

Ensuring equitable diabetes care for vulnerable and hard-to-reach groups



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It is vital that we diabetes nurses truly understand the full circumstances of the person sat in front of us during our consultations. Of course, our priority has to be helping to manage the person's diabetes to the best of our ability, but we should also strive to have a rounded understanding of other issues that may impact on an individual; this approach is vital if we wish to provide the highest standard of care.

There doesn't seem to be a day goes by when the NHS isn't criticised for its poor care of a vulnerable person, or the inability of NHS staff to show respect or provide dignity when dealing with the vulnerable and hard-to-reach patient population. It is widely acknowledged that more has to be done to protect this group and ensure best care. As such, the *Journal of Diabetes Nursing* has decided to review such issues with this dedicated section "Diabetes care for vulnerable and hard-to-reach groups". It is hoped that this section will support practitioners in their day-to-day care of people with diabetes.

Vulnerable and hard-to-reach groups

It is difficult to understand the full extent of the problems some of our patient's face, so it is first important to define the types of people who could fall into these categories so that we can identify those who may need additional care. Individuals may be vulnerable or hard-to-reach and have problems accessing the best possible care for one or a combination of underlying reasons (Agency for Healthcare Research and Quality, 1998):

- Financial circumstance or place of residence.
- Health and age.
- Functional or development status.
- Ability to communicate effectively.
- Race/ethnicity.
- Eroding safety network.

What will be the drivers for good care?

Research suggests that people who are vulnerable have a much worse outcome and that mortality and

morbidity are increased by deprivation. For example, Engelund (2013) commented that:

"Obesity is seen more frequently in people of low education or low income. Very often people with low literacy skill can have trouble reading prescription labels and a serious number of vulnerable patients offered patient education do not participate or are not capable of translating what they have learnt into everyday life."

Although this is not new information, the fact we still have not reduced these rates of poor outcome would indicate we still have a lot of work to do. When you consider additional threats of homelessness, reduced cognitive function or reduced willingness to engage in health services, it is easy to see how these risk factors can add up. We have to be more inventive with our care packages and more innovative with our management plans to support these individuals to improve engagement in their diabetes management.

The articles in this section support us with this learning, helping us to understand problems faced by someone with a learning disability, especially when trying to reduce the risk of eye complications and potential blindness. In addition, an article outlines the considerations needed in a hard-to-reach population: the travelling community. The health needs of this population are often much worse than other communities due their "self-reliance" and "staying in control" mind-set (Greenfields, 2009). This article provides information and support so that we can effectively care for this group of people. ■

Agency for Healthcare Research and Quality (1998) *President's advisory commission on consumer protection and quality in the healthcare industry*. AHRQ, Maryland, US. Available at: <http://1.usa.gov/1jgWqvK> (accessed 30.04.14)

Engelund G (2013) *Targeting vulnerable people with diabetes?* Seno Diabetes Center, Denmark. Available at: <http://bit.ly/LeMTle> (accessed 25.04.14)

Greenfields M (2009) *Falling by the wayside*. Diabetes Update, Winter 2009: 28–31