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Introduction to the IDN edition on older people with diabetes

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Introduction

This edition of International Diabetes Nursing focuses on older people with diabetes. It addresses some key care issues from the perspectives of experts who manage older people with diabetes. We hope the papers stimulate thought and some debate, including through letters to the editor.

Most guidelines for the care of older people with diabetes are based on the best available evidence, but they are essentially expert consensus opinion, because there is very little randomised control trial evidence to support recommendations. Evidence for best practice care in aged care homes is especially lacking. One reason for the lack of evidence is that many older people with diabetes do not meet the 'exclusionary' inclusion criteria.[1] While clinical guidelines must be based on the 'best available evidence': it is also imperative that they make clinical sense and that the content, language and design meet the needs of clinicians. That is, the content must be relevant to specific situations in which older people with diabetes receive care.

Perspectives about old age from ancient writings

There is a great deal of wisdom from ancient philosophers and healers, such as Cicero, Solon and Plato,[2] which can be summarised as follows:

- Growing older is normal and inevitable.
- The rate at which a person ages is individual and the speed at which an individual ages depends on their humours (genes and behaviours).
- It is important to plan for older age while one is young.
- Eating a healthy diet and exercising regularly are important to health.
- People need to learn something new everyday.
- People should contribute to society.
- Society has a collective and individual responsibility to take care of its older people.
- It is important to plan for the end of life.

Although diabetes was recognised in ancient civilisations, indeed, it was named in Greece, the prevalence is unknown.

Modern perspectives about old age

Diabetes is common in modern society and the prevalence is increasing.[3] The global percentage of people age 60 and older was 11.7% in 2013 and is continuing to increase to 21.1% by 2025 (International Federation on Ageing (IFA) undated). Interestingly, most of these ancient recommendations/observations are still current, although the language has changed. For example, we espouse the importance of healthy eating and regular exercise to health and fitness, and keeping mentally active to maintain cognitive function. We also regard them as key diabetes prevention strategies.

Sadly, ageing is now regarded as a disease to be cured, or at least delayed if it cannot be prevented, rather than a normal life stage. Research papers and the media frequently contain articles about the latest anti-ageing products and techniques. The focus on 'anti-ageing' engenders ageist attitudes and stereotypical, discriminatory language, which is common in many aspects of society, including in health care. Such language has negative effects on older people's self-esteem and health outcomes.[12]

Modern research has verified some traditional practices, such as the efficacy of tai chi (exercise and mind care) to maintain mobility, psychological well-being, reduce fear of falling and improve sleep and cardiac function.[4] Likewise, strength training and adequate protein in the diet help preserve muscle mass and have cognitive benefits in older people.[5] However, strength training should commence well before old age as part of preparing for older age when young because muscle mass and function decline by 5–10% from age 30 and result in sarcopaenia.[5] Sarcopaenia contributes to T2DM and diabetes exacerbates the progression to sarcopaenia and frailty and the functional and other consequences.[6] Insulin appears to protect protein synthesis in muscle in young people, but not in older people.[7]

The global imperative to plan for end-of-life care has emerged in the past 5 years, as evidenced by the frequency with which it is reported in the media and increasingly in academic publications. Reports confirm that most people want to die in their own homes, but less <10% actually do die in their place of choice.[8] Significantly, older people contribute a great deal to society through volunteer work, including the unpaid work of caring for older relatives.

Diabetes and older age

Diabetes represents an international global challenge because of the increasing prevalence and the associated

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complications.[3] Life span is increasing and more people are surviving to older age. Older age is a risk factor for diabetes due to age-related pathophysiological changes that affect glucose homeostasis as well as genetic, immune function, environmental and other risk factors.[3,7,9]

Most older people have T2DM, but modern management means people with T1DM live longer. In addition, Type 1 can be diagnosed in older age. Although the basic management of both types of diabetes is similar in many ways, there are some important differences, primarily the dependence on insulin in Type 1. Inadequate documentation of the type of diabetes can lead to inappropriately withholding insulin and preventable ketoacidosis in older people with Type 1.

People with diabetes have three to five diabetes complications and other comorbidities that affect quality of life, functional status and life expectancy.[7,9,10] Medicines are usually required to manage diabetes and its complications and comorbidities; thus polypharmacy is common; therefore pharmacovigilance is imperative.[11]

Who are older people?

It is challenging to define 'old age'. Most older people do not regard themselves as old.[12] Older age is variously described as older than 60 or age 65 and older (IFA undated). It seems 'the older one gets, the older old is!' However, chronological age is not a useful basis on which to plan care: identifying functional status and life expectancy are useful starting points.[6,10,13]

Each older person is an individual and has unique life experiences, inherited characteristics and social circumstances. They travel a lot and have a significant amount of accumulated wisdom and learned patterns associated with their diabetes and self-care that help them cope with their diabetes and other health problems. However, changed circumstances and uncertainty can cause stress and increase the cognitive load, which can affect self-care, pattern recognition and confidence. Importantly, older individual's unique values, preferences and life goals and their opinions must be known and respected.

Therefore, it is essential to tailor care to suit the individual (personalised care). To personalise care, it is essential that health professionals understand ageing, diabetes and their cumulative effects on physical and cognitive function and collaboratively develop care plans *with* the older individual, and sometimes their family carers. Such care must encompass general health and social care as well as diabetes care and be regularly reviewed.

Health professionals caring for older people with diabetes need to understand diabetes and its management as well as functional and cognitive changes that accompany older age and be able to adopt a proactive risk management approach to care that encompasses managing the medicine burden, enhancing independence, planning to stop driving, accepting help and/or admission to a care home, and for palliative and end-of-life care. Such changes need to be sensitively and carefully considered because some changes such as stopping driving and being admitted to a care home represent significant losses and can be detrimental to an individual's mental health and autonomy and lead to isolation and depression.[14]

Communication

Good communication using acceptable language is important. The impact of language on people with diabetes is described in two position statements.[15,16] Older people are a highly stigmatised group. Negative ageist attitudes, stereotypes and inappropriate language (baby talk and 'elder speak') are common in the media, society and in health care and affect health professional and 'patient' relationships. Importantly, ageist language and attitudes influence treatment decisions and drive the exclusionary research inclusion criteria (www.cib.org.yk/faqs/definitions.aspx). Ageist language also has a significant effect on the self-esteem, confidence and outcomes of older people.[12]

Focus of care

As people grow older the focus on preventing diabetes complications by achieving 'normoglycaemia' is likely to change to a focus on managing complications, promoting comfort and reducing unnecessary treatment burden.[6,10,13] Tight control in people 75 and older affects cognitive function and quality of life and significantly increases the risk of hypoglycaemia and associated adverse events, such as falls, myocardial infarction[17] and dementia.[18]

Introducing palliative care early in combination with usual care can improve outcomes, including nutrition status, physical and cognitive function and life expectancy.[8] Regular comprehensive assessments are important to identify functional and trajectory changes early and modify the care plan if needed. Such assessments should include general health assessments, including vaccination status, screening for breast and other cancers and conditions and oral health.[6,13,19]

Family carers

In addition, it is essential to monitor the health of family carers, the 'hidden patients'.[20] Family carers are at increased risk of adverse health outcomes due to the burden of care and uncertainty about the value of commencing or stopping treatment and the eventual outcome. They often lack of knowledge about how to perform diabetes self-care tasks, such as blood glucose monitoring and injecting insulin, even when they have lived with their relative with diabetes for a long time.[21] However, older people are often cared for by strangers because the family is not always able to provide care due to the demands of modern life where both partners work and children move away from home and from rural areas to the city.

Companion animals and pets

Companion animals, especially dogs and cats, are very important to many older people and sometimes they are the only family they have. A growing body of research highlights the health and social benefits of companion animals.[22,23] These include benefits in care homes and end-of-life care settings and when a partner dies. Older people sometimes find it difficult to care for their animals, for example, during illness and when their functional capacity changes. They can become very concerned about their pet's welfare and often prioritise it above their own welfare. Having to leave pets when they move to a care facility can be particularly stressful, even when the home has visiting animals.

Summary

Caring for older people is a privilege. It can be challenging, very rewarding and often sad. Older people with diabetes are unique individuals and their care must be designed with them where possible. Care must suit their individual needs, values and preferences and be regularly reassessed. It must include planning for end-of-life care. Care is often delivered by family members. The must be educated and supported. In hospitals, care homes and other care settings care must be delivered by appropriately educated, compassionate health professionals.

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