One size does not fit all: Considering the needs of older people

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One of the fundamentals of diabetes care is the enabling of self care wherever possible and appropriate. This involves many factors, but timely and easy access to information is key. A recent report by the International Longevity Centre-UK (ILC-UK) reveals a continuing generational divide in access to, and trust of, health information (ILC-UK, 2015). Unlike their younger counterparts, who are more likely to use pharmacists, and online and telephone services, older people are more likely to trust doctors and nurses. ILC-UK consequently recommends that these traditional health information services are retained, rather than being replaced by online and telephone services.

This report has obvious implications for our diabetes services, as most provide online information and telephone support, as well as direct care. Given the current emphasis on austerity in the NHS, replacing direct access with phone or online support may appear to be an ideal way to save costs, but if this approach denies access to information for older people, it is likely to be financially counterproductive, as it may result in avoidable admissions and re-admissions.

As our older population increases, it is important not to adopt a "one size fits all" approach when we are reviewing or planning services, but instead recognise that different groups will have different needs. It is also important that we recognise trends and changes in our diabetes population, and the following articles demonstrate this with their focus on the challenges of managing type 1 diabetes in older people, and diabetes with dementia.

In my experience over the last 25 years, there has been a significant change in type 1 diabetes due to longevity; longer life expectancy has meant that comorbidities, frailty and inability to self care feature more in type 1 diabetes care, making the condition more complex. As a result, new and additional challenges now exist when planning and providing older people's care, balancing patient safety with acute and chronic disease management.

Jane Menon and Rachel Yates discuss the difficulties in providing safe care to this group, both in acute care and in the community. This recognises the necessity in clinicians communicating effectively to ensure plans of care are explicit, agreed and able to be implemented, with identified triggers for action. They consider barriers to achieving stable glycaemia, advocate individualised management options and highlight the specific risks of acute complications, such as hypoglycaemia and diabetic ketoacidosis. Usefully, they also reflect upon measures to reduce these admissions and improve post-discharge care.

Jill Hill's article on diabetes and dementia discusses both their increasing prevalence (both being associated with ageing) and how their combination results in the individual having very complex needs. She discusses the implications of dementia plus diabetes, and vice versa, and how forgetfulness or the inability to continue giving insulin and correct doses will impact on safe care and independence. She highlights how simplification of treatment regimen may be indicated but difficult in certain individuals, which is also highlighted in the previous article.

Both articles demonstrate the new and complex challenges in caring for this patient group; the implications for our diabetes services and whether we have the specialist nursing skills required to give best care. Given that these rising demands are unlikely to be matched by rising resources, it would be valuable for colleagues to share, via the *Journal of Diabetes Nursing*, how they are successfully managing these high-risk groups and any service changes that have enabled this to happen. Please do get in touch. ■

International Longevity Centre-UK (2015) *Next generation health consumers: The changing face of health seeking behaviour across Europe*. ILC-UK, London. Available at: http://bit.ly/1BkQtYg (accessed 17.03.15)