End-of-life care: The really big questions

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As specialist nurses working in diabetes, we are challenged every day to optimise diabetes control and achieve specific glycaemic targets in order to reduce the risk of micro- and macro-vascular complications. In the UK, we have NICE and SIGN guidelines, as well as Quality and Outcomes Framework targets to help us on our way. Furthermore, each organisation describes a defined care pathway for glycaemic control based on medicines management that includes a "get out clause" as targets must be tailored to the individual.

Inappropriate targets

There are some people where the recommended HbA_{1c} targets are not appropriate. Common sense and some guidance tells us that caution should be taken with people with dementia, or people with other reasons for cognitive decline. Others include the frail older person, those with end-stage renal/liver function who are not eligible for transplantation, people with end-stage respiratory failure or cardiac disease, and the dying.

In all of these groups, the clinical needs of the individual need to be weighed against the risk of taking diabetes medications; these risks include hypoglycaemia, poly-pharmacy and drug interactions, quality of life and safety.

We have an aging population. In 2012 the national census revealed that over 1 in 6 people in England and Wales is over 65, with the growth in the over 90 age group "particularly strong" and the number of centenarians having risen by two thirds to 12 650 (Office for National Statistics, 2013).

It stands to reason that DSNs will need to learn and pass on new skills to other healthcare professionals who are involved in the care of people with diabetes. These new skills include:

- How to recognise when an individual is entering an end-of-life phase.
- How to broach the topic of end-of-life care.
- How to discuss relaxing glycaemic targets when the individual may have spent a lifetime trying to reach the current recommended targets.
- When and how to adjust diabetes management when renal and cognitive function may be deteriorating without inducing diabetes symptoms.

Help is at hand; the American Diabetes Association and American Geriatrics Society (2012) and International Diabetes Federation (2013) have published clear guidance on the care of older people with type 2 diabetes. These include specific glycaemic targets depending on the number of comorbidities experienced by the individual. Furthermore, NICE will undoubtedly be reviewing all the evidence when they complete the new type 2 diabetes guidance in 2015. Diabetes UK has led the way in developing "condition specific" guidance for end-of-life care, even before the independent review of the Liverpool Care Pathway (Neuberger, 2013) recommended that such guidance should be in put into place. The Diabetes UK clinical guidelines (2012) limits target-setting in those receiving end-of-life care to the use of capillary blood glucose and these targets are confined to a specific range in order to reduce the risk of hypoglycaemia and hyperglycaemia; no HbA_{1c} targets are recommended. Treatment algorithms for people with type 1 and type 2 diabetes during the last year of life are also given. The emphasis should be on making people as comfortable as possible, rather than driving down blood glucose to unrealistic levels. ■

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