How to Support Residents with Diabetes and how to get the most from your Care Home
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Introduction – practical help in supporting Residents with Diabetes

A Diabetes UK report Guidelines of practice for residents with diabetes in care homes found that up to one in 10 residents of care homes have diabetes. This is likely to be a gross underestimate.

The aim of this pack is to help you understand more about diabetes, its effects, and the special care you need to take with residents who have diabetes.

It covers diet, foot care, treatment and control of diabetes, special problems that may arise with older people, and sources of advice and help.

Many elderly people have poor vision. In diabetes, poor control of glucose levels can make this worse and can also damage the back of the eye. Therefore it is important that residents with diabetes have an annual medical examination which includes an eyesight check and an examination of the back of the eye. The check-up should also include checking blood pressure and weight, a urine test and examination of the feet.

People with diabetes have an increased risk of poor circulation and reduced feeling in their feet. This is why good foot care is especially important for the older person with diabetes. It is very important to avoid damage to the skin from incorrect toenail cutting, poorly fitting footwear or from exposure to heat or to water that is too hot.

Eating a normal healthy diet and taking regular simple exercise helps to maintain good control of diabetes. Regular monitoring, usually by urine or blood tests can assess control.

Diabetes care has advanced greatly over the past few years. The risk of developing diabetes-related complications can be reduced considerably by good long-term control of the condition and by good general healthcare, whether arranged by the person with diabetes or their carer.

Diet
The diet for people with diabetes is a normal, healthy diet, high in fibre and low in sugar, salt and fat. This diet is suitable for all residents, not just those with diabetes. But residents with diabetes are special in one respect – they do need to eat regularly (if taking insulin or certain tablets, those treated with diet only, don’t need to worry about this so much) and they do need to include starchy food in each meal. The main dietary principles for people with diabetes are as follows:

• Take care the resident doesn’t become overweight. It is more difficult to control diabetes in overweight people.
• If the resident is overweight, cut down on fried and fatty foods such as full fat milk, fatty meat, cheese, butter and margarine.
• Cut down on sugar and very sweet foods, such as chocolate, sugary drinks and cakes. This helps to keep the blood glucose levels well controlled.
• The main part of each meal should be made up of high fibre carbohydrate foods such as wholemeal bread, jacket potatoes, pasta, rice and pulses.
• Eat regular meals and include a wide variety of foods in the diet.
• Avoid specialist diabetic foods such as ‘diabetic’ sweets, chocolate and biscuits. These are of no special benefit. They may contain the same amount of fat and calories as comparable foods and may cause stomach upset and diarrhoea if taken in large amounts.

Sugar
There is an alternative available for most sugary foods through wholesalers and supermarkets. For example, you could use the following:
• artificial sweeteners such as saccharin and aspartame
• preserves such as reduced sugar jam and marmalade
• sugar-free diet drinks
• fruit tinned in natural juice rather than syrup
• plain biscuits such as digestives or rich tea instead of chocolate biscuits
• Puddings such as sugar-free instant whips, jellies and home made low-sugar puddings.

Small amounts of sugar do not affect blood glucose levels significantly when taken as part of a healthy diet and may be used in baking, for example, in conjunction with whole meal flour. There is no reason why residents with diabetes should not eat small portions of cakes or chocolate occasionally, providing this is part of a balanced and healthy diet. Diabetes UK’s cookbook Home baking (£4.95) contains recipes for reduced sugar, high fibre cakes, biscuits and breads.

Fibre
A high fibre diet that includes wholemeal bread, potatoes, bran based cereals, can improve bowel function and prevent constipation. Some types of fibre, such as in porridge, fruit, vegetables and pulses also help to improve blood glucose control in people with diabetes. Wherever possible, include high fibre foods in the diet, preferably with each meal. Cakes and pastries can be made with 50 per cent wholemeal flour. It is very important to drink plenty of fluids – about eight to 10 cups per day – when taking a high fibre diet.

Fat
If residents with diabetes are overweight, the amount of fat they eat should be reduced. The best way to do this is by grilling or baking rather than frying foods, and by using low fat alternatives such as semi-skimmed milk and low fat spreads.
Regular eating

Residents with diabetes need to eat regularly, especially if they are taking tablets or insulin injections. This means that they need to have breakfast, lunch, an evening meal and a bedtime snack (some may also need snacks throughout the day). High fibre, starchy foods should be encouraged at each meal to help control the glucose levels.

If a resident with diabetes has a poor appetite, it may be appropriate to provide dietary supplements such as milky drinks. For more information on dietary supplements and on how to adapt the diet for underweight residents, contact a state registered dietitian.

Modifying recipes and meals

As you can see, the healthy diet recommended for residents with diabetes is not a ‘special’ diet. It will benefit all residents. Modifying your recipes and meals does not necessarily mean developing a whole new set of menus. Instead, to give healthy options that are still tasty, you can modify your existing recipes in the ways that we have suggested. Diabetes UK can provide further information on diet and how existing recipes and meals can be modified.

Alcohol

People with diabetes do not need to give up alcohol, although they do need to take some special precautions. Men should not drink more than three units of alcohol a day and women should not drink more than two units.

One unit of alcohol
- half pint of ordinary strength beer or lager
- one pub measure of sherry, vermouth, aperitif or liqueur
- one standard glass of wine
- one pub measure of spirit, e.g. gin, vodka or whisky

The special precautions that people with diabetes need to take into account are:
- never drink on an empty stomach because of increased risk of hypoglycaemia
- use sugar-free or slimline mixers for spirits and shandies
- Some tablets should not be taken with alcohol – this should be checked with the doctor or pharmacist. You can also obtain this information from Patient advise leaflets.
Foot care

Good footcare is especially important. Elderly people with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes. This is because diabetes may lead to poor circulation and reduced feeling in the feet.

Residents with diabetes should have their feet washed daily using warm water and mild soap, and dried carefully. The feet should be carefully examined for changes in appearance – for example, soreness, cracks between the toes, breaks in the skin, changes in colour or swelling. Any such changes should be recorded and reported to the doctor. Toenails should be cut to follow the shape of the toe. Residents should wear well-fitting shoes and should change their socks or stockings each day. A non-medicated cream (such as E45) can be used for dry skin.

A state registered chiropodist or podiatrist (who will have the letters S.R.Ch after her/his name) should be seen regularly. This is particularly important for any resident who has any of the following:

- reduced feeling in their feet
- poor circulation (cold feet, shiny or discoloured skin, loss of hair on feet and toes)
- a foot deformity or poor skin condition
- Eyesight or physical problems which prevent good self-care.

Residents with diabetes should not:

- wear garters
- go barefoot
- Use over-the-counter corn treatments or remove hard skin.

Hot water bottles and electric blankets should be used with great care. It is important not to neglect any injury. If any new redness, swelling or discharge from the foot appears, the doctor should be contacted.

For information on how to contact a state registered chiropodist or podiatrist see page 10.

Treatment and monitoring of diabetes

Most elderly people manage their diabetes either by diet alone or with a combination of diet and tablets. However, you may have residents who need injections of insulin.

Tablets
The tablets that are used to treat diabetes do not cure the condition. They help to control the blood glucose level by lowering it. There are different types of diabetes tablets. It is important that staff know the name and strength of the tablets being taken by residents. Occasionally diabetes tablets can make the blood glucose go too low (see pages 6 – 8 for information on hypoglycaemia). If this happens regularly, it is important
that the doctor is informed. The dose or type of tablet may need to be changed. Food should be eaten within half an hour of taking all tablets except Metformin.

Insulin
If a resident is treated with insulin, regular meals are especially important. If for any reason a meal is delayed, check for signs of hypoglycaemia. If the resident is unable to eat for any reason, substitute their meals with fluids such as fruit juice, milk or Lucozade and inform the doctor. The insulin should not be stopped.

Monitoring of diabetes is very important. It is done by testing either the urine or the blood for glucose. The method and frequency of testing will need to be discussed with the resident’s doctor or diabetes specialist nurse and clearly documented in the resident’s file. Some residents will be able to do the tests themselves. Others will need help. It is very important that all staff who may be required to help a resident to test their urine or blood are properly trained and are fully informed about the individual requirements of each resident. The results should always be recorded in the resident’s file.

Major deficiencies in diabetes care provision in institutions have been identified:

- Lack of care plans and case management approaches for individual residents with diabetes. This leads to lack of clarity in defining aims of care and metabolic targets, failure to screen for diabetes-related complications, no annual review procedures, and no allowance made for age and dependency level
- Inadequate dietary (nutritional) guidance policies for the management of residents with diabetes
- Lack of specialist health professional input especially in relation to community dietetic services, diabetes specialist nurses and ophthalmology review. In addition, there is a lack of state registered podiatrists for residents with diabetes of all ages, especially those at highest risk of diabetic vascular and neuropathic damage
- Indistinct medical supervision of diabetes-related problems due to lack of clarity of general practitioner and hospital specialist roles. This leads to inadequate and unstructured follow-up practices
- Inadequate treatment review and metabolic monitoring including blood glucose measurement
- Insufficient medical knowledge of diabetes and diabetes care among institutional care staff
- Presence of restrictive/tight work routines and shift patterns along with inadequate allowance for social and behavioral problems, especially in children’s homes
- No structured training and educational programmes for institutional care staff in relation to diabetes and other medical conditions which impact onto the management of diabetes.
- The above represent general statements which are likely to apply with different degrees throughout care homes in the UK. In general, nursing homes provide better monitoring facilities and increased nursing care as would be expected.
Barriers to effective diabetes care

- Several important barriers to providing improved diabetes care within long-term care homes exist. It should be recognised that deficiencies in care may be interpreted as ‘barriers’ and vice versa. These may be summarised as follows:
  - lack of sufficient training in diabetes care among home care staff
  - lack of structured provision of educational opportunities for nursing staff combined with lack of continuing professional education. A part consequence is a high turnover of the workforce
  - high ratios of unqualified staff who may have little experience of residents with diabetes.
  - lack of available resources in terms of staff time, catering services, and equipment
  - lack of clear boundaries of both medical and nursing responsibilities which may be exacerbated by poor communication channels
  - lack of appreciation by institutional staff of the special medical, psychological and social needs of residents with diabetes
  - lack of understanding by both care and nursing staff of modern dietary principles
  - high level of co-morbidities and communication difficulties in residents with diabetes
  - restrictive professional boundaries which prevent secondary healthcare professionals from having specific inputs into care homes especially within the independent sector
  - lack of national standards of diabetes care within long-term care homes. As a result of many of these barriers to care, common management difficulties arise. These are compounded by vulnerable and characteristic problems in residents with diabetes (characteristically seen in older residents) which include:
    - anorexic symptoms and reduced calorific intake may lead to nutritional deficiency and inappropriate weight loss. This also increases the likelihood of hypoglycaemia in those residents on sulphonylurea. or insulin therapy and make achieving satisfactory glycaemic control impossible. Possible contributory factors include: severe physical and cognitive impairment as well as neurological and gastroenterological disorders associated with dysphagia including stroke;
    - recurrent skin, chest and urine infections which predispose the resident with diabetes to marked hyperglycaemia or metabolic decompensation due to hyperosmolar nonketotic coma or ketosis (HONK)
    - urinary incontinence secondary to hyperglycaemia, urinary tract infections, poor mobility, and cognitive impairment
    - increased risk of leg ulceration and pressure sore development which can rapidly deteriorate and require hospital admission
    - communication difficulties which are common among older long-term care residents and can lead to unrecognised diabetes care needs. Predisposing factors include: cognitive impairment, dysphasia and dysarthria from cerebrovascular or neurological disease, and sensory impairments such as visual and hearing loss

• Increased vulnerability to hypoglycaemia. Several factors predispose residents with diabetes to this metabolic complication: cognitive impairment leading to missed meals because of poor memory and orientation; those taking sulphonylureas or insulin; anorexic conditions including gastroenterological disorders, malignancy, and acute infective illnesses. Lack of awareness of the symptoms of hypoglycaemia by the residents themselves and poor diabetes knowledge of care staff compound this situation. Lack of monitoring in many care homes also increases the risk of hypoglycaemia.

• Increased reliance on others to provide food/meals, poor understanding of dietary needs by care staff, and rigidity of meal times also contribute to diabetes management difficulties.

• Increased risk of adverse drug reactions in residents taking multiple drugs (polypharmacy) prescribed for co-existing disease. This may be exacerbated by infrequent review of medication and lack of monitoring renal and hepatic function.

Care home blood glucose monitoring

• Routine blood glucose monitoring is unusual in residential settings (6,7) and where present, care staff have insufficient knowledge of diabetes care to act appropriately on the basis of the readings obtained (6). In nursing homes where blood glucose monitoring (BGM) occurs with greater frequency but is still inadequate, the use of monitoring becomes essential since more residents with diabetes will be requiring insulin. In addition, the high frequency of acute illness and repeated infections makes monitoring a paramount activity to achieve effective diabetes care.

The following important considerations are required:

• The use of reagents strips and readings obtained by direct visual comparison with a colour chart on the reagent bottle is subject to gross error for several reasons and generally is not recommended. However, the use of reflectance meters and other similar equipment may be costly and requires a degree of quality control assessment. This may not be feasible in long-term care homes but the assistance of the Medical Devices Agency may be needed.

• The use of monitoring equipment requires a certain degree of training although some diagnostic companies may be prepared to provide this.
each care home would be required to define who would be responsible for monitoring although they would be encouraged to use qualified staff only (especially nursing staff) although useful contributions could be provided by trained care staff, family carers who visit often, and community district nurses where available. The difficulties of establishing effective monitoring in residential homes should not be overlooked. In addition, care staff requires education about interpreting the results obtained and deciding whether simple action is required or whether the doctor should be informed.

A reporting mechanism needs to be established. In each setting, a named care worker responsible for diabetes care may be a feasible future goal.

the frequency of monitoring and metabolic targets need to be established on an individual basis. This requires a consensus decision between the general practitioner, any community nursing support, and care home qualified staff. Daily measures are required during periods of acute illness but otherwise, twice weekly or weekly measures may be reasonable outcomes to aspire to. A fasting venous plasma blood glucose every six months and a glycosylated haemoglobin (HbA1c) taken at annual review by the care home GP are measures which may be of some clinical usefulness in monitoring the metabolic control of most residents.

Glycaemic goals will vary with each resident but should be sufficient to avoid recurrent hypoglycaemia (requires a fasting glucose level of > 6 mmol/l) and a random glucose < 11 mmol/l to avoid osmotic symptoms and lethargy, and is likely to minimise longer term vascular complications. Setting targets to optimise well-being is essential. It should be remembered that the average stay in many nursing homes of elderly residents is of the order of two years with a wide variation making the development of visual loss, neuropathy and macrovascular disease possible where a policy involving gross relaxation of glycaemic control is present.

recording glucose measures accurately requires appropriate documentation which could be standardised on a local basis.

Potential and important roles of a general practitioner in providing diabetes care to residents of care homes

The number of residents in care homes is likely to increase substantially in the next decade and new ways need to be established which structure medical responsibility for their care. Important contributory roles of a general practitioner might include:

organising an agreed care plan for each resident: this will require coordination with their practice nurse, diabetes specialist nurse, community dietitian, care home staff, carer and resident
supervising and participating in an annual review for each resident either at the surgery or within the care home
• providing emergency diabetes care as appropriate, e.g. treatment of prolonged hypoglycaemia
• assisting in planning a procedure to screen for diabetes in newly admitted residents to care homes
• agreeing a framework of direct referral of residents in care homes who require secondary sector specialist diabetes care including referral to ophthalmologists and vascular surgeons
• ensuring that diabetes care within care homes is included in clinical audit projects/ reviews in their locality
• assisting in the development and delivery of specific education and training packages developed locally for care staff

Diabetic footcare and provision of podiatry in long-term Care homes
Previous reports testify to the high prevalence of diabetic foot disease in residents of care homes. The risk for foot ulceration is increased in those with advancing age, presence of neuropathy and/or peripheral vascular disease, immobility, and other chronic dependent states.
In general, many care homes, although not all, have ready access to a state registered podiatrist. However, one of the principal reasons for visiting homes is for cutting toe nails. Podiatry can be provided directly in the care homes, or in day care centers, health centers, outpatient clinics or other clinic settings. Referral may be made by the general practitioner or by a hospital medical team. However, podiatrists have several additional important skills including a preventative role which is of great importance for people with diabetes. Podiatry within care home settings must be integrated with the other health professional inputs as part of a recognition of the importance of multidisciplinary care.

Primary roles in the management of residents with diabetes
• Assessment of pre-existing foot pathologies: physical deformity, callus formation, infection, ulceration, vascular status, toe nail pathologies, and suitability of current footwear. This involves an initial inspection followed by regular surveillance.
• Active treatment of diabetic foot disease.
• Education of residents, carers, and care staff in the prevention of diabetic complications involving the feet, correct toe nail cutting, heel protection and use of the most appropriate footwear. This may also involve the supply of suitable insoles and orthotics where appropriate.

Barriers to current provision of podiatry
Several barriers to effective provision of podiatry into long-term care homes exist:
• Lack of education about the scope of podiatry and the importance of preventative action by care staff, nursing and medical staff, and residents themselves leads to delay in referral for podiatry treatment.
• Lack of health professional appreciation of the important role of podiatry in the prevention and treatment of diabetic foot disease.
• Staff accompanying residents from residential homes to clinics and health centers have only a rudimentary knowledge of their charge which can reduce the value of the visit.
• Lack of treatment facilities/ accommodation at each care home preventing the most effective treatment being delivered.
• Some homes employ private podiatrists which require residents to pay extra fees. This may have a deterrent effect on organising more equitable podiatrist input.

Future action likely to increase the benefits of podiatry in long-term care homes includes:

• accessing full medical history
• providing treatment area with lighting
• adequate clinical waste disposal
• hand washing facilities
• an improved line of communication between care homes and podiatry departments to ensure early and direct referrals
• establishing an educational programme for care staff and residents on preventative footcare. This should include advice about daily foot inspection, corn cures and avoiding extremes of heat
• providing footcare leaflets (e.g. from Diabetes UK, local diabetic clinic) to each care home in conjunction with an educational programme
• regular identification of ‘at risk’ feet by the podiatrist and institution of appropriate follow-up management and footwear protocol.
• These actions should lead to an improved level of diabetes footcare.

Care plans for residents with diabetes in care homes

Each resident with diabetes should have an individual care plan agreed between the patient (or relative), general practitioner and home care staff. This should include the following:

• identification of a designated member of care staff for overseeing diabetes care for each resident, whose knowledge has been assessed by a diabetes nurse specialist (DSN) or district nurse (DN) trained in diabetes care
• identification of a designated doctor (usually the GP) who will accept overall medical responsibility for diabetes care of the resident and ensure that diabetes care follow up takes place
• a specific dietary plan (including a weight assessment) for each resident designed by a community dietitian with an interest in diabetes. This should follow discussion and agreement with the relevant kitchen staff
• a detailed list of diabetes-related complications, other co-morbidities, and current on-going problems in medical and social care. This will also include a basic initial assessment of physical and mental function, a full list of medications including antidiabetic treatment and provide dosage and frequency information
• a rehabilitation programme designed to maximise existing physical and cognitive function which should be delivered within each care home where possible. This will require inputs from both a physiotherapist and an occupational therapist
• a procedure which arranges an annual review for each resident with diabetes
• arrangements within each care home to screen regularly for diabetes-related complications, e.g. diabetic foot ulcers outside the procedure for annual reviews
• an agreed set of metabolic targets (e.g. blood pressure, glycaemic control) for each resident. This is to be accompanied by an agreement on the level and intensity of blood glucose monitoring required
• a series of simple but appropriate outcome measures which reflect the adequacy of diabetes care and the impact on the resident with diabetes on health and social services support. This may include the frequency of hypoglycaemia, number of hospital admissions for metabolic decompensation or acute illness related to diabetes care, and level of well-being experienced by the resident with diabetes. In order for care plans to be operable and of benefit, care staff will need to be aware of management strategies during ‘sick-days’ of the resident with diabetes and also how to manage effectively the occurrence of hypoglycaemia. These can sometimes be incorporated into protocols of care available within each care home.

Diabetes annual review arrangements for residents of care homes

Annual review arrangements for older adults with diabetes have previously been published. The components of this can be broadly implemented for residents in care homes with some additional items. The basic plan for an annual review should include:
• full clinical examination which includes a basic assessment of physical and mental function
• height/weight in order to calculate body mass index (BMI)
• lying and standing blood pressure
• urinalysis for protein
• glycated haemoglobin or fructosamine estimation
• urea and creatinine estimation
• visual acuity measurement with and without pinhole
• fundoscopy through dilated pupils for adolescents and adults
• examination of feet and lower limbs for deformity, infection, and ulceration. This will include identifying those residents with ‘at-risk’ feet, e.g. those with sensory Neuropathy or poor vascular supply.

Residents of care homes will also require a review of the following:
• medication list which includes a review of dosage and possible side-effects, e.g. frequency of hypoglycaemia for those on sulphonylureas or insulin
• dietary plan
• appropriateness of current aims of care in the light of any major functional change in the resident during the preceding year.

As part of the annual review process, the need for continued specialist follow-up can also be assessed. This review process can incorporate an element of clinical audit by recording outcome measure data.

Why is it important for Staff to have specialised Diabetes Training?

Fiona Kirkland, a consultant nurse in diabetes at East Staffordshire Primary Care Trust, showed that structured education by a nurse led to a 75 per cent drop in hospital admissions and an 86 per cent drop in hypoglycaemic episodes.

Ms Kirkland said: "It is apparent that people with diabetes in care homes could benefit from a higher quality of diabetes care.

"Our study and the work we have completed show that just a few hours of structured education with a diabetes specialist nurse can dramatically improve the quality of people’s lives."

Findings are reported in the Nursing Standard, and were presented at Diabetes UK’s recent annual conference.

What are the statistics?

• In the UK we estimate that care home residents with diabetes are spending 250,000 days in hospital

• Older people with diabetes make up around half the diabetic population. They should have the highest quality care and education to empower them to self-care and reduce the risk of hypos and complications

• In the UK we estimate that structured education can reduce the number of hospital visits by up to 75%

• There are currently 2.1 million people with diabetes.
In a survey by East Anglian Ambulance Trust over half of diabetes emergency call outs were by people over 60, and the majority of these were hypoglycaemic episodes.

The future for people with Diabetes in care homes?

A Diabetes care for life: promoting quality diabetes management in care homes - How Others Do It - By Diana Piper and Sarah Tiley

As specialist nurses working in primary and secondary care, we had realised for some time that our care home residents might not be receiving the systematic diabetes care that is available to the more independent.


With the support of our local diabetes services advisory groups (LDSAGs) a working group was convened to examine existing care and to recommend a framework that would help to optimise diabetes management in care homes. We had planned to integrate into this any recommendations in the (then unpublished) NSF for Diabetes: Standards document (Department of Health, 2001a). We decided to focus on:

- Screening
- Care planning
- The annual review
- Staff education.

These areas were chosen as a basis for quality care and encompassed many of the forthcoming NSF Standards.

Group membership

To give credibility and ensure effective outcomes, it was necessary to form a compact working group that included cross-boundary membership.

The social services district boundary embraced four PCTs and two acute healthcare trusts. Representation was sought from residential and nursing home registration and
from inspection officers because the Care Standards Act (Department of Health, 2001 (then) soon to be published, was known to apply to both. The membership was as follows:

- Community pharmacist
- Practice nurse
- Community nurses (2)
- Nursing home registration and inspection officer
- Residential home registration and inspection officer
- Senior dietitian
- Chief podiatrist
- Tissue viability nurse (at a later stage)
- Diabetes specialist nurse (2).

Throughout the project, the work of the group was fed back to the LDSAGs. To ensure patient and GP involvement, members were asked to discuss the project's progress with their colleagues and with self-help groups.

The process

The working group met once every 2 months and kept in close email contact. Initial discussions centred on current evidence and advisory documents. It was possible to theme these and resolve them into four simple standards (see below). They needed to be SMART (Specific, Measurable, Achievable, Realistic and Timely).

The group held the view that care home staff should ensure that their clients had access to this care, and that responsibility for providing it would be shared with healthcare professionals. Members of the group were invited to develop aspects of these standards into resource and educational materials, which we entitled Diabetes Care for Life.

At intervals, drafts were submitted for consultation to the LDSAGs, care homes, user groups and the Community Health Council.
The standards

Standard 1: Each adult resident in a care home will be screened annually for diabetes.

The lack of current national screening guidelines makes this standard somewhat controversial. However, we believe it to be justified by the high prevalence of diabetes, often previously undetected, in care home residents (Sinclair et al, 2001).

Before agreeing on this standard we surveyed the current prevalence of diabetes in local nursing and residential homes. The 5.2% prevalence in residential homes and 10.5% in nursing homes is low and confirmed the need to begin screening this group of people. For practical reasons, it was considered satisfactory for screening to be performed on a urine sample, either by the staff in the care home or at the local health centre.

Standard 2: Each resident with diabetes will have their diabetes care documented in their care plan.

The guidance in Diabetes Care for Life emphasises the importance of involving the resident or a relative in the development of the care plan and states that a registered nurse will write the diabetes aspects of care. This standard embodies Standard 3 of the NSF for Diabetes: ‘The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes’. It is one way of facilitating effective communication between patient, health professionals and carers.

The recommended contents of a care plan are described but the format of the care plan is left to the individual home. Care planning together with the resident and carer should take place each time management is assessed.

Standard 3: Each resident will have an annual review of their diabetes in the most appropriate setting.
Yearly review is a minimum standard and many people with diabetes will have more frequent assessment. The guidance describes what to expect during an annual review and how carers might help with this aspect of management. This might include checking that blood tests have been performed before the appointment, or reporting any changes in physical or clinical circumstances which the person with diabetes might be unable to explain unaided. The care plan should be updated at the annual review.

Standard 4: Each care home will have a named member of staff trained in the care of people with diabetes.

This standard requires that training should be provided by healthcare professionals trained in diabetes care, and that knowledge of care home staff, including the catering team, should be updated at least every 3 years. Aspects covered in the education sessions are shown in Table I.

Resource document

The topics included in the education sessions are described in more detail in the Diabetes Care for Life document. The aim is to provide a continuing resource for staff (Table 2). Each member of the working group wrote a chapter describing his/her area of practice.

Dissemination

Care homes were well prepared for the standards. They had been consulted throughout the project. The care home inspection and registration officers had also discussed the project on their visits. The Diabetes Care for Life document was sent to each care home with an explanatory letter requesting the home to send one person to a study session. An accompanying flyer described the supporting education sessions: a half-day for unqualified staff and a whole day for nursing home qualified staff as they would be undertaking more of the diabetes care.

Applications for the education session were enthusiastic. Some care homes exceeded the minimum criterion expressed in Standard 4 by sending several members of staff. A small fee was charged to cover costs. At each presentation it was suggested that these standards should be implemented over the next 1-2 years, thus progressively improving
the quality of diabetes care for residents. Written evaluation of the sessions was positive and no participant felt that the standards were unachievable.

The community nurses on the working group held study sessions for their colleagues, explaining their role in care planning. Similarly, the specialist and practice nurses presented the standards to the practice nurses at their local meetings.

Next steps

Systematic audit will be used to monitor the standards, initially with a cycle of 2 years.

For Standard I, all homes will be asked for their prevalence of diabetes. The inspection officers have agreed to collect data for Standards 2, 3 and 4. The results of the audit will be used to inform the review of the Diabetes Care for Life document in 3 years time. By then we should have demonstrated whether the standards are reasonable. Development of competency-based education for care home staff might be an effective way of enhancing care even further.

Conclusion:

Diabetes Care for life has provided us with a framework for enabling quality diabetes management in care homes. It has also been an exercise in partnership and collaborative working, driven by enthusiasm and shared learning.

The following is a section from Help The Aged’s Website:

‘What are the main problems in care Homes?’

There is a mismatch of affordable, quality care home places available to meet the need and that older people’s choice is being eroded. The problems are as follows:

- Erosion of choice - Older people are being steered away from care homes as they are viewed as a care option of ‘last resort’ rather than a positive choice.

- Unfair - The UK Government wants older people to be cared for in their own homes, but inadequate funding for social care is failing to give them the companionship and security they need. With ever competing priorities, older people always come last in the funding queue.
• Erratic quality care - Care homes struggle to provide good quality care: a dwindling workforce, increasing costs and a poor image all mean that successful care homes should be championed.

Erratic quality of care?

The care home sector is fragmented. Some care homes deliver a high standard of individual care where people feel secure and part of a small community. But many older people suffer in care homes that are isolated from the mainstream health and social care services, and need updating to meet 21st century demands.

It is time for a fundamental shift in attitudes to older people and their care. The system itself, based on the Poor Law, is too rigid and is out of date to meet current and future needs. Such a change is daunting, but let’s looks at what works for older people now and replicate it. Help the Aged welcomes the review of social care funding undertaken by Sir Derek Wanless on behalf of the Kings Fund in 2006. The evidence has confirmed the need for much more money. We urge the UK Government to address the findings of this crucial report before it is too late. We insist on a public debate to discuss changing attitudes to older people and how the money can be found for their care.

Older people should be allowed and empowered to choose their own care home and care package if they wish. That means more quality care homes are needed, and the Direct Payments system (which provides older people with money to spend on their own care) should be made more accessible.

What you can do if you are dissatisfied with your Care Home

We encourage you to tell the care service provider your concerns so they can put things right.

But we understand that some people are worried about sharing their concerns and complaints with providers.

In these cases, you can contact the Commision for Social Care Inspection (CSCI)-this is the organisation that care homes are accountable to. They carry out inspections of Care homes rather like Ofsted Inspections.

What they will do

They will write to you to confirm that they have received the information you have given them.

They will then look at the information and decide how to respond.

They are responsible for making sure that providers meet the regulations and standards that apply to them.
If the provider is not meeting those regulations and standards, they will take further action.

They may ask the provider to investigate, or they may look into it themselves

What happens next?
If they find evidence that the provider has not met the regulations, they will tell them what they must do to put things right.

They use their inspection powers to find the information they need to make these and other decisions.

How long will it take?
They will aim to complete their enquiry within 20 working days. If they are not able to do this, they will keep you informed of what is happening and why.

Who else can help?
If the care you are receiving is paid for by your local council, you may be able to use the statutory social services complaints procedure.

Speak to their complaints manager, who can tell you how to do this.

General advice on making a complaint

If you are unhappy with the way you have been treated by your local council or NHS you may want to make a complaint. The different steps you can take are outlined in this information sheet. But first, here is some general advice on how to deal with any complaint.

• Decide if you want to make an informal or a formal complaint. To make an informal complaint, speak to someone to try to sort things out as quickly as possible. You can clear up many problems by having an informal chat with a member of staff at the organisation. Most people make an informal complaint first as a formal complaint is more serious and may take longer to resolve.

For a formal complaint, ask for information about the procedure and put your complaint in writing. Someone will investigate and then reply, in writing, telling you what they are going to do about it. All service providers must have a complaints procedure. It must set out how service users, or those acting on their behalf, can complain about the service.

• Be clear about what it is you are unhappy about. Your complaint is more likely to be resolved to your satisfaction if you can be precise about what you are complaining about.
- Say what you want the result of your complaint to be. Do you want an apology? Do you want an explanation of what went wrong and why? Do you want something to be changed so that other people don’t have the same experience you have had?

- If you want compensation, this may be possible in some cases, but the complaints procedure may not be the right route for you. You may want to get advice on this.

- Try to be as clear and concise as you can in any letters you are writing.

- If you speak to someone about your complaint, by telephone or in person, it is a good idea to make a record of the time, date and name of the person you spoke to. For example, you may have made your initial complaint in person, or made a phone call to check your complaint has been received. Follow up any conversations with a letter confirming what was discussed. Make sure you keep a photocopy of any letters you send and keep all letters and emails you receive.

- If you are making a formal complaint, state this clearly in your letter. This will mean that your care home, local council or NHS service will have to deal with your complaint within set time limits. There is more information on the time limits for care home, local council and NHS complaints in the next three sections of this information sheet.

- You may find it useful to get further advice before making a complaint: for example, from your local Citizens Advice Bureau,

- If you live in a care home and you are not happy about the home, its staff or the treatment you receive, you can make a complaint. You can also make a complaint if you are the relative of somebody who lives in a care home and are not happy about their treatment. You have the right to feel safe, and to be treated with dignity and respect.

**Legal action**

If you have been through all the stages above and you’re still not happy, you may be able to go to court for a judicial review to try to resolve your dispute. Judicial review is only possible if there are legal grounds to challenge a decision or action of a public authority, like the council or CSCI, not a private care provider. This can be very expensive unless you are eligible for legal aid.

If you are eligible, the Legal Services Commission will be able to help you find a suitable solicitor. Your local Citizens Advice Bureau should be able to advise you about whether you are eligible for legal aid. Contact details for your local Citizens Advice Bureau will be in your phone book.
Getting help with making a complaint

If you want help with making your complaint, you can get advice from your local Citizens Advice Bureau or Age Concern group.

There are different independent bodies in each UK country which inspect and report on care services.

- If you are in England you should contact the Commission for Social Care Inspection (CSCI) helpline for advice.
  Telephone: 0845 015 0120 or 0191 233 3323
- If you are in Scotland you should contact the Care Commission.
  Telephone: 01382 207100
- If you are in Wales you should contact the Care Standards Inspectorate for Wales (CSIW). You can complain directly to it about social care received from care homes.
  Telephone: 01443 848450
- If you are in Northern Ireland you should contact the Northern Ireland Regulation and Quality Improvement Authority.
  Telephone: +3532 1425 0610

Advocacy services

You can get advice and support to make a complaint from an independent advocacy service. An advocate is someone who can support you and speak on your behalf. An independent advocacy service has expert knowledge of how the system works; it uses this knowledge to represent your interests and assist you to get your point across more effectively.

- Your local council social services department should be able to give you information about local advocacy organisations that can help you to make a complaint.
- The charity Counsel and Care can provide details of advocacy organisations in your area. Call 0845 300 7585.
- Your local Age Concern may provide an advocacy service. Contact details should be listed in your phone book.
- You can ask your local Citizens Advice Bureau for advice and support in making a complaint. Check your phone book for contact details.

- You can also contact the advocacy Service at Diabetes UK, on 0207 424 1000
Get involved

It’s your health service, so get involved to ensure older people’s concerns are central to the way services are developed. You can make your views known and respond to consultations on health services in the following ways:

- For social care, the care home regulator is the Commission for Social Care Inspection Tel: 020 7979 2000.

- For health and social care, contact the Commission for Patient and Public Involvement in Health. Tel: 0121 345 6100.

The Following information comes from the CSCI

‘CSCI (The Commission for Social Care Inspection)   Key Inspection Standards

The CSCI has identified key national minimum standards, for care homes. This means that the standards they have identified, are the very minimum that a care home should be offering. These are standards that are particularly important and have a direct effect on the safety and welfare of people who use services.

A common type of inspection that will be carried out on a care home is a “key inspection”. The CSCI look at the experience for service users for the key standards of the service inspected. They will also assess what the home is doing with the other standards if necessary. At “themed inspections” (about particular issues) and “random inspections” (for example, surveys sent to people or unannounced visits) we will focus on any standards necessary.

Some of the CSCI Standards

**Needs Assessment- Outcome**

No service user moves into the home without having had his/her needs assessed and been assured that these will be met. New service users are admitted only on the basis of a full assessment undertaken by people trained to do so, and to which the prospective service user, his/her representatives (if any) and relevant professionals have been party. The assessment should be considered against the statement of purpose to ensure that the service is able to meet the needs of the new service user.

The service user may choose to use an advocate. An independent advocate is an individual who is independent of the home or of any of the statutory agencies involved in the purchasing and provision of care in, or regulation of, the care home.
This person may act on behalf of and in the interests of a service user who feels (or it is felt) unable to represent him/herself. Service users who wish to advocate for themselves, are supported in doing so.

It is not a legal requirement for a home to provide or fund an advocate. But the home should set out in the service user guide how a service user may access advocacy services.

The Mental Capacity Act 2005 (MCA) introduced the Independent Mental Capacity Advocate (IMCA) service on 01 April 2007. When someone is considered to lack capacity as defined in the MCA’s Code of Practice (section 3.9 – 3.23) and has no one to speak for them, an IMCA can be appointed. They can make representations about the person’s wishes, feelings, beliefs and values, at the same time bringing to the attention of the decision maker all factors that are relevant to the decision.

Training for assessments – The staff working with the Department of Health’s Single Needs Assessment process have only their ongoing professional training. There is no recognised qualification for those undertaking care needs assessments within residential care or domiciliary care services. Modules within the Registered Managers Award and National Vocational Qualifications in Care will cover care needs assessment.

The Department of Health guidance on the single assessment process identifies a number of organisations that have developed recognised assessment tools. The assessment tool, which is going to be used, has to adequately cover the elements identified in these Standards.

Information from medical staff need to be part of the assessment process as their contribution will provide a clearer understanding of the needs of the prospective service user.

For individuals who are self funding and without a Care Management Assessment/Care Plan, the registered person carries out a needs assessment covering:

- personal care and physical well-being;
- diet and weight, including dietary preferences;
- sight, hearing and communication;
- oral health;
- foot care;
- mobility and dexterity;
- history of falls;
- continence;
- medication usage;
- mental state and cognition;
- social interests, hobbies, religious and cultural needs;
- personal safety and risk;
- carer and family involvement and other social contacts/relationships.
Service users and their representatives know that the home they enter will meet their needs.

The registered person is able to demonstrate the home’s capacity to meet the assessed needs (including specialist needs) of individuals admitted to the home.

- All specialist services offered (e.g. services for people with dementia or other cognitive impairments, sensory impairment, physical disabilities, learning disabilities, intermediate or respite care) are demonstrably based on current good practice, and reflect relevant specialist and clinical guidance.

- The service user’s plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the service user (see Standard 3) are met.

- Decisions about the time a resident gets up in the morning and goes to bed at night should be made with them and, if necessary, recorded on their care plan. Care staff will then be clear both as to the residents’ wishes and the expectation on them as carers. Fundamental to the decision should be the resident’s wishes and not the routines of the home or the convenience of staff.

- The service user’s plan meets relevant clinical guidelines produced by the relevant professional bodies concerned with the care of older people, and includes a risk assessment, with particular attention to prevention of falls.

- The service user’s plan is reviewed by care staff in the home at least once a month, updated to reflect changing needs and current objectives for health and personal care, and actioned.

- Nutritional screening is undertaken on admission and subsequently on a periodic basis, a record maintained of nutrition, including weight gain or loss, and appropriate action taken.

- The registered person enables service users to have access to specialist medical, nursing, dental, pharmaceutical, chiropody and therapeutic services and care from hospitals and community health services according to need.

- Service users, where appropriate, are responsible for their own medication, and are protected by the home’s policies and procedures for dealing with medicines.

- The registered person ensures that there is a policy and staff adhere to procedures, for the receipt, recording, storage, handling, administration and disposal of medicines, and service users are able to take responsibility for their own medication if they wish, within a risk management framework.

- Service users and their relatives and friends are confident that their complaints will be listened to, taken seriously and acted upon.
• The registered person ensures that there is a simple, clear and accessible complaints procedure which includes the stages and timescales for the process, and that complaints are dealt with promptly and effectively.

• The registered person ensures that the home has a complaints procedure which specifies how complaints may be made and who will deal with them, with an assurance that they will be responded to within a maximum of 28 days.

• A record is kept of all complaints made and includes details of investigation and any action taken.

• Service providers are required to have a complaints procedure, setting out how people who use services or those acting on their behalf can complain about the service. This helps providers to improve the quality of the service that they provide and empowers people who use them.

• The registered person ensures that written information is provided to all service users for referring a complaint to the CSCI at any stage, should the complainant wish to do so.'

National Minimum Standards for Care Homes

For a full copy contact Telephone

• 0845 015 0120

• 0191 233 3323

Email enquiries@csci.gsi.gov.uk

Improving meals and mealtimes in the future

There has been a significant upwards shift in society’s expectations of how care should be provided. The Government’s 2006 White Paper ‘Our health, our care, our say:’ a new direction for community services promotes greater involvement, choice and control to
the people who use services. It was found that care homes that perform well are better at ensuring that what happens in the home reflects the needs of the people who live there.

Improving and developing practice needs to be matched by workforce capacity and development. Care homes that meet the national minimum standards for meals and mealtimes are more likely to have: staff that consult with the older people in their care on their needs; managers who meet the training needs of their staff; and sufficient staff numbers to support older people in enjoying their meals.

Care homes in England must register with the Commission for Social Care Inspection and are legally required to conduct their business in accordance with the Care Home Regulations 2001. Additional to the regulations, national minimum standards (NMS) are published by the Department of Health for care homes. These standards are not legally enforceable but they do identify what a care provider needs to do in order to meet the regulations.

The Commission monitors care home processes for assessing and reviewing older people’s nutrition, weight and dietary requirements as part of the inspection process. However, inspectors are not tasked with, nor qualified to, assess for malnutrition.

The Commission assesses whether care homes provide older people with “a wholesome appealing balanced diet in pleasing surroundings at times convenient to them”. The meals and mealtimes standard takes a holistic approach to meals, identifying the steps to ensure older people’s physical, social, cultural and emotional needs are met and thereby increasing the likelihood that meals will be eaten.

While nutrition and funding are undeniably important for older people in care homes, the connection between appetite and meeting people’s emotional, cultural and social needs has been largely absent from public discussions.

Some of the public comment has reflected an apprehension that, if nutritional needs becomes the sole focus of meal provision, older people will lose their ability to choose the food they like. Older people living in their own home choose what, how and when they wish to eat and drink. In care homes they largely rely on staff to make food and drinks available to them and there is a risk that older people may unnecessarily lose their independence and control over this important part of their lives.

“Most evenings, the dinner consists of sandwiches. There is no alternative, no choice. Some users would like something cooked or warm. The preferences of Caribbean service users are not taken into consideration. Very rarely there is a choice of suitable cold drinks for diabetics. They are, at times, given sugary drinks, in the absence of anything else but water. The cook is not qualified and does not understand about special diets, for example for diabetics.” (Anonymous)
Basic Care Checklist for your Residential Home

The checklist

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<tr>
<th>Question</th>
<th>Y/N</th>
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<tr>
<td>Is there a full assessment of the likes and dislikes of each older person on their admission to the care home and do staff know and act upon this assessment?</td>
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<td>Are older people actively consulted about what food and drinks are provided and their availability in the care home?</td>
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<td>Do staff have the necessary skills to discover the preferences of older people with communication difficulties?</td>
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<td>Are older people and staff involved in the development of care plans and are these plans reviewed regularly?</td>
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<td>Is the number of staff available at mealtimes sufficient to appropriately respond to the social, physical, emotional and cultural needs of older people?</td>
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<td>Is there an adequate handover during shift changes to inform staff of any changes in older people's meal needs and preferences?</td>
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<tr>
<td>Are staff adequately trained in identifying and responding to nutritional issues relating to ageing and specific health needs?</td>
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<td>Are staff aware of the importance of facilitating choice and promoting independence for the well-being of older people?</td>
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<tr>
<td>Are staff aware of the importance of cultural, social and religious practices relating to meals and mealtimes for each of person in their care?</td>
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<tr>
<td>Do staff have an adequate understanding of nutrition and hydration issues for older people, particularly for those with common health concerns?</td>
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<td>Are aids and the right crockery available to support older people in retaining as much independence as possible during mealtimes?</td>
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<tr>
<td>Are the tasks associated with the production, presentation and delivery of meals well co-ordinated?</td>
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<tr>
<td>Are staff aware of their responsibilities for meeting the national minimum standards associated with the provision of high quality meals?</td>
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<tr>
<td>Do staff have a good understanding of food hygiene standards?</td>
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Diabetes UK Careline and Advocacy Service

Diabetes UK Careline provides support and information to people with diabetes as well as friends, family and carers. We can provide information to help you learn more about the condition and how to manage it.

The Careline is staffed by trained counsellors who can provide a listening ear and the time to talk things through.

The Advocacy Service provides basic advocacy, in the form of letter writing and phone calls on your behalf, if you are having a problem with your diabetes care.

By telephone

Diabetes UK Careline: 0845 120 2960, Monday-Friday, 9am-5pm

Diabetes Advocacy Service: 0207 424 1000

By email

Send your questions by email to: careline@diabetes.org.uk.

Or advocacy@diabetes.org.uk

By post

Send your letters to:

Diabetes UK Careline/or Advocacy
Macleod House
10 Parkway
London
NW1 7AA.

Your Local Contact Details:

Central Office
10 Parkway,
London
NW1 7AA
Tel: 020 7424 1000
Email: info@diabetes.org.uk

Diabetes UK Cymru
Tel: 029 2066 8276
Email: wales@diabetes.org.uk

Diabetes UK North West
Tel: 01925 653 281
Email: n.west@diabetes.org.uk

Diabetes UK Northern and Yorkshire
Tel: 01325 488606
Email: northyorks@diabetes.org.uk
Diabetes UK Northern Ireland
Tel: 028 9066 6646
Email: n.ireland@diabetes.org.uk

Diabetes UK Scotland
Tel: 0141332 2700
Email: scotland@diabetes.org.uk

Diabetes UK Eastern
Tel: 01376 501 390
Email: eastern@diabetes.org.uk

Diabetes UK East Midlands
Tel: 0115 950 7147
Email: east.midlands@diabetes.org.uk

Diabetes UK London
Tel: 020 7424 1116
Email: london@diabetes.org.uk

Diabetes UK South East
Tel: 01372 720148
Email: south.east@diabetes.org.uk

Diabetes UK Scottish
Tel: 01823 324007
Email: south.west@diabetes.org.uk

Diabetes UK West Midlands
Tel: 01922 614500
Email: w.midlands@diabetes.org.uk

Diabetes UK Careline
Tel: 0845 120 2960
Email: careline@diabetes.org.uk

Diabetes UK Careline Scotland
Tel: 0845 120 2960
Email: carelinescotland@diabetes.org.uk
Fact Sheet

Advocacy Pack Feedback Form-

Could you please take the time to fill out this evaluation form and return it in the SAE provided? This will help us make our Factsheets more helpful and useful for future readers!

How useful did you find this pack? Very □ OK □ Poor □

What did you find most useful in the pack?
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How did you use this pack? Personally □ Professionally □

Did the pack answer your questions? Yes □ No □ Partially □

How did you hear about the pack? Friend □ Work □ Website □ Other □

What changes would you make to the pack?
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What other subjects would you like an advocacy pack on?
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