Diabetes care in care homes and for the housebound

Andrea Taylor

ARTICLE POINTS

1 Increasing numbers of older people need diabetes care because the population and incidence of diabetes is rising.

2 People with diabetes who live in care homes or who are housebound currently receive an inadequate standard of diabetes care.

3 Diabetes UK identified a lack of diabetes training and awareness among care home staff as a major obstacle to good diabetes care in care homes.

4 National standards for care homes for older people (DoH, 2001b) aim to ensure that residents' healthcare needs are recognised and met and that residents are cared for by staff who are properly trained.

KEY WORDS

- Care homes
- Housebound
- Responsibility
- Needs
- National standards

Introduction

The prevalence of known diabetes within residential homes is approximately 12% (Sinclair et al, 2001). However, it is recognised that large numbers of people living in residential homes with diabetes remain undiagnosed. A more realistic estimate is that one in four residents has diabetes (Sinclair et al, 2001). With more people living into their eighties and diabetes on the increase, the requirements of people who need diabetes care and access to diabetes services will rise. This article reviews the literature, current practice and the future for older people with diabetes who live in care homes or are housebound.

A recent report identified that 446 250 people currently live in care home settings (RCP, 2000). The number of people of retirement age is predicted to rise by 57% between 1995–2031 in the UK. The number of people aged over 84 is predicted to rise by 79%, with almost half the growth expected in the decade 2021–31 (CCNAP, 2002). The NSF for Older People (DoH, 2001a) reported that the number of people aged over 65 years has doubled in the last 70 years and the number of people over 90 years will double in the next 25 years.

The prevalence of diabetes is higher in elderly people and in some ethnic minority groups than in the rest of the population. Of people aged over 65 years, 10% have diabetes. More than 25% of people of Asian origin aged over 60 years have diabetes (BDA, 1996). Recent changes in diagnostic criteria that lower the threshold defining diabetes are likely to result in increases in reported prevalence (WHO, 1999). Type 2 diabetes accounts for over 80% of the population with diabetes (Audit Commission, 2000) and generally affects people over the age of 40 years.

The literature

Little has been written about the care of older people with diabetes but information that is available appears to have common themes. It seems that people with diabetes living in care homes throughout the UK are either not receiving diabetes care or are receiving inadequate diabetes care.

Sinclair and Gadsby (2001) demonstrated that residents with diabetes are a highly vulnerable and neglected group. They are characterised by a high prevalence of macrovascular complications, marked susceptibility to infections (especially of the skin and urinary tract), increased hospitalisation rates and high levels of physical and cognitive disability compared with ambulatory people with diabetes.

Sinclair et al (1997) identified how the special needs of people with diabetes in care homes can be met:

- Each resident should have an individualised diabetes care plan agreed between the resident (or relative), the doctor who is responsible for their diabetes care and the care home staff. The plan should include details relating to diet, treatment, monitoring, glycaemic targets, personal care and observations such as weight and recording fluid intake.
- Increased community support from experienced healthcare professionals. Care home staff should be able to access educational sessions.
- Access to other specialist healthcare professionals (podiatry, orthotics, opticians). Appropriate referral to a vascular clinic, diabetologist or geriatrician.
- A yearly review should be in place to encompass overall diabetes management and glycaemic targets in the light of physical, psychological and cognitive status.
- All residents with diabetes should be included in local audits and be registered on the local district and GP diabetes register.

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Current practice

Very little is known about the provision and quality of diabetes care in care homes in the UK. Primary care and secondary care physicians are uncertain about their clinical responsibilities to this vulnerable group. As a result the healthcare needs of residents with diabetes may be overlooked (Sinclair, 1999).

Recent UK studies highlight problems in care delivery. Sinclair et al (1997) and Benbow et al (1997) found that input from healthcare professionals was scant and fragmented, and knowledge of diabetes amongst care home staff was poor. Benbow et al (1997) found that 64% of residents had no record of anyone being responsible for their diabetes review and management in the proceeding year. Although people living in care homes are registered with a GP, most GPs attend residents only when called by the staff for a specific problem.

Most structured care takes place in outpatient departments or GP surgeries. Older people often have problems with transport and mobility and need an escort; routine follow-up and proactive diabetes care can be neglected. In a review of a GP diabetes clinic, the main group of non-attendees were housebound or living in care homes (Gadsby, 1994).

Responsibility

To provide residents with the daily support that they require for good diabetes control, staff need basic skills in blood glucose monitoring, injecting insulin and awareness of dietary needs for people with diabetes. National Vocational Qualifications exist to fulfil these needs but a lack of resources for training and high staff turnover work against the development of these skills.

The following list of deficiencies in diabetes care within care homes was compiled from the Diabetes UK report (BDA, 1999):

- A lack of care plans and case management approaches for individuals with diabetes. This leads to a lack of clarity in defining aims of care and metabolic targets, failure to screen for diabetes-related complications, no annual review procedures and no allowance for age and dependency level.
- Inadequate dietary guidance policies for the management of residents with diabetes.
- Lack of healthcare professional input, especially in relation to community dietetic services, DSNs and ophthalmology reviews.
- Lack of state registered podiatry provision for residents with diabetes of all ages, especially for those at the highest risk of diabetic vascular and neuropathic damage.
- Indistinct medical supervision of diabetes-related problems due to lack of clarity of GP and hospital specialist roles leading to inadequate and unstructured follow-up.
- Inadequate treatment review and metabolic monitoring including blood glucose measurement.
- Insufficient medical knowledge of diabetes and diabetes care among the staff of care homes.
- No structured training and educational programmes for staff of care homes in relation to diabetes and other medical conditions, which impact onto the management of diabetes.

The report identified lack of diabetes training and awareness among care home staff as a major obstacle to good diabetes care. It highlighted the poor communication between care home staff, social services, diabetes care teams and other NHS teams. This was attributed to a lack of clear boundaries of responsibility. Ruta et al (1997) suggests that, in general, little genuine interdisciplinary teamwork exists in primary care.

GPs are usually responsible for the care of people with diabetes in care homes. This may be the person's own GP or one allocated from a neighbouring practice. In some areas there may be a community consultant geriatrician who has responsibility for people in nursing homes as part of their community role.

Complexities of medical responsibility for people in care homes becomes more problematic when diabetes is added to the mix. With no clear framework in place, diabetes care risks coming bottom of the general care list. People with diabetes in care homes risk falling through the net of specialist service provision.

Needs

Given their circumstances, residents may be unable to demand the services they need, or be able to express their needs. The Diabetes UK (1999) report identified the lack of a set of national diabetes standards for care homes as an obstacle to good diabetes care of this

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1 The Diabetes UK (1999) report identified the lack of a set of national diabetes standards for care homes as an obstacle to good diabetes care of this section of the population.

2 Individually tailored care plans must be developed to ensure that individual care needs are met.

3 Multidisciplinary teams must work together to improve care standards of people with diabetes by assessing individual needs and provide services appropriately.

4 The NSF for Older People lends an opportunity for a cultural shift in the planning, co-ordination and delivery of services, taking into account the needs and experiences of older people with diabetes.

DO YOU CARE?

Do you care? is a CD that was developed by a multidisciplinary group to address the educational needs of care home staff: http://www.yorkshirediabetes.com/downloads/index.html

section of the population.

As part of the modernisation of the regulatory system, national standards for care homes for older people were published in 2001 (DoH, 2001b). The standards aim to ensure that residents' healthcare needs are recognised and met and that residents are cared for by staff who are properly trained. Standard 28 states that by 2005 a minimum of 50% of care staff will be trained to NVQ Level 2. Care homes will be obliged to assess the holistic needs of new residents and demonstrate that they can meet any healthcare requirements before acceptance.

Individually tailored care plans must be developed to ensure that individual care needs are met. To deliver this care, care homes will have to address the needs of staff training in diabetes and the development of better working partnerships with diabetes care teams. *Saving lives: our healthier nation* (DoH, 1999) acknowledges the importance of partnerships across all professional, statutory and voluntary organisations, and therefore includes health needs assessment.

The National Care Standards Commission will take over responsibility for inspecting care homes (which were previously the responsibility of local councils and health authorities). Exactly how the arrangement will work in practice remains to be seen, but on the basis of these standards the commission will require care home staff to get the training they need and provide quality care of older people with diabetes.

Conclusion

Multidisciplinary teams must work together to improve care standards of people with diabetes by assessing individual needs and provide services appropriately.

The NSF for Older People (DoH, 2001) provided an opportunity for a cultural shift in the planning, co-ordination and delivery of services, taking into account the needs and experiences of older people with diabetes. This group must be given the option of control over what happens to them throughout the care process. This can only happen if greater emphasis is placed on patient and healthcare professional education.

The high level of morbidity and disability among residents with diabetes in care homes is a major challenge for the primary care team and other agencies and healthcare professionals, which will demand a greater commitment from those already involved.

Resources are needed to back up standards. It is disappointing that no additional monies were made available with the publication of the NSF for Diabetes. It is a priority for primary care organisations to identify funds in local development plans to address the needs of our vulnerable elderly population in the UK. ■

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