



Caring for elderly people with diabetes in residential homes: launch of revised UK good clinical practice guidelines

At the recent Diabetes UK Annual Professional Conference held in Liverpool (3–5 March 2010), as part of a symposium on 'Diabetes in the Elderly', a revision document prepared by a Task and Finish Group under the auspices of Diabetes UK was launched, addressing 'Good clinical practice guidelines for care home residents with diabetes'.¹ In his foreword to the document the Working Group Chair, Professor Alan Sinclair, comments that, despite much progress on integrated diabetes care in the community, significant deficiencies still remain in the provision of high quality diabetes care within residential settings. The Working Group identifies the special difficulties of ensuring optimal diabetes care to this particularly susceptible section of our population, recognising the essential need for improvement; it makes recommendations based as best possible on published evidence, focusing on practical and clinical issues for older residents living in residential care homes in the UK and the important educational needs of those who look after them.

Reviewing the epidemiology of diabetes in elderly people as part of the symposium, Nigel Unwin (Newcastle) described an exponential increase in the prevalence of diabetes as the population ages, and the inevitable consequences to health outcomes. The likelihood of admission to a residential care home is doubled with diabetes and, when screened, up to 20% of care-home residents may be identified as having diabetes.² Diabetes may not only contribute to its own raft of distressing symptoms, but it is also a great magnifier of other ailments not necessarily directly due to diabetes itself. To that extent, problems experienced by elderly people are likely to be compounded by the additional consideration of diabetes, and these become even more evident when encountered in residential care. Frailty, weakness, mobility difficulties, mood disturbance and cognitive decline are sadly all too familiar with advancing years, while other co-morbidities, often of multiple nature, serve to increase vulnerability.

Getting the balance right Hypoglycaemia

Getting the balance right between quality of life and longevity is perhaps the single most difficult consideration, emphasising the essential need for personalised treatment.³ Undue hyperglycaemia should be avoided as it reduces wellbeing and increases risk of intercurrent infection, but these latest guidelines rightly recognise that hypoglycaemia, as an adverse consequence of treatment, remains highly prevalent in residents with diabetes. Understanding risk factors for hypoglycaemia – such as the presence of co-morbidities, polypharmacy

and increased hypoglycaemia unawareness – is crucial to the prevention of hypoglycaemia with the aim of both improving quality of life as well as reducing the otherwise increased risk of unnecessary hospital admission.

Chronic pain

Although well recognised but perhaps less well managed is the knowledge that chronic pain, predominantly of degenerative musculoskeletal as well as neuropathic nature, is a very prevalent cause of impaired wellbeing in older patients and the document reports that in residential settings pain is very likely to be under-reported, undetected and undertreated. A four-step approach to assessment and management of pain within care homes is a welcome and useful inclusion within the guidelines document.

Mental health

Underpinning the provision of effective diabetes care in residential homes is recognition of the special mental health needs that affect a large proportion of those in care, and again there are concerns of sub-optimal treatment. Disturbed mood status, particularly depression, and impaired cognitive states, including advanced dementia, are addressed, and appropriate guidance is given, taking into account its considerable complexity.

Delivering the RD Lawrence lecture at the Diabetes UK annual professional conference, Mark Strachan (Edinburgh) stated that type 2 diabetes is a significant risk factor for dementia and observed that poorer cognitive function may be linked to a history of preceding severe hypoglycaemia. Major cognitive deficit at least doubles the risk of severe hypoglycaemia which in turn adversely affects brain function, yet another vicious cycle so common in diabetes and, indeed, clinical medicine as a whole. Low mood, high stress levels and other diabetes complications such as retinopathy and visual impairment all have further capacity to impair intellect. Cognitive decline is accelerated in patients with type 2 diabetes and is in itself an independent predictor of adverse clinical outcomes, including increased risk of cardiovascular events and reduced survival. Although poor cognitive function is undoubtedly associated with increased hypoglycaemia risk, it is interesting – and indeed reassuring – to note that current strategies towards more intensive glucose lowering therapies may not inevitably increase hypoglycaemia rates in the presence of either mild or, indeed, severe cognitive dysfunction, and should not necessarily restrict risk-modifying treatment solely on the basis of cognitive impairment.⁴



Conclusion

To achieve improvements in diabetes care within residential and nursing homes, these good clinical practice guidelines seek to encourage a sustained commitment from all involved health care professionals, implementing and monitoring high quality policies of diabetes care. The essential importance of diabetes education for care-home staff is underlined, recognising that barriers to effective diabetes care exist that need to be addressed. Generic issues of screening for diabetes and its complications, provision of foot care and ophthalmological services, and the special circumstances of 'End of Life Care' should allow flexibility of management at a personal level, with individualised care plans, defining responsibilities of professional care determined in the best interests of the patient.

The Task and Finish Group of Diabetes UK is to be commended on this comprehensive, practical and evidenced-based document which provides much needed

good clinical practice guidance for this particularly vulnerable group of care-home residents with diabetes.

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Conflict of interest statement

There are no conflicts of interest.

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