EDITORIAL

Diabetes in the elderly living in care homes

Diabetes en el paciente anciano que vive en hogares de acogida

Megías and Vasco, in this issue of Rev Clin Esp,1 draw attention to the increasing problem of the identification and appropriate management of diabetes in older people who live in long term care establishments.

Diabetes prevalence increases into older age in both men and women.2 The majority of the population living in long-term care settings in Europe, including nursing homes, are aged 65 years and older. These patients often have multiple co-morbidities, and suffer from physical and cognitive frailty for which they are prescribed a large number of drugs. This adds complexity to the diagnosis and management of diabetes. The authors explore the variations in the application of standard diagnostic tests for diabetes in the older population. The gold standard diagnostic test for identification of diabetes in this population remains elusive and, for those diagnosed, good diabetes management must balance a focus on achieving good glycaemic control to reduce the risk of vascular complications, with consideration for co-morbidity, age-related changes in physiology and the increased risk of side effects of medication. It is known that older individuals are at particularly high risk of iatrogenic hypoglycaemia and that symptoms of hypoglycaemia are less likely to be perceived in this group than in younger individuals.3

Older adults living in care homes require frequent review of diabetes management and amendment of treatment goals as their needs change. For example, too great an emphasis on strict glycaemic control can contribute to an increased frequency of hypoglycaemic episodes and might not achieve the same degree of benefit in terms of reducing adverse vascular outcomes found in younger individuals. Blood glucose level monitoring remains an important aspect of diabetes management at all ages, with the aim of avoiding both hyperglycaemic and hyperglycaemic events. However the use of HbA1c targets for monitoring blood glucose becomes more pragmatic and potentially more acceptable and appropriate in the later years of life.4 The symptomatic burden of the extremities of blood glucose levels and the impact this could have on quality of life in older individuals should not be underestimated.

The emphasis in chronic disease management has moved towards education and empowerment of the individual with the support of specialist teams as required. It is recommended that a patient-centred approach to the care of individuals with type 2 diabetes is implemented.5 However, care home residents often rely on others for assistance in diabetes management, including, for example, glucose monitoring, provision of an appropriate diet, access to specialist services and advice, and administration of medications. This can lead to the disempowering of individuals, as a lack of desire or capacity to be actively engaged in the management of their condition may be inferred. Access to good quality care could also suffer as care home populations might face inadequacies in healthcare provision.6 There is evidence that many care home residents are interested in understanding and taking control of their diabetes and would welcome the opportunity to do so.7 In order for care homes to begin to empower residents and facilitate patient-led diabetes management there is a need for training and support of care home staff in appropriate diabetes management for elderly individuals, so there may be both financial and logistical barriers to the provision of care and training needs.

Until recent years there has been a lack of evidence or advice relating to the management of people with diabetes living in long-term care settings. This has begun to change. In 2010 Diabetes UK published revised “Good Clinical Practice Guidelines for Care Home Residents with Diabetes”8 These guidelines provide a framework within which current diabetes management in care homes can be assessed in terms of how well it meets standards related to several areas of care, including glucose monitoring, provision of appropriate diet, monitoring of vascular risk factors and assessment of diabetes related complications. Using this guidance as a starting point against which to assess diabetes care in this frail, elderly population enables measurable outcomes to be established, which all care homes should aim to achieve, and provides a platform for good clinical governance.

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References


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