

# Community diabetes nursing in our ageing population

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## Introduction

As outlined in the recently published NSF for Diabetes, diabetes is becoming a more common condition worldwide, affecting people of all ages in every population (DoH, 2002a). Diabetes currently affects 10–25% of the elderly population in the UK and there are concerns about the quality of care given to older people who are housebound or in residential care (Croxson, 2002). This article discusses the importance of equality of diabetes care throughout the population as a whole, and outlines how a diabetes team in Nottingham is ensuring that this is put into place.

While the prevalence of type 2 diabetes is increasing, the population of the UK is ageing. Education and support is becoming more important than ever before. As primary care continues to lean towards aggressive treatment of diabetes to prevent long-term complications, it is inevitable that there will be an increase in the number of older people who require insulin as part of their diabetes management.

## Equality in diabetes care

How can we ensure that there is equality in diabetes care for our ageing population? Liberating the talents is a Department of Health document that aims to help PCTs and nurses to deliver a standard of diabetes care fit for the 21st century (DoH 2002b). This document states that 'change is needed' and 'with an ageing population and chronic illness increasing, prevention becomes more important'.

The NHS plan is of great relevance to the treatment of type 2 diabetes (DoH, 2000), and with the subsequent publication of the NSF for Diabetes it is time to address how we can improve standards of diabetes care for our ageing population. The plan outlined in Figure 1 can be used as a basis to initiate the thought process of who will need to be involved at a local level (DoH, 2002b).

## The Nottingham project

A model of care for people with diabetes

has been piloted by the Nottingham City PCT over the last 2 years. The vision is to develop an integrated diabetes service that is responsive to the needs of all people with diabetes within the primary care setting.

The Nottingham project team has developed a close working relationship with local primary healthcare teams in order to standardise patient-centred care. The project nurse is an experienced diabetes nurse who has been involved with the diabetes management plan of many housebound older people. This has included joint visits with district nursing teams to empower people in their own homes. Examples of the role of the project nurse are seen in *Table 1*.

Involving the social services team of home-care workers who visit housebound people has been helpful. The social services are a workforce who, when educated to a

### Figure 1. How to plan diabetes services

- Bring everyone together who is involved in caring for the particular group or community.
- Joint multi-agency teams at different levels to support integrated services.
- Involve local people.
- Involve front line staff.

## ARTICLE POINTS

**1** There are concerns about the quality of care given to older people who are housebound or in residential care.

**2** The Nottingham City PCT has piloted a model of care for people with diabetes, over the last 2 years.

**3** Support groups, which are formed by residents, have been set up in Nottingham City PCT as a way of including older people in their diabetes care.

**4** In order to effectively deliver care for older people with diabetes (who may also be housebound), we need to establish what they see as best practice.

**5** Strategies are needed to reduce the inequalities in diabetes care and education.

## KEY WORDS

- Older people
- Support groups
- Best practice
- Equality of care

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**Table 1. The role of the project nurse**

- Continuity of specialist diabetes advice at a local level.
- Allowing people to choose which insulin delivery device to use.
- Empowering people to be able to go on holiday safely and be sure of their ability to give the correct amount of insulin instead of having to carry 'ready drawn up' insulin syringes.
- Giving patient-centred care 'close to home' without referral to secondary care.
- Linking primary and secondary care when people with diabetes are discharged from hospital and need further intervention by the district nursing services.

basic standard of diabetes knowledge, can continually reinforce diabetes education to older people with diabetes and their families.

In the early days of the Nottingham project, the project nurse developed a basic education programme for the home-care team. This covered information about diabetes, treatments and situation-specific material. A group education session was used to present this information and discuss some of the situations that the home-care team may come across when visiting people with diabetes in their own homes.

Deakin and Littley (2001) found that an educational package for care-home staff increased the knowledge of staff and improved the quality of care of people with diabetes, up to a year after intervention.

Standard 10 of the NSF for Diabetes is 'detection and management of long term complications' (DoH, 2002a). This standard states that all people with diabetes will receive regular checks for long-term complications. We need to have a system in place where a designated group will take responsibility for the recording and assessment of the findings of these regular checks. In Nottingham City PCT, the Nottingham Diabetes Guidelines for the Management of Diabetes are used to assist in the management and recording of the annual assessment of people with diabetes, including the housebound.

Current practice is that the work is undertaken by district nurses, practice nurses who do home visits, or the

hospital-based diabetes service (in which case, the elderly person with diabetes may have to be transported to their appointment for annual review). The latter can cause problems and time-wasting for the person with diabetes, who has to wait for transport on outward and return visits.

The vision is to take a team approach so that the individual is reviewed either at home or in their local practice if they are able to visit it.

**Including older people with diabetes in their own diabetes care**

Support groups have been set up in Nottingham City PCT as a way of including older people with diabetes in their diabetes care. Formed completely by older people with diabetes, there are now three of these patient support groups, and they are increasing in numbers of people attending.

The support groups provide the opportunity for members to meet on a monthly basis in a relaxed atmosphere close to their own homes (usually within walking distance). The groups often develop into informal teaching sessions with people discussing their own experiences of living with diabetes. The project nurse attends meetings periodically to offer support and structured education about diabetes and its management. Health centres within the area actively advertise the groups, and suggest that people go along and meet others with the same condition. Figure 2 shows examples of advertising material used. The support groups can be a particularly useful resource for

**PAGE POINTS**

**1** We need to have a system in place where a designated group will take responsibility for the recording and assessment of the findings of checks for long-term complications.

**2** The vision is to take a team approach so that the individual is reviewed either at home or in their local practice, if they are able to visit it.

**3** Support groups provide the opportunity for members to meet on a monthly basis in a relaxed atmosphere close to their own homes.



*Figure 2. Samples of material used to advertise support groups.*

people who have been recently diagnosed with diabetes and who may feel alone in their lack of understanding of the condition. Figure 3 shows a practice-based education session in action. It is hoped that in the near future provision will be made for those people who cannot easily travel alone, so they too may have access to this support.

Practice-based education for older people with diabetes should provide the following: annual updating for existing patients; information, education and support for people newly diagnosed with type 2 diabetes; and an adequate support mechanism for people who are commencing insulin treatment. There should be liaison between primary care colleagues, general practitioners, district nurses, practice nurses, dietitians, podiatrists, community pharmacists and the administration staff.

### What do patients want?

In order to effectively deliver care for older people with diabetes (who may also be housebound), we need to establish what they see as best practice.

Older people with diabetes confirm that they are happy to be seen at their local practices. Pooley et al (2001) interviewed people with type 2 diabetes and health professionals who deliver the care. They explored issues that they perceived as being central to the effective management of diabetes, primarily within a primary care setting. Five concepts were found to be key: the importance of having sufficient time in consultations; continuity of care; opportunities to ask questions; the extent to which people feel they are listened to; and each individual's experience of life with diabetes.

### Conclusion

Education for people with type 2 diabetes cannot be age restricted and unequal in quality. We need to raise the profile of diabetes within the general public, as well as among people with the condition. Strategies are needed to reduce the risk of developing type 2 diabetes in the population as a whole, and to reduce the inequalities in diabetes care and education (DoH, 2001).



Figure 3. A practice based education session in action.

Croxson S (2002) Diabetes in the elderly: problems of care and service provision. *Diabetes Medicine* **19** (Suppl 4): 66–72

Deakin TA, Littley MD (2001) Diabetes care in residential homes: staff training makes a difference. *Journal of Human Nutrition and Dietetics* **14**: 443–47

Department of Health (2000) *The NHS plan: a plan for investment, plan for reform*. DoH, London

Department of Health (2001) *National Service Framework for Diabetes: Standards*. DoH, London

Department of Health (2002a) *National Service Framework for Diabetes: Delivery Strategy*. DoH, London

Department of Health (2002b) *Liberating the talents: helping primary care trusts and nurses to deliver the NHS plan*. DoH, London

Nottingham Health Action Zone evaluation report (2002) *The Development and Assessment of an integrated diabetes service in Nottingham City Primary Care Trust (South locality)*. Leaflet

Pooley CG et al (2001) 'Oh it's a wonderful practise... you can talk to them': a qualitative study of patients' and health professionals' views on the management of type 2 diabetes. *Health and Social Care in the Community* **9**: 318–26

### PAGE POINTS

1 Education for people with type 2 diabetes cannot be age restricted and unequal in quality.

2 Strategies are needed to reduce the risk of developing type 2 diabetes in the population as a whole, and to reduce the inequalities in diabetes care and education.