Accessing diabetes care: Those who can, and those who cannot

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It has long been recognised that older people with diabetes have specific and different problems compared with their younger peers (Sinclair, 2008). As the population is ageing and becoming more obese, we are seeing much more diabetes in older people, so as clinicians we need to be aware of these issues and of how best to provide diabetes care and services.

In terms of diabetes care, we need to consider the effects of how complications, both acute and chronic, affect the safety and quality of life of older people with diabetes. This is particularly the case with glycaemic control, where slavish adherence to Quality and Outcomes Framework and NICE targets may mean that blood glucose levels run too low, increasing the risk of hypoglycaemia. However, hyperglycaemia in older people can also be associated with a number of distressing consequences: increased susceptibility to infection, lack of mobility, memory impairment, and mood and sleep disturbance (Shaw, 2008). While the benefits of good glycaemic control remain beyond argument, it is important that the risks and benefits are discussed, as older individuals will often have health problems in addition to their diabetes.

Polypharmacy is also a significant factor in their sense of wellbeing, as more medications tend to increase side-effects as well as confusion regarding when and how often to take them. The NICE report (Nunes et al, 2009) on medicines adherence describes how admissions result from incorrect dosing or omission of medication. As most treatments are metabolised via the liver or kidneys, and the function of these organs reduces with age, there is a greater risk of accumulation of certain drugs, which can have serious consequences, and may even cause death.

In terms of treatments, there has been much discussion regarding too tight glycaemic control in the older person with diabetes, but it should also be noted that similar problems will occur when blood pressure is controlled too tightly, resulting in hypotension. This can cause falls, accidents while driving and so on, and in my experience can make the person feel so awful that they cannot risk leaving their homes.

A significant proportion of older people reside in nursing and rest homes, and there have been many studies that have suggested or demonstrated how access to specialist or routine care is denied (Shah et al, 2006). The accompanying article by Eileen Breslin adds to this debate. She describes a retrospective survey to assess whether residents in nursing homes receive the same standard of care as their ambulant counterparts living in their own homes.

Eileen's objective was to determine the level of diabetes care given in relation to national diabetes management guidelines. Her methodology was a quantitative questionnaire distributed to 19 nursing homes in South and East Belfast. She identified the diabetes prevalence as 11.8%, and found that one third of the target population did not have any venous blood samples taken in the previous 18 months. She also found a number of residents did not receive foot screening, eye or dietary review within this period either. Her conclusion was, given the gaps she identified, that additional training and education for the staff in all aspects of diabetes care was needed.

I am sure many of us will have had similar experiences, which makes this lack of care to this vulnerable group all the more tragic. Perhaps some of her strategies and processes will enable us to gain the data and obtain the resources required to keep these people safe and with a good quality of life. ■

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