Improving access to the hard-to-reach: Care home residents

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Around 50% of people with diabetes are over the age of 65 years and this is likely to increase (Wild, 2009). This has been confirmed as 49.5% in the area in which I work (The Information Centre, 2006). Many of this group of people with diabetes may have comorbidities and, according to local data, up to 10% may live in care homes. This shows that the complexity of care appears to be ever increasing in this vulnerable population.

For the purpose of this editorial, residential and nursing homes are classified together as care homes. The reason for this is that although a registered nurse may be present within nursing homes, levels of knowledge around diabetes and competency are initially unknown and variable.

In an average care home, 25% of the residents will have diabetes (Sinclair et al, 2001) – some may have been previously diagnosed, but such information may have been lost as the person has moved through different social and healthcare providers.

Barriers to delivering high-quality care

Having previously been a care home matron for 5 years, I am able to have some understanding of the barriers to specialist support and the delivery of high-quality care.

First, access and translation of new existing therapies and evidence, and how to apply this to an older population (usually older than the top age of the research) is very difficult.

Second, the often unrecognised influencing factor, "we don't know, what we don't know", blocks the potential to seek out information.

Third, care home staff are mostly guided in their care delivery by the resident GP or district nurse who may not have a specific interest in diabetes management. If this is the case then key markers of poor diabetes management may be missed, i.e. it may not be recognised that a resident is chronically hypoglycaemic – HbA_{1c} blood test results may suggest that glycaemia is not a problem, until further investigation is provoked.

Fourth, suspicion can be a barrier. Normally, the only people apart from the usual healthcare professionals who visit the care home are those who inspect and measure against standards. The questions we are asked include – "why are we getting visits? No-one has complained". Arranged visits may be blocked, making support very difficult. An open, non-judgemental and persistent approach is essential. Sometimes it is necessary to encompass additional support of local practices to even begin to visit the care home.

Solutions to overcome the barriers

Solutions can be difficult and must be tailored to meet the needs of the individual care home. In-house diabetes education in the afternoon allows some staff to attend.

Assessment of people with diabetes within a group setting (with the person's consent) allows key problem areas (such as foot care) to be explored and changes to medication and management to be planned. In my experience, the person with diabetes also seems to enjoy this approach.

Inclusion of the multidisciplinary team is essential. Locally, the GPs have been very supportive, which has been a major influencing factor in the success of this improvement in care delivery.

Outcomes achieved through cost savings related to reduced admissions has led to the commissioning of a care home diabetes specialist nurse as a strategic approach to assess the management of diabetes care in local care homes and agreeing individual management plans and local standards of care.

Conclusion

The team of carers supporting care delivery is slowly and constantly changing in most care homes. However, the core group tends to remain the same.

This is a vulnerable population of people with diabetes, where the appropriate use of resources to increase knowledge and skills in the carers leading to informed delivery of care would have a big impact. To quote a Diabetes UK campaign in 2008: "Small change, big difference". ■