The importance of good old-fashioned care

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I think that most healthcare professionals would have been horrified by the recent report from the Parliamentary Health Service Ombudsman (2011) into the care of older people in the NHS. Many of the examples of poor care described involved a lack of meeting the basic needs of vulnerable people in hospital, for example not helping someone to have a drink of water or to eat their meal, inadequate pain relief, and lack of maintaining dignity by leaving people in a urine soaked bed or dressing them in someone else's clothes. This is particularly depressing given all the publicity surrounding Mid Staffordshire Hospitals NHS Trust where many of the complaints were focused on a similar neglect of basic needs of vulnerable people (Boseley, 2010).

The following article describes how addressing the basic needs of vulnerable adults improved their diabetes control and quality of life. With increasingly sophisticated technology in diabetes such as insulin pumps and continuous glucose monitoring, and many new expensive drug therapies, it is good to be reminded that good old-fashioned "caring" is still important and effective. None of these people were put on insulin pumps or high technology diabetes treatments – it was social and caring support that improved their diabetes status.

Andrew Lansley's "No decision about me, without me" summarises the vision of the evolving NHS, with people having more choice and control of how their health needs are managed. Patient empowerment through structured education and care planning is an essential part of diabetes care, with standard 3 in the National Service Framework for diabetes devoted to this (Department of Health [DH], 2001). However, people with mental health problems, the homeless, and some older people are generally disempowered in all aspects of life, so empowerment in diabetes care may seem impossible and unimportant. They often have chaotic lives, irregular meals, a poor diet, forget to collect medications or to take them, are unable to self-monitor and regularly miss clinic and GP appointments. The following article describes three examples of vulnerable adults who were supported to improve their diabetes control by healthcare professionals providing regular healthy meals, building up caring relationships and taking time to build up trust and identification of the best person to coordinate care.

These people may feature on exception reports in QOF but also as accident and emergency attendances for severe hypoglycaemia. The very people who need the most support for their diabetes often miss out because they do not attend regular diabetes appointments so they get discharged. For some, the cause behind missing routine care is the reason their diabetes is more complex (for example, they may have mental health problems such as depression and schizophrenia).

The concept of the multidisciplinary team is well established in good diabetes care but the team needs to be extended in the case of vulnerable adults to include social and mental health services. In Birmingham, the mental health trust have employed a diabetes nurse but maybe diabetes teams should be employing mental health nurses? The involvement of social services in the care of vulnerable people is not a new idea. The NHS Plan (DH, 2000) advocated that health services be designed around patients, with social services and the NHS coming together with new agreements to pool resources to stop people "falling in the cracks" between the two services.

Providing holistic care and a supportive environment can improve diabetes outcomes in vulnerable adults, as described in the article. The cost of this care may seem expensive as it sounds labour intensive. However, savings in reduction in diabetes emergencies and complications in the long-term make this worthwhile. The cost of "caring" may be comparable to expensive therapies but is just what is needed for this group of people. ■