

The state of diabetes care in residential homes

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Article points

1. An ageing population means that more older people are being cared for in residential care homes and they often have complex conditions, such as dementia and diabetes.
2. After an audit in 2013 showed poor diabetes care in care homes, the Care Quality Commission developed clear recommendations to ensure that older people in care homes receive the best possible diabetes care.
3. The recommendations focus specifically on recognising and managing hypoglycaemia, foot care and care home staff training. Care homes are encouraged to develop a clear policy on diabetes care, as well as individual care plans.

Key words

- Care homes
- Diabetes care
- Older people

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The huge increase in the number of older people with both diabetes and dementia has led to an increase in the number of people requiring residential care. The American Diabetes Association and Diabetes UK have each produced valuable documents to provide guidance for management of diabetes in older people. In response to an audit of diabetes care in residential homes that took place on 2013, the Care Quality Commission (CQC), which is responsible for monitoring standards of care, has produced clear recommendations about how it expects people with diabetes in care homes to be looked after. This article provides practical advice about how care home managers can meet the demands of the CQC, specifically regarding developing a policy for diabetes and individual care plans. This article also discusses diabetes training for staff working in residential care homes.

There has been recent media interest in the effects of the ageing population on the NHS and social care (Ross, 2013). Modern treatments are prolonging life and, as a consequence, older people are living longer with complex medical conditions, which often include diabetes and dementia. Many frail older people are no longer able to manage in their own homes and are cared for in one of the 9000 care homes in England. This has led to increased pressure on GPs who are currently threatening to withdraw their responsibility for care homes because of the unsustainable workload (Gayle, 2016).

Sinclair et al (2001) and the Care Quality Commission (2015) suggest that more than a quarter of care home residents have diabetes, whether diagnosed or undiagnosed. The prevalence of diabetes rises steeply with age (see *Figure 1*) and the median age of those with diabetes is currently 60–69 years, with 20%

of people over the age of 65 known to have the condition. The rising incidence of type 2 diabetes is particularly marked in the 8th decade of life (*Figure 2*).

Management of diabetes is normally based on the principles of education and self-management, but older people in care homes are rarely able to make their own decisions about self-care. The reasons for this may be institutional or medical, but the overwhelming cause is the high prevalence of dementia among this group.

Prevalence of dementia in care homes

In 2002, the UK Medical Research Council set up the Cognitive Function and Ageing Study (Matthews and Denning, 2002). This was a population-based study of 13 004 older people. The headline findings were that almost 5% of people aged 65 years or older

lived in institutions and, of those, 34% (95% confidence interval [CI], 30–39) had dementia. Within residential institutions, the dementia prevalence was 62% (95% CI, 52–71).

More recently Lithgow et al (2012) studied 403 residents in Glasgow City nursing homes. Two hundred and thirty-four (58%) already had the diagnosis of dementia. The remaining residents were tested using the Standardised Mini Mental State Examination, of whom 31.8% were scored as having possible dementia, thus giving a ceiling dementia rate of 89.8%.

Stewart et al (2014) surveyed 10 randomly selected care homes in south-east London. A total of 301 residents were examined and the mean age was 83.5 years (standard deviation, 9.8). Women made up 65.8% of the sample. Dementia was diagnosed by clinical consensus and the use of the Clinical Dementia Rating Scale (Hughes et al, 1982). Dementia was present in 76.1% of the study group; 10.0% had mild dementia, 24.6% had moderate and 40.5% had severe.

Thus, the evidence suggests that the prevalence of dementia in care homes ranges from 60–90%.

Setting standards for diabetes care in older adults

Two national diabetes organisations, the American Diabetes Association (ADA) and Diabetes UK, recognised the need for guidance on managing diabetes in older people and have produced clear standards for diabetes care in this age group.

The ADA together with the American Geriatrics Society (AGS) published a consensus report in 2012 expressing the views of US experts in the fields of diabetes and gerontology (Kirkman et al, 2012). The report provides a comprehensive review of diabetes care in the older person, including a section on glycaemic targets. It makes the distinction between those who are functionally and cognitively normal and therefore have a good life expectancy, and those with physical and/or cognitive disabilities, whose life expectancy is poor. The report recommends that for the latter group, glycaemic targets should be relaxed. This means agreeing individualised targets, but symptomatic

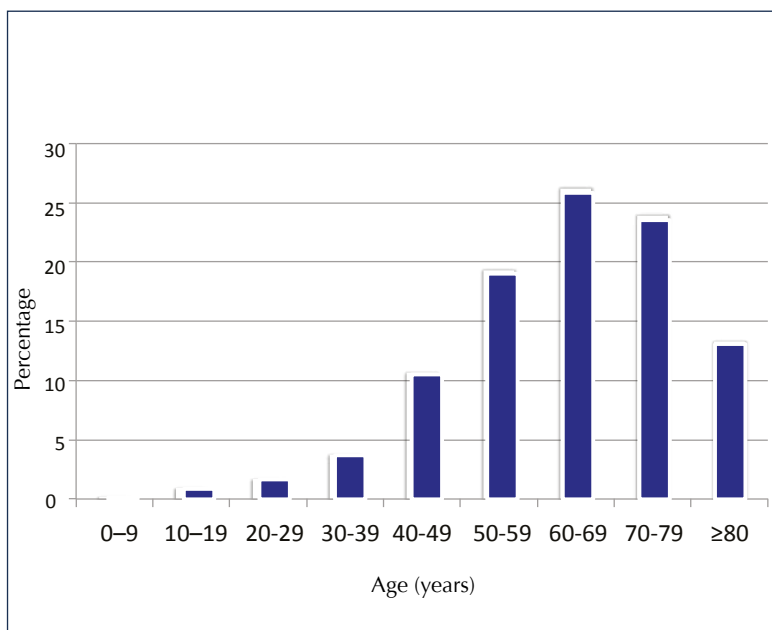


Figure 1. Prevalence of diabetes at different age groups. Source: National Diabetes Audit: England and Wales 2012–13.

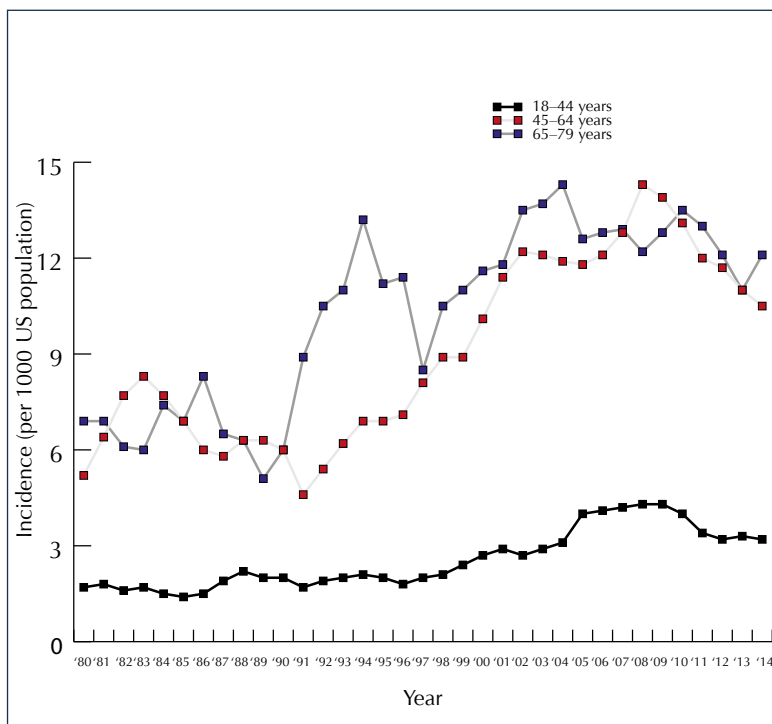


Figure 2. Incidence of diagnosed diabetes per 1000 population, 1980–2014. Data source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, USA.

hyperglycaemia and significant hypoglycaemia must be avoided.

Diabetes UK published the UK-version of this guidance in 2010 (Diabetes UK, 2010), setting standards for diabetes care in residential homes.

Page points

1. The uptake of the Diabetes UK guidelines was investigated in a nationwide audit of care home residents carried out in England in 2012 and 2013.
2. The audit revealed some disturbing deficiencies in diabetes care: 37% had no written policy for management of hypoglycaemia; 65% had no policy for screening for diabetes and 63% of homes did not have a designated member of staff with responsibility for diabetes.
3. As a result of pressure from diabetes organisations, the Care Quality Commission has produced guidance for those inspecting the quality of care for diabetes in care homes.

The main Diabetes UK recommendations can be summarised as follows:

- Care homes should have a policy in place for management of diabetes.
- Each resident should have an individual care plan, based on an annual assessment of functional status, including vision, cognition and nutrition.
- The care plan should be agreed between the individual with diabetes (or their carer), the GP and the care home staff.
- Care home staff should have access to a diabetes education and training programme.

The National Diabetes Care Home Audit, 2012/13

The uptake of these Diabetes UK guidelines was investigated in a nationwide audit of care home residents carried out in England in 2012 and 2013 (Institute of Diabetes for Older People [IDOP] and Association of British Clinical Diabetologists [ABCD], 2014). This audit was commissioned by ABCD and led by Professor Alan Sinclair, then Director of IDOP. The audit revealed some disturbing deficiencies in diabetes care. Only 23% of care homes responded to the audit, raising concerns about the standard of care in institutions that did not respond. Of the 2043 responding care homes, only 1541 (75.4%) reported that they had residents with diabetes. The total number with “recognised” diabetes was 5087 out of a care home population of 48 978. Based on previous surveys, this prevalence (10.4%) is much lower than expected and could reflect poor documentation of, or failure to recognise, existing diabetes.

Key findings of the audit:

- 47% of responding care homes were unaware of the Diabetes UK guidelines.
- 37% had no written policy for management of hypoglycaemia.
- 65% had no policy for screening for diabetes.
- 63% of homes did not have a designated member of staff with responsibility for diabetes.
- 64% of care homes did not have a copy of the resident’s annual diabetes review, highlighting poor communication with primary care.

- 33% of care homes had no access to staff training to support their diabetes care.

The findings of the care homes audit are echoed by participants in a series of focus groups, which investigated the views of staff working in residential and nursing homes (Fox et al, 2013). Poor communication with both primary and secondary care, and limited access to education and training were the concerns most frequently highlighted by care home staff.

What has changed since the National Audit?

As a result of pressure from diabetes organisations, the CQC has produced guidance for those inspecting the quality of care for diabetes in care homes (CQC, 2015).

The CQC guidance specifies the elements of good diabetes care, which should form part of a diabetes policy:

1. Diabetes screening on admission that is recorded and audited.
2. Availability of a fully stocked and maintained hypoglycaemia kit.
3. A risk calculation and assessment tool for diabetes foot disease.
4. Access to good quality diabetes education and training for care home staff.

The CQC concluded that:

“Good leadership and management in relation to the care of diabetes includes regular audit and assessment of these elements in practice.”

The CQC policy also gives some examples of the information that should be included in a care plan:

- Action that should be taken when the glucose levels are above or below a certain level.
- Details about the person’s diet and when to involve a dietitian.
- How to care for feet and when to involve a podiatrist.

Writing a policy and care plan for the frail older person

The Diabetes UK guidelines provide a good starting point for writing a policy and care plan in line with CQC recommendations (Diabetes UK, 2013). Appendix 6 of the guideline sets

out a helpful template for a diabetes policy. This consists of 11 pages of detailed, practical suggestions, covering all aspects of diabetes care, including three of the elements specified by the CQC, namely hypoglycaemia, foot care and staff training.

The Diabetes UK guidelines also provide a Diabetes Resident's Passport (appendix 4), which is a comprehensive individual care plan for people with diabetes. The passport includes documentation of the following potential problems of diabetes in older people, all of which are also identified in the ADA/AGS report:

- Other medical conditions.
- Hearing and vision.
- Polypharmacy.
- Cognitive impairment.
- Depression.
- Vulnerability to hypoglycaemia.
- Nutrition.
- Mobility.

The Passport includes an assessment of mobility and activities of daily living and a MUST (Malnutrition Universal Screening Tool) score to measure nutritional state. There are prompts for assessment of mood and memory and for screening for the complications of diabetes, though these should be adapted if End of Life Care (EOLC) is in place.

The care plan should be developed in consultation with the professionals responsible for diabetes care (such as the GP and practice nurse).

Recent NICE guidance

NICE recently published the latest guidelines for type 2 diabetes in adults (NICE, 2015). This does not contain a specific section on older adults but the introduction states

“There needs to be flexibility, to ensure that the care of older people with diabetes also addresses their broader health and social care needs.”

NICE advises that glycaemic targets should be individualised, with particular consideration for people who are older or frail. Intensive management is not suitable for those with a reduced life expectancy or with significant

comorbidities, as the consequences of hypoglycaemia may be serious in this age group.

Hypoglycaemia

Older people are more vulnerable to hypoglycaemia. Age impairs the counter-regulatory response and hypoglycaemia unawareness is more common in older people. This is important as cognitive impairment increases the risk of hypoglycaemia and severe hypoglycaemic episodes may lead to dementia, creating the potential for a “vicious circle” (Punthakee et al, 2012). Renal impairment and poor nutrition reduce the insulin requirement and increase the risk of hypoglycaemia. Both hypo- and hyperglycaemia may increase the risk of falls in people with functional impairment. The symptoms and signs of hypoglycaemia are often specific to the individual and it is important that care homes document the signs that should alert staff to the possibility that a resident's blood glucose is falling.

Training of professionals working in care homes

In the first place you should approach your local diabetes team as many offer training specifically designed for professionals working in care homes. Alternatively, you could access a national programme and a few are listed below:

- The Skills for Care programme (www.skillsforcare.org.uk) provides learning and development support and practical tools to adult social care organisations in England. This includes training in dementia care.
- Diabetes UK provides basic training in diabetes for health professionals, which is available on www.diabetesinhealthcare.co.uk.
- The Leicester Master's in Diabetes programme is introducing a module called Diabetes in the Older Person, which will be piloted in June and July 2016 (details available at: <https://le.ac.uk/courses/diabetes-msc>).

End-of-life care

End-of-life care is designed to help people die with dignity and free from pain, but it can be particularly difficult to decide how best to

Page points

1. Diabetes UK has written a guideline to help care homes develop a policy and care plan for the frail older person.
2. The guideline consists of 11 pages of detailed, practical suggestions, covering all aspects of diabetes care, including the three of the elements specified by the Care Quality Commission, namely hypoglycaemia, foot care and staff training.
3. Recent NICE for type 2 diabetes advises that glycaemic targets should be individualised, with particular consideration for people who are older or frail. Intensive management is not suitable for those with a reduced life expectancy or with significant comorbidities.

“All care home staff should receive basic training to enable them to understand the practical aspects of diabetes care.”

manage diabetes in this situation. In 2013, Diabetes UK commissioned *End of Life Diabetes Care*, a comprehensive document addressing all aspects of the care of people with diabetes who are near the end of life (Diabetes UK, 2013).

Technically, the definition of “end of life” applies to any person likely to die within the next 12 months, but the spectrum ranges from people who are at the point of death to residents of care homes with frailty and/or dementia. Care homes should use this document as a resource when planning the care of residents nearing the end of life, in collaboration with the individual’s GP and, if necessary, the diabetes specialist team.

Conclusion

Diabetes UK and the CQC have set out clear guidelines for the management of care home residents with diabetes. We call for managers and senior nurses of individual care homes to use these guidelines to develop a diabetes policy and recommend that they do this in collaboration with the local diabetes specialist team. This should include a simple, structured, individualised plan that can be easily followed by staff in the care home. All care home staff should receive basic training to enable them to understand the practical aspects of diabetes care. ■

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