

Care of the older person with diabetes: When the target misses the person



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Is there a sea change in diabetes care? Are we rediscovering that there is a patient at the end of the prescription? I have been delighted to attend, and recently hear about, national presentations that challenge the supremacy of HbA_{1c} targets in directing care decisions. In clinical practice, we know that many factors influence our decisions; certainly, biomedical such as HbA_{1c} results, and renal and liver function will have an influence, but we should also consider how the person is managing and living with their diabetes, their views and their capabilities.

The Quality and Outcomes Framework (QOF) has resulted in many improvements; it has organised diabetes care for many practices, because it linked payments with targets. Unfortunately, this may have driven an reduction in HbA_{1c} without consideration of the person's needs or desires, or in some cases, safety. This is when the target misses the person.

It is not unusual to assess people admitted to acute units with hypoglycaemia who have had HbA_{1c} levels <24 mmol/mol (6%) in previous years, and who are on sulphonylureas despite declining renal function. The tests may have been done, but because declining renal function and declining HbA_{1c} is not flagged on QOF, these results may be missed and not acted upon. This directly affects the care and safety of the person with diabetes. This is of particular concern in the older and frail person with diabetes, who will often have declining renal function, other comorbidities and dementia, which can complicate their adherence to medication and their response to it. Consequently, there may be an increase their HbA_{1c} that prompts a knee-jerk increase in treatment, which may further their problems rather than solving them. A more holistic view is needed, incorporating other tests, listening to these people and their family/carers, and when rebound hyperglycaemia is suspected, reducing their treatment.

It is not only systems such as QOF that can

disadvantage the older person with diabetes; their diabetes is often more complex due to comorbidities and poly-pharmacy, plus there is a lack of randomised controlled trials to support therapeutic recommendations.

The effects of diabetes on ageing, and vice versa, are not generally known, so it is timely that the International Diabetes Federation has published the *Global Guideline for Managing Older People with Type 2 Diabetes* (IDF, 2013). The accompanying article provides an overview of the guideline and suggests some ways that it can be implemented by DSNs and practice nurses. There is recognition of working collaboratively and in an interdisciplinary team, and a philosophy behind the principles of care for older people.

The core principles emphasise that “one size does not fit all”, and that the care plan should include the person, their family/carers, and be holistic and personalised. Regular comprehensive assessments and medicine reviews are fundamental, and should always consider the risk/benefits and life expectancy. Prevention is highlighted, which includes managing risks, such as falls and medicine-related adverse events, and that the needs of family/carers must be considered. It is common for me to review a 103-year-old being cared for by her 80-year-old daughter, with the carer looking more deserving of the bed than the patient!

As a clinician, I am delighted to read a guideline relevant to clinical practice, which addresses many of the problems the older person with diabetes is facing, and gives guidance as to how to avoid or minimise such issues, and improve care and safety. We could do worse than to reduce the importance of HbA_{1c} in relation to this patient group; HbA_{1c} should be part of the diabetes jigsaw, not the sum of it. ■

International Diabetes Federation (2013) *Global Guideline for Managing Older People with Type 2 Diabetes*. IDF, Brussels. Available at: <http://bit.ly/1izxDlj> (accessed 26.03.14)