Do we need DSNs for elderly and older people?

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Introduction

Many articles report the care of elderly and old people with diabetes to be inadequate, of poor quality (Croxson, 2002; Fahey et al, 2003), to be failing them (Forbes et al, 2002, part 2) or simply non-existent (Sherriff et al, 2000), particularly if they live in nursing or residential homes (Sherriff et al, 2000; Taylor, 2003; Fahey et al, 2003). It could be argued that this large group of people are the most difficult to care for with their high incidence of other conditions and co-morbidities compared with their younger counterparts. This article discusses what benefits a DSN for elderly and older people could bring to this large, potentially vulnerable population.

The combination of old age and diabetes brings with it innumerable problems (Kerr, 2004). Diabetes is said to affect between 10% and 25% of the elderly UK population. Approximately 60% of the people known to have diabetes are aged over 60 years (Croxson, 2002). Elderly people are defined as being 60–79 years and old people as being over 80 years (Croxson, 2002).

Special needs of older people

Compared with younger people with diabetes, I would argue that this large group of people are the most difficult to treat and care for, having potentially more diabetes related conditions than the younger population with diabetes.

Elderly people with diabetes have special needs (Sherriff et al, 2000). They have a higher incidence of co-morbidity, including stroke, impaired cognition, previous myocardial infarction, cardiac failure, peripheral neuropathy, intermittent claudication, ulcers and blind registration (Dornan et al, 1992).

These diabetes related problems lead to challenges in everyday life for the elderly person with diabetes as well as complications in their diabetes care. These problems include less clear target-setting for glycaemic and blood pressure control, the treatment of other conditions complicating diabetes therapy, access to care limited by poor mobility, more drug side-effects, and the ability to self-care and self-medicate.

Dementia is also a common problem in elderly people with diabetes (Croxson, 2002; Kerr, 2004). Furthermore, assessment and treatment time may be increased if the elderly person has a number of diabetes related conditions to assess as well as problems related to old age.

Target-setting for blood glucose and blood pressure control in elderly people with diabetes is less clear, as discussed in Dornan et al's study (1992). Interestingly, Croxson (2002) refers to several trials that have demonstrated improvements in cognition and well-being if glycaemic control in the elderly is improved.

This therefore supports the view that good blood glucose control benefits people with diabetes, irrespective of age.

Education issues

Elderly people need more education time to empower those who want to be empowered and to enable carers to confidently deliver diabetes care to this population. A DSN caring for elderly people could provide the time and expertise to do this.

Hypoglycaemia is also a big concern for elderly people who may have difficulty recognising it (Croxson, 2002). They need to be given enough time, and to be educated at a slower pace if necessary, to

ARTICLE POINTS

1 It could be argued that this large group are the most difficult to treat and care for.

2 Little is known about older people and diabetes or how best to deliver effective care to them.

3 We need to appreciate the health beliefs of older people to help them individually, and we should have a clear vision, aiming to do more than just improve their HbA_{1c} and glucose levels.

4 DSNs for elderly and older people would be the ideal professionals to coordinate and communicate between multidisciplines to ensure this group of people receives good diabetes care.

5 Many elderly and older people need to be educated at a slower pace in order to absorb the information compared with younger people with diabetes.

KEY WORDS

- **Elderly patients**
- **Old patients**
- **Specialist DSNs**
- **Education**
- **Home treatment**

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1 Little is known about older people and diabetes, or how best to deliver effective care for them (Forbes et al, 2002, part 2).

2 Better understanding of the health beliefs of older people with diabetes is needed as well as DSNs having a greater appreciation of what is important to the person with diabetes.

3 A DSN for elderly people would be the ideal professional to communicate between multidisciplines to ensure this group of people receive good diabetes care.

4 Poor mobility and lack of transport can reduce an elderly person's chance of acquiring diabetes care.

absorb the information compared with younger people.

Filling gaps in knowledge

Older people value their health. Surveys have consistently shown that health is an important concern of older people (Forbes et al, 2002, part 1).

Little is known about older people and diabetes, or how best to deliver effective care for them (Forbes et al, 2002, part 2). We need to appreciate the health beliefs of older people to help them individually and we should have a clear vision, aiming to do more than just improve their HbA_{1c} and glucose levels. This emphasises that the elderly need professionals who are familiar with the problems associated with old age.

Taylor et al (2002) showed that elderly patients with type 2 diabetes who were transferred to insulin therapy and DSNs were more concerned with improved well-being, whereas the doctors' main emphasis was on glycaemic control. This would suggest that a better understanding of the health beliefs of older people with diabetes is needed as well as DSNs having a greater appreciation of what is important to the person with diabetes.

Poor adherence to treatment is often believed to exist in the older population (Goldstein and Daly, 1997). However, there is often a reason why – such as unpleasant side effects to medications, inconvenient treatment regimens or lack of understanding. Given more time and understanding, some of these difficulties could be overcome.

Benefits of having a DSN for elderly and older people

Geriatricians with training and expertise in diabetes have an important role to play in managing these patients (Sinclair, 1999). It would therefore seem logical that DSNs with training and expertise in caring for older people have an equally important role to play in managing and delivering care to this specific group of people.

What benefits could a DSN for elderly and older people bring to this group of people? Like children, adolescents and pregnant women, I believe that this large group of people is special and has specific needs. They therefore require professionals who are skilled in caring for elderly and older people and who can provide the most appropriate care for them and ensure they have easy access to all members of the multidisciplinary team.

Fahey et al (2003) suggest that better co-ordinated care for these patients would avoid the problems of overuse of unnecessary or harmful drugs, underuse of beneficial drugs and poor monitoring of chronic disease. A DSN for elderly people would be the ideal professional to coordinate and communicate between the multidisciplines to ensure this group of people receive good diabetes care.

Solving mobility problems

Poor mobility and lack of transport can reduce an elderly person's chance of acquiring diabetes care. The housebound elderly person is significantly less likely to have regular monitoring of their HbA_{1c}, feet, eyes, urine, smoking habits and blood pressure. A DSN for older people could visit them rather than a frail elderly person having to be transported to the healthcare provider and risk harm during the journey (Croxson, 2002).

A number of research studies have shown that a significant number of elderly housebound people with diabetes plus others in care homes do not receive regular diabetes care. In 2000, Sherriff et al discussed the findings of their research on the care of elderly patients with diabetes in nursing homes. They found that there were substantial numbers of elderly people with diabetes who were literally, 'out of sight and out of mind'.

Dedicated care programmes

Some DSNs in a few districts have implemented innovative ways to develop the education of older people with diabetes at home, in group sessions, with other healthcare professionals (Peck, 2003) and care home staff (Gallichan, 2002).

I was, however, unaware of there being any DSNs specifically caring for older people with diabetes until hearing Roger Gadsby's (GP in Nuneaton, Medical Advisor for Warwick Diabetes Care) talk on diabetes management in care homes at the

recent Diabetes UK conference in Birmingham.

Gadsby, who has strived to improve the care for elderly people with diabetes for many years, asked the audience to raise their hands if their diabetes service had a DSN with a special interest in caring for elderly people. He looked surprised, as did our team, when as many as 15 hands rose out of approximately 80 people. Although equally surprised, I was very pleased to see that some diabetes teams now have a DSN dedicated to caring for this potentially vulnerable group of people. However, I suspect there are far more diabetes teams like ours without a DSN specifically caring for their older population.

The older and more dependent people become, requiring care in nursing or residential homes, the more distant they seem to be to receiving diabetes care. Given their dependency on other people, they are unlikely to be able to demand the services they need or be aware of the care they are entitled to.

There is a lack of research data about diabetes care for older people, particularly those over 75 years. Not enough is known to be sure that the same approaches to diabetes care are appropriate for both the younger and older populations (Forbes et al, part 1). Croxson (2002) says that evidence-based medicine can be practiced on older people with diabetes whilst waiting for the results of ongoing trials, as most trials have been performed in younger people with diabetes.

Conclusion

Elderly and older people represent the majority of our diabetes population. They have specific needs, which could be addressed by their own DSNs, who are interested and dedicated to ensuring this group of people receive good diabetes care. ■

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