purchased some groceries so that he would have food to eat, and she contacted his physician and other community care providers to develop a follow-up plan. She expressed concern that this man was not only poorly nourished but also experiencing hypoglycemia because he did not have access to the kinds of food he needed. This situation illustrates how diabetes (as well as other social challenges), while not necessarily the primary diagnosis or reason for the home care referral, affects the work that nurses do.

To fully appreciate these challenges, it is also important to consider the caseload and physical aspects of community nursing. Each of the 5 nurses we accompanied on client visits carried a daily caseload of about 8 to 10 clients. Nursing shifts typically ran from 7 AM to 4 PM or from 4 PM to 11 PM, and nurses were expected to take breaks and complete any necessary paperwork during their shift. Several nurses commented that charting and other required documentation was generally completed on their own time. Some nurses covered a wide geographic region, requiring significant travel to other parts of the city. Weather conditions, traffic and lack of available parking had to be overcome, and nurses relied on their own vehicles and maintenance of these for transportation.

Despite these challenges, the nurses in our study had worked in the field for several years and appreciated the autonomy of community work. Most of the clients we visited appeared to value the nurses' care and looked forward to their regular visits. The nurses, cognizant that their visits were often the only social contact clients encountered, appeared to be highly skilled in establishing a friendly rapport with their clients. From our observations, the nature of the home visits appeared to differ considerably from hospital and clinic encounters. They generated a different kind of nursing routine, involved autonomous practice and often resulted in nurses advocating for additional client care resources. In the section that follows, we address each of these themes and elaborate on its significance for nurses by drawing on the focus group data and post-visit discussions with the nurses.

### Themes

Over the course of the 12 visits, it became readily apparent that nursing care in the home setting presented nurses with unique challenges and required particular skills to effective-

ly deal with a range of situations. The following scenarios are examples of nurse/client exchanges that were observed during the study.

#### *Healthcare professional as house guest: the home as a site of clinical encounters*

Unlike a hospital or clinic setting in which the client enters the clinical domain and is expected to follow the protocols set out by health professionals, home care requires the health professional to enter the client's domain. The degree to which nurses viewed their presence as an "intrusion" on what some clients might consider to be their "private" space varied considerably among nurses. For example, during the visits, some nurses removed their shoes before entering a client's home so as not to track in mud or water from outside, and/or to respect clients' cultural practices. These nurses asked the clients "if it was OK to sit" in particular chairs, enter rooms or access appliances they needed, such as the microwave for sterilizing materials or the sink for washing hands. Other nurses kept shoes and coats on, took charge of seating arrangements and accessed what they needed within the home without asking the client's permission. These nurses explained this direct-access approach as being part of their strategy for "getting in and getting out," a phrase we heard frequently during the focus groups. With active caseloads dispersed throughout the community, coupled with the time-sensitivity of some of the medications they had to administer (such as insulin), some nurses felt considerable pressure to get through each visit as expediently as possible. They explained that by leaving on their shoes and coat, they were sending the message that they weren't staying long, and by "taking charge" of the visit, they were able to get everything done that they needed to do more efficiently.

During the focus groups, we asked nurses how they felt about providing care in people's homes. Each of the 3 focus groups generated a similar range of responses. Some nurses felt it was a privilege to be granted admission into someone's private home, while others saw home care as a luxury that clients ought to feel grateful for receiving. The latter group explained that if clients wish to receive care in their homes, then they might need to adjust their living arrangements to suit their care needs. All of the focus group participants seemed to agree that providing care in the home gave them insight into clients' living conditions, something hospital and clinic nurses do not have access to. They saw this as being particularly useful in helping clients manage their diabetes, since having access to cupboards and refrigerators informed them of clients' eating habits.

The issue of reconfiguring space in a client's home to be able to perform a particular nursing function, such as dressing a wound or testing blood glucose levels, did not seem to present concerns. Participants explained that "nonsterile" (but "clean") conditions were part of the job. Several commented that they enjoyed the challenge of having to find creative ways

of "making do" with less-than-ideal conditions for completing certain procedures. They suggested that to work in home service delivery, good problem-solving skills are required. In fact, 1 group of nurses said that figuring out innovative ways to manage such situations gave them "a thrill" and was among the main reasons they chose to work in home care. The sense of fulfillment the nurses derived from their ability to find creative solutions to challenging problems was also expressed with respect to autonomy of practice. For the most part, home care provides nurses with the opportunity for independent practice. They generally visit clients independently, perform nursing tasks on their own, report to other home care providers via written means or through case managers and, in many situations, take the initiative to acquire additional resources, medical updates and teaching tools.

#### *Autonomous practice: where is the team?*

As mentioned previously, providing home care nursing to clients with diabetes required nurses to respond to problems on the spot without the opportunity to call on a colleague for help, as might happen in an institutional setting. In some cases, clients received the care of a personal support worker through the CCAC, who happened to be with the client at the time the nurse visited. In these situations, the nurse spoke with the other care provider to obtain any new information or sometimes to help translate. Most of the time, however, nursing visits did not coincide with the visits of other care providers. This meant that not only were nursing issues dealt with solely by the 1 visiting nurse, but also that nurses faced issues that fell within the realm of expertise of other disciplines, such as social work, dietetics or physiotherapy. In addition, accessing physicians, as the nurses routinely needed to do, proved to be incredibly difficult at times. Nurses were required to make frequent telephone calls and take physicians' return calls from home long after they were off duty. They also had to send clients to the emergency department at the local hospital if doctors could not be reached to address immediate medical needs. The nurses reported that there was no formal mechanism for physicians to report medication changes to home care nurses and that it was often by accident that they found out a doctor had changed a medication or dosage.

While client access to physicians is not managed by the CCAC system, access to other disciplines such as dietetics is. Limited involvement with dietitians was a particular source of frustration for the nurses. Participants in all 3 focus groups suggested that clients with diabetes require greater access to dietitians than is currently available and that nurses need opportunities to work side by side with dietitians when caring for individuals with diabetes. They also noted a greater need for foot care services and social work support. They explained that by the time many clients move through the waiting list for these services, the allotted visits for nursing care have been completed and the opportunity to develop a

comprehensive care plan is missed. This limited supply of healthcare resources and expertise was an ongoing source of frustration for the nurses and required frequent negotiation with clients, families and CCAC personnel.

### ***Working with limited resources***

Nurses in the 3 focus group sessions highlighted the limited resources available to community nursing and the challenges they faced as services were rationed. They noted that advocating for additional client services through CCAC case managers was frequently a part of their daily work. They felt that often the number of nursing visits allocated by the CCACs was not sufficient to meet agreed-upon client care goals, and they therefore had to justify their requests to continue service in order to achieve these goals. This tension was sometimes compounded by use of diabetes care pathways, implemented by some CCACs to provide consistent care across the community. The nurses explained that these pathways were not always flexible enough to address diverse diabetes care needs. In addition, they suggested that diabetes was often viewed within the healthcare system as a relatively minor or "simple" condition to treat, and therefore clients with diabetes did not always receive as much support as they required. The nurses felt that these issues challenged their professional judgment and their ability to provide optimal care.

### **Suggestions for change**

Despite the challenges described thus far, the nurses in this study expressed passion for their chosen career and commitment to working in home care. They viewed their role as contributing significantly to the health of the community, derived great satisfaction from the care they were able to provide and expressed strong commitment to community nursing. While they faced considerable challenges, this commitment enabled them to think about how the system could be improved. The nurses suggested 3 main areas for enhancing diabetes services in the home setting: development of diabetes teaching tools specific to the needs of home care clients; development of new models for provision of diabetes home care services; and implementation of diabetes prevention strategies in the community.

Nurses noted that most tools developed for people with diabetes do not account for low literacy levels or the need for simple messages, nor do they provide advice that is appropriate for homebound and frail clients. Furthermore, the cultural diversity of clients in the catchment area in which this study was conducted required materials that were available in multiple languages. Dietary advice that is culturally appropriate and lends itself to inexpensive foods, limited food selection or availability of and reliance on convenience items was also identified as a major need.

Nurses suggested that both clients and the healthcare system could also benefit from consideration of different mod-

els of delivering diabetes services in the home. They favoured a system that fostered interdisciplinary collaboration and access to diabetes expertise; timely access to client care information; and practical mechanisms that would enable them to remain abreast of new developments in the field of diabetes care. While 1 of the nursing agencies involved in the project had a certified diabetes educator on staff to support front-line nurses, the other did not. Nurses from the latter agency suggested that this would be helpful. Several participants referred to the palliative care initiative in Toronto, known as the Hospice Palliative Care Network (HPCNet), as a potential starting point for developing a comprehensive diabetes care program in the community. The HPCNet program is a collaborative effort of palliative community care providers who coordinate and deliver services to persons who are dying and their families, within the (old) city of Toronto. The highly trained interdisciplinary teams provide client education, pain management, case management, consultation with primary caregivers and support to community members. The nurses viewed this model as an effective way of providing clinical expertise and support to community health providers, timely and compassionate care to clients and interdisciplinary collaboration within the home setting, and they suggested that a similar approach be considered for managing diabetes.

Finally, the nurses emphasized the need to prevent diabetes, which they perceived to be increasingly prevalent among their clients. In addition to primary prevention efforts, they noted that many of their clients had been known to be at high risk of developing diabetes for years. Despite such risk, these clients received little support from family doctors and other healthcare providers, including home care professionals, to try to prevent or delay the onset of the disease. They suggested that within the home care system, clients known to be at risk of developing diabetes could be offered diabetes prevention interventions developed specifically for this target group. They surmised that by preventing diabetes, caring for other health conditions would be more effective.

### **IMPLICATIONS FOR PRACTICE**

By focusing on the perspectives and experiences of front-line nurses, we have attempted not only to illustrate their needs and challenges, but also to shed light on the complexities of providing diabetes home care in an urban Canadian setting. Although this pilot study involved a relatively small sample of nurses from only 2 agencies in 1 particular community, the findings suggest directions for changes to practice and for further research that would likely have broad impact in Canada.

Providing and receiving diabetes care in the home creates roles and protocols for both clients and healthcare providers that differ from conventional client/provider relationships. The blurring of boundaries between public and private space

that takes place while providing and receiving home care requires both clients and healthcare providers to reframe their sense of ownership over the space in which care occurs. Twigg (18) suggests that “the coming of care” into the home represents not only a crossing of that boundary but also the intrusion “of the formal world of service provision into the private world of values.” Greater consideration of such boundaries by healthcare providers might enhance mutual understanding of client and home care personnel roles and responsibilities.

In addition to the need for diabetes tools appropriate for home care clients, new models of service delivery that foster collaboration among disciplines and improved methods of resource allocation are warranted. Information systems that provide care providers with access to medication changes and other client details could enhance efficiency and improve communication within the system.

Understanding the roles and perspectives of other providers is also worthy of attention. While the nurses in this study perceived their goals and mandates to be different in some client care situations from those of other home care personnel, there has been relatively little research conducted on how priorities are established and resources allocated within the home care sector. In particular, this study points to the role of the case manager as an important determinant of what kind of care is provided and how much. Exploration of case managers’ perspectives would no doubt highlight different challenges and opportunities and bring about an enhanced understanding of home care service delivery.

The findings of this pilot study suggest that highly experienced home care nurses, while committed to their work, often feel challenged to provide comprehensive diabetes care. As the demand for their services increases, which it is predicted to do, new approaches to preventing and managing diabetes are warranted. Although diabetes prevention initiatives have not typically been targeted at home care clients, this group of consumers may benefit from interventions that are specific to their unique circumstances.

Finally, our findings point to the need for service delivery models that facilitate greater interdisciplinary collaboration and access to diabetes expertise. With the growing expectation in Ontario that generalist nurses will practice a wide range of diabetes management skills, demand for ongoing updating and day-to-day practice support is likely to increase. (The emphasis on promoting the diabetes management skills of generalist nurses is evidenced by the development of several best practice guidelines related to diabetes care by the Registered Nurses’ Association of Ontario [19].) Furthermore, the need to collaborate closely with other disciplines such as dietetics and social work in order to provide coordinated and comprehensive diabetes care is enhanced by current clinical practice guidelines that emphasize more aggressive diabetes management approaches (20).

In presenting the findings of this pilot study, we have

shared the perspectives and experiences of front-line nurses who provide diabetes care in the home setting and highlighted opportunities for innovation and collaboration. Research that explores models of interdisciplinary care and the roles of key personnel is needed to develop the expertise necessary to prevent and effectively manage diabetes in the home care setting. Furthermore, greater understanding of the blurring of boundaries between private and public space within the context of home care delivery would likely foster stronger relationships between home care providers and their clients. Finally, the findings of the study underscore the importance of effective communication among home care providers and other sectors of the healthcare system and suggest the need for information systems that link all players. Greater attention to these issues, from both the diabetes community and home care organizations, could have a significant impact on addressing the burgeoning diabetes challenge at our doorstep.

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## AUTHOR DISCLOSURES

No duality of interest declared.

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