Diabetes Management
Sutton Care Home Forum

Pauline Strugnell
Senior Diabetes Nurse Specialist
Sutton and Merton Community Services
The Royal Marsden Hospital
Objectives

- Scale of the problem
- Special problems with older people
- Goals of management
- Staff education
- Diabetes Specialist Team
Increasing – longevity and obesity

Highest prevalence at age 60-74 years (17.6 %)

Prevalence of diabetes in nursing home residents has increased to 27 %.

Older people with diabetes use primary care services and hospital care 2 or 3 times more frequently

Hospital admissions - length of stay last twice as long
Over a third (35.17%) of residents do not know about signs and symptoms of hypoglycaemia
17% (203) homes had no system in place to check whether those who self-medicate had taken their medication
64.5% homes had no policy for screening for diabetes
36.7% homes had no written policy for managing hypoglycaemia
63.2% of homes had no designated staff member with responsibility for diabetes management
Recommendations

- Screening for diabetes on entry to home and every 1-2 years thereafter
- A written policy within the home regarding all aspects of diabetes care provision
- Individual person-centred care plans for diabetes
- Training in diabetes for staff delivering care
- Integration with local GP, primary and specialist care services having a high priority for local commissioners
- Regular audit of diabetes care against established standards
Special problems in older people

- Similar spectrum of macrovascular and microvascular complications as their younger counterparts with diabetes
- However, higher absolute cardiovascular risk than younger adults
- High risk for
  - polypharmacy
  - cognitive impairment
  - urinary incontinence
  - functional disabilities
  - depression
  - falls – three fold persistent pain
Overall goals of management

- Individualised management - balance safety and risk
- Management of hyperglycaemia
- Avoidance of hypoglycaemia
- Risk factors management (i.e. hyper / hypotension)
  drug interactions due to polypharmacy
- Prevent undesirable weight loss
- Management of coexisting medical conditions
- Detect dementia
- Depression

Encourage self-care
“High blood pressure, high cholesterol, high blood sugar, high anxiety... getting high is no fun at my age!”
<table>
<thead>
<tr>
<th>Functional Category</th>
<th>HbA1c target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Functionally Independent</td>
</tr>
<tr>
<td>Category 2</td>
<td>Functionally Dependent</td>
</tr>
<tr>
<td></td>
<td>A  Frail</td>
</tr>
<tr>
<td></td>
<td>B  Dementia</td>
</tr>
<tr>
<td>Category 3</td>
<td>End of Life Care</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Guidelines

Good clinical practice guidelines for care home residents with diabetes

A revision document prepared by a Task and Finish Group of Diabetes UK

Quick reference guide

Issue date: May 2009

Type 2 diabetes

The management of type 2 diabetes

March 2010

Some recommendations were updated and replaced by ‘Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings’ (NICE clinical guideline 90). More information on the management of neuropathic pain is available from www.nice.org.uk/guidance/CG90

September 2010

Quick reference guide

Issue date: July 2004

Type 1 diabetes: diagnosis and management of type 1 diabetes in adults

March 2010

Some recommendations have been updated and replaced by ‘Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings’ (NICE clinical guideline 90). See www.nice.org.uk/guidance/CG90

In this document changes are marked with black strike-through.
Details of all changes can be found at www.nice.org.uk/ta/ta1542/guidanceChangesApr2010

Clinical Guideline 15

Developed by the National Collaborating Centre for Chronic Conditions
Staff Education

- Adhoc advice
- Patient specific training
- University Accredited Courses
- In-house training
- Bridging the Gap
Diabetes training

Champions (Level 3)

- Team champion on diabetes
- GPs

Registered practitioners (Level 2)

- Community Nurses and Therapists

Health Care Support Workers (Level 1)

Champions (Level 3)

- Team champion on diabetes
- GPs

Registered practitioners (Level 2)

- Practice based and Community Nurses and AHPs

Health Care Support Workers (Level 1)
Level 1 – Diabetes training for HCA’s

<table>
<thead>
<tr>
<th>Core Module - Half day</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is diabetes? Causes, signs and symptoms</td>
</tr>
<tr>
<td>• Effects and side effects of medication</td>
</tr>
<tr>
<td>• Monitoring weight, BP, BGM</td>
</tr>
<tr>
<td>• Nutrition and diet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice staff - Half day</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountability</td>
</tr>
<tr>
<td>• Annual reviews and health checks</td>
</tr>
<tr>
<td>• Complications and Screening</td>
</tr>
<tr>
<td>• Hypoglycaemia and Hyperglycaemia</td>
</tr>
<tr>
<td>• Foot care and integrity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Health Care and Support staff - Half day</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountability</td>
</tr>
<tr>
<td>• Screening and reviews</td>
</tr>
<tr>
<td>• Skin care recognition and referral</td>
</tr>
<tr>
<td>• Sick day complications</td>
</tr>
<tr>
<td>• End of life</td>
</tr>
</tbody>
</table>
Level 2 - Diabetes training for nurses and AHPs

Day 1
- Signs and symptoms
- Early intervention with diabetic complications
- Oral care
- Nutrition and diet
- Impact of diabetes on mental health
- Monitoring
- Effective communication and multi-agency planning

Day 2
- Medication and insulin
- Promoting self-care
- Care planning and co-ordination
- Diabetes and end of life care
Sutton and Merton Intermediate Diabetes Specialist Team (Tier 3)

1 Consultant
4 wte Diabetes Specialist Nurses
2.5 wte Diabetes Specialist Dietitian
1 administrator
Podiatry Team
Diabetes Specialist Clinics in Sutton and Merton

Patrick Doody

Morden Road

Robin Hood Lane

Cricket Green

Jubilee Centre

St Helier
Referral Process

How to make a written referral

1. Identify the service to which you would like to refer
2. Download the appropriate referral form from this list
3. Fax, email or post the referral form to the SMCS Administration Centre

Fax: 020 345 85 888
Email: rmh-tr.smcsadmin@nhs.net
SMCS Administration Centre
PO Box 70926
London SW19 9FS

<table>
<thead>
<tr>
<th>Community Respiratory Team</th>
<th>See verbal referral instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continence Service</td>
<td>Referral form (.doc, June 2013)</td>
</tr>
<tr>
<td>Diabetes Service</td>
<td>Diabetes referral form (.doc, August 2013)</td>
</tr>
<tr>
<td></td>
<td>Desmond Group Education referral form (.doc, June 2013)</td>
</tr>
<tr>
<td></td>
<td>GP Diabetes Telephone Advice Service Referral Form (.doc, June 2014)</td>
</tr>
</tbody>
</table>

Downloadable forms:
- Information for referrers (.pdf, January)
- Referral form (.pdf, January 2014)
- Medication form (.doc, June 2013)
Referral Form
Thank You for Your Attention