Primary Care CHECK LIST for Managing Diabetes in Care Home Residents

Developed by Professor A J Sinclair on behalf of the National Advisory Panel on Care Home Diabetes (NAPCHD) August 2022. Suggested Check-list frequency is every 6 – 12 months.

Key Considerations to Acknowledge	**Yes**	**No**
1 in 4 residents of care homes have diabetes, mainly (>90%) type 2 diabetes- be aware that type 1 diabetes can be present: continuing very poor glucose control (glucose > 15 mmol/l, ketones in urine, urgent need for insulin and predisposed to DKA.[1]		
Be aware that residents with diabetes have a high prevalence of frailty (>60%), multiple comorbidities, polypharmacy, and susceptibility to infection (chest, skin and urinary): **this will guide you in setting goals for each resident**		
Be alert to the possibility of sub-optimal nutritional status and even malnutrition in your residents with diabetes living in care homes – can be as high as 30% or more; **this predisposes residents with diabetes to infection, pressure sores, hypoglycaemia and adverse drug reactions**		
Remember that there is no strict evidence base to guide you in setting glucose targets in residents with diabetes – but try and avoid glucose levels < 6 mmol/l (remember that hypoglycaemia is a glucose < 4 mmol/l) and avoid poor glucose control (glucose > 11 mmol/l)[2]		
Key Areas to address – ***what can go wrong inside the care home?***		
Aim to agree with the resident/family, and care staff **a glucose target plan** and how often it is reviewed[3]		
Encourage care staff to inform you of those residents with continuing poor glucose control (>11 mmol/l) which can lead to fatigue, increased risk of infections, metabolic decompensation and increased risk of hospital admission		
Agree with care staff a plan for dealing with hypoglycaemic episodes (glucose < 4 mmol/l) due to overtreatment, insulin errors, poor nutrition, and developing acute illness: this will involve recording such episodes, using a 'hypo' kit or box within the care home for treatment, and reviewing glucose-lowering medication with care staff and primary care or community pharmacists: for stable control residents, this can be three monthly, and for poor control residents may need to be as frequent as weekly		
Work with care staff to ensure that each resident with diabetes has had a **nutritional assessment including a 'MUST' score**[4] in the last 6 months		
Work with care staff to ensure that **each resident have their feet inspected weekly (daily in the presence of diabetes foot disease)** and liaise closely with local diabetes specialist teams in the presence of foot ulceration		

Key Actions to improve diabetes care		
Encourage and support the care home to have a diabetes operational policy: to include 'hypo' box, foot risk assessment tool, access to training/education diabetes for care staff, screening for diabetes at admission to care home, 4-6 monthly renal function tests, diabetes audit scheme[1]		
Liaise with and support care staff to **ensure that each resident with diabetes has an Individualised care plan** including nutritional assessment and meal planning		
Where feasible and with agreement with resident/family, **aim to simplify all treatment regimens and de-intensify: avoid complex insulin regimens** and use once-daily long-acting insulin wherever feasible and appropriate in both type 1 and type 2 diabetes		
Discuss and seek an agreement with the resident/family, care staff and other relevant clinicians, **the capillary blood glucose monitoring frequency**. If the care home does not have capacity to monitor capillary blood glucose, liaise with community nurses. Aim for once – twice daily BM measures depending on staff capacity, and can be twice-weekly if control is stable. Use similar protocol with type 1 diabetes if resident is well, glycaemia is acceptable and stable, and insulin doses are stable. Use of flash glucose monitoring (FGM) is encouraged where feasible.		
A sensible and straightforward plan for glycaemic targets in the care home is: – avoid glucose levels < 6mmol/l, and aim to keep levels 6-9 mmol/l (pre-meal) and 7-11 mmol/l (2h post meal) if well. HbA1c target range should be: 53-58 mmol/mol in mild frailty; 53-64 mmol/mol in moderate frailty; and 58-69 mmol/mol in severe frailty: check HbA1c 3-6 monthly if possible		
Play a key role in liaising with care staff to **agree a hospital avoidance scheme** for residents with diabetes[5]. Encourage the use of common shared medical records between the care home, community, and hospital services to enhance management and safety		

Compliance column: Use **√** to acknowledge fact or indicate if complete; DKA: Diabetic Keto-acidosis

References

1 National Advisory Panel on Care Home Diabetes (NAPCHD), April 2022. All documents available at: NAPCHD – fDROP

2 Sinclair AJ, Gadsby R, Abdelhafiz AH, Kennedy M. Failing to meet the needs of generations of care home residents with diabetes: a review of the literature and a call for action. Diabet Med. 2018 Jun 6. doi: 10.1111/dme.13702. [Epub ahead of print]

3 See Appendix A, NAPCHD document, April 2022

4 See Appendix B, NAPCHD document, April 2022

5 See NAPCHD Main Strategic Document, Task 7d, April 2022