Royal Commission into Aged Care Quality and Safety

Submission from Diabetes Australia

20 May 2019

Overview

Diabetes is the equivalent of a slow motion emergency in Australia's aged care system, and little is being done to address it.

Diabetes has a serious impact on older Australians - there are currently over 669,000 people living with diabetes aged 65 years and over, and of these, nearly 200,000 people with diabetes are aged 80 years and over. It is estimated that the prevalence rate of diabetes in residential aged care ranges between 18% -34%.

Sadly, the care that this vulnerable group of Australians is currently receiving is sub-standard.

Too many older Australians with diabetes are dying prematurely. This is a situation we should be ashamed of – and we can change.

Too many older Australians with diabetes experience a very poor quality of life when this is avoidable.

Too many older Australians with diabetes are developing serious complications due to inadequate care being delivered by poorly trained staff in the aged care system.

Too many older Australians with diabetes are being overdosed or under-dosed with insulin and other medications due to inadequate diabetes management practices in the aged care system.

Diabetes Australia makes the following recommendations for action to better support older Australians with diabetes.

Recommendations

Regulatory Approach

1. Diabetes management should be clearly reflected in the Aged Care Quality Standards.
2. Standards need to be supported by detailed guidelines for the provision of quality diabetes management and care, consistent with best practice clinical guidelines.

3. Professional development and competencies in diabetes care must be embedded in the Quality Accreditation processes.
4. Provider information on adverse events and safety and quality issues and trends to be captured and reported nationally.

The Importance of the Person

5. People living with diabetes either in residential aged care or in the community need to be involved in decisions about their diabetes.
6. People in residential aged care should be supported to self -manage their diabetes if they are willing and able to do so safely.
7. People living in the community should be supported to remain in their own homes and manage their diabetes with support from affordable, accessible services.

Safety and Quality

8. An older person with diabetes in the aged care sector should have a personalised, comprehensive diabetes management plan, developed in conjunction with the older person and their key care providers (within and outside the facility, if in residential care). This plan should consist of the following:

   General diabetes care:
   - glycaemic management such as HbA1c (3- 6 monthly)
   - blood pressure
   - pathology including lipid profile, renal function, liver function
   - complication monitoring and screening for feet, eyes, oral health
   - cognitive status, depression and anxiety assessment
   - nutrition and weight assessment.

   Individualised diabetes care:
   - blood glucose target ranges
   - sick day management plan
   - hypoglycaemia risk assessment and management plan
   - standing order for glucagon for all people with type 1 and high risk type 2 diabetes.

Leadership and Accountability within the Aged Care Sector

9. Aged care providers must be accountable for the diabetes care they deliver, including sanctions when this is not the case.

10. Providers need to ensure that:
    - all people living with diabetes receive quality, planned and timely care in accordance with best practice clinical guidelines
    - skilled and qualified managers are directing care
    - training is prioritised for all staff
    - appropriate systems are in place to support the delivery of quality care
    - clinical data is actively monitored, reviewed and actioned at a facility level

Workforce Education and Training

11. Providers of aged care must ensure sufficient numbers of appropriately trained staff to deliver consistent, quality care to people living with diabetes and this should be reflected in minimum staff/resident ratios.
12. Provision of regular training for personal care staff in diabetes care including hyperglycaemia, hypoglycaemia, and healthy eating.
13. Provision of regular training for nurses in diabetes care including prevention and management of hyperglycaemia and hypoglycaemia and sick day management and healthy eating.
14. In addition to the current mandatory medication training which includes insulin, glucagon and their administration, training must include insulin action profiles, timing of doses and consideration of blood glucose level monitoring.
15. Provision of training opportunities for GPs to develop skills and knowledge in diabetes management for the older person, with a focus on blood glucose monitoring, target ranges versus reportable range and sick day management.
16. Provision of opportunities for aged care staff and GPs to increase their knowledge and understanding of new technology which is available to support in diabetes management, particularly in the areas of monitoring and insulin administration.

Access to Diabetes Health Professionals

17. Timely access to skilled diabetes health professionals is needed to support GPs and clinical staff to ensure that people with diabetes receive quality care.
18. Providers be encouraged to use external health professionals to support staff to deliver quality diabetes care.

Undiagnosed Diabetes in Aged Care Facilities

19. All new residents to residential aged care should be screened on admission for diabetes.
20. All current residents should be screened annually or sooner if symptomatic.

Introduction

Diabetes has a major impact on older Australians:

- there are currently over 669,000 people living with diabetes aged 65 years and over, and of these, nearly 200,000 people with diabetes are aged 80 years and over.
- over 191,000 Australians with diabetes are aged 65 years and over and need multiple daily insulin injections to live.

Whilst there are limited reliable figures available it is clear that there are very large numbers of people with diabetes currently living in residential and community aged care and many of these people require multiple daily insulin injections. It is estimated that the prevalence rate of diabetes in residential aged care ranges between 18% -34%.

Sadly, the care that this vulnerable group of Australians is currently receiving is sub-standard.

Too many older Australians with diabetes are dying prematurely. This is a situation we should be ashamed of – and we can change. Too many older Australians with diabetes experience a very poor quality of life when this is avoidable. Too many are developing serious complications due to inadequate care being delivered by poorly trained staff in the aged care system. Too many are being overdosed or under-dosed with insulin and other medications due to inadequate diabetes management practices in the aged care system.

The Implications

Diabetes is a serious, progressive and complex condition with significant complications such as foot ulcers and amputations, vision loss and blindness, kidney damage and dialysis, heart attacks and stroke, anxiety and depression.

Sadly, it appears that if you are old and in the aged care system, you often don't receive the care that is needed to prevent these complications.

You may be living with the foot ulcers that never heal, recurring urinary tract infections, or be regularly having falls that are passed off as happening because you are 'just old'.

Too often there is no proactive planning or risk assessment of older people with diabetes to identify the predictable problems and deliver care that prevent problems and help maintain quality of life.

Older people with diabetes, whether living in the community or in a residential aged care facility, are a high risk population. They often live with other concurrent illnesses and

experience more disability. They are also at an increased risk of hospitalisation and, when in hospital, are more likely to stay longer.

The quality of care delivered to older people with diabetes should be of the same standard provided to younger people and consistently delivered regardless of whether the person is in a facility or at home. This is currently not the case.

The quality and standard of care delivered to older Australian with diabetes is very variable. Standards of care need to be raised, and consistency improved.

This will not be achieved by one dimensional thinking. We need urgent change including:

- regulatory level action
- changing the culture and attitudes towards older Australians with diabetes
- education and training of the workforce
- proactive clinical governance and management systems

Changing the culture and attitudes about diabetes in older Australians is absolutely critical. Too often diabetes and its management are under-estimated, ignored or regarded as something to be tolerated by aged care providers.

Optimal diabetes care for older Australians, enabling them to maintain quality of life and wellbeing, should be a core focus in aged care and not an optional extra, which is how it is currently viewed.

Regulatory Approaches

Older Australians with diabetes entering an aged care facility, and their families, should not have to wonder if the staff know about diabetes, and the care they receive should not rely on chance or good luck. Diabetes care, standards and process need to be mandatory activities in the aged care sector.

There is an urgent need for minimum standards and guidelines for diabetes management to be included in the Aged Care Quality Standards. How can we expect diabetes care to be consistently managed to required standards when it is not recognised adequately within the Aged Care Quality Standards?

A person with diabetes, or their family, should have access to information which will assist them in making decisions about their future aged care provider. This should include information, data and outcomes relating to diabetes care. Aged care providers need to be transparent and accountable for the care they deliver. This is currently not occurring.

A nationally consistent diabetes care data set should be collated and reported by all aged care services. This would enable comparison and analysis of trends in safety and quality issues such medication incidents and avoidable hospital transfers. These data should be

reviewed by aged care providers and facilities and assessed in relation to ongoing continuous quality improvement activities in diabetes care.

A mandated, proactive and systematic approach to diabetes care is the first step to ensure accountability by aged care service providers and their senior management. This should include:

- individualised diabetes care plans for all people with diabetes
- risk assessments for people with diabetes for complications and problems
- proactive planning for when an older person with diabetes becomes sick with another illness and this impacts their diabetes
- mandatory staff training in diabetes
- screening of all new residents/clients for existing but undiagnosed type 2 diabetes
- access to experienced diabetes health professionals including credentialed diabetes educators and endocrinologists
- mandatory collection and reporting of diabetes care data
- mandatory reporting of adverse events related to diabetes

Refer recommendations 1, 2, 3, 4.

The Importance of the Person

Too often we see the elderly person with diabetes being made to fit the aged care system, rather than the aged care system fitting the person.

Many older Australians with diabetes have been self-managing their diabetes for a long time and they know how to monitor their blood glucose levels and what works for them.

This knowledge of the person is often disregarded or deemed irrelevant by aged care services who have a culture of "this is not how we do things here". This is clearly seen in how medications, such as insulin, are given. People with diabetes know when they need to have their insulin, but this often does not occur - despite requests. The lack of staff knowledge of how the drugs actually work and why timing is important is leading to many people experiencing adverse events such as unnecessary lows ("hypos") and unnecessary high blood glucose levels. Both are serious and can lead to falls, confusion, and loss of consciousness.

Many aged care services have less than adequate number of staff and diabetes care is delivered based on what can be provided rather than what should be provided to the individual.

> "I have encountered one facility with 60 people and only one RN so that medication rounds were started one hour before meals and some residents were receiving

their [insulin] a long time before having food. I found this out because of reports of hypos [low blood glucose levels]"

Credentialed Diabetes Educator (CDE)

In addition, families and carers often have excellent knowledge of how diabetes has been managed. It is important that they are involved in the development of a personalised diabetes management plan when their loved one moves into care. This is fundamental to quality care and yet it does not happen routinely in aged care.

"A 79 year old man with type 1 [diabetes] had been managing his insulin very well for years. He adjusted the dose depending on what he ate and his blood glucose levels. When he moved into an aged care facility, the staff took over monitoring and he was quite happy about this.

However, monitoring often took place more than half an hour after the meal or just after a snack. This then made it appear that his levels were too high. He felt very judged by staff who regularly made reference to his diet and that he must be sneaking foods. Based on the monitoring results his GP was about to increase his insulin, which would almost certainly have triggered a hypo (low blood glucose level), potentially resulting in confusion or a fall.

Luckily for the resident his daughter is a credentialed diabetes educator and had observed the timing and monitoring and alerted the GP.

This is not an uncommon scenario, where residents are not listened to, and the understanding of types, timing and monitoring of a high risk medicine such as insulin is often not well understood."

Credentialed Diabetes Educator (CDE)

There are many people with diabetes living in the community who have had to move into residential care, largely as a result of the need for assistance with insulin injections which they can no longer manage. Access to services that provide this care are sometimes unaffordable for many people and compounding this factor is that, if a nurse can visit, often the timing of these visits does not coincide with optimal times when insulin should be given. In many cases providers do not have staff who are qualified to administer insulin.

"Many older people need support with insulin injections and it is not always easy in these situations to limit the injections to once per day, especially for a person with type 1 diabetes, who is likely to require as a minimum 2-3 injections per day. It is very distressing for people to be told that they have to go into residential care purely for insulin injections. I have a patient who is an older woman who is very capable of reliably measuring her glucose levels but needs support with insulin injections. And if an affordable arrangement was available for a health professional

to attend each day, this person could stay in their own home. This is certainly not an isolated case."

Endocrinologist

Refer recommendations 5, 6, 7.

Safety and Quality Issues

Medications and monitoring

With over 191,000 people with diabetes aged over 65 and requiring daily insulin injections, the potential for harm is significant. Insulin is one of the most dangerous medications administered regularly in aged care. Although commonly used, the knowledge of aged care staff about this drug is variable at best, and often totally inadequate and dangerous.

Insulin is a complex drug with many different types available, with some fast acting and others slow acting, which can be delivered by a number of different delivery devices. Insulin therapy requires regular dose adjustment and staff administering insulin must have an understanding of how insulin works in the body and its impact on the individual.

Too much insulin or not enough insulin and a person will experience a dangerously low 'hypo' or a high blood glucose level. Both are equally dangerous and can lead to confusion, falls and unconsciousness and sometimes death.

Too many older Australians with diabetes are experiencing unnecessary high and low blood glucose levels putting them at greater risk of confusion and falls, and at worst creating a potentially life threatening situation.

We know that the potential for harm from insulin and diabetes medication mismanagement is significant, yet the following practices are not uncommon:

- the wrong insulin given, the wrong dose given, the insulin given at the wrong time
- inappropriate omission of insulin doses
- staff have limited or no knowledge of how to use injection devices or simply use the wrong injection device
- staff making insulin dose adjustments without appropriate clinical guidance
- glucagon injections are not readily available
- staff have limited understanding of oral diabetes medications - including when to use, what to use, monitoring and risks

Each person with diabetes will have different blood glucose target ranges for what is best for them. The priority for most older people is a target range that enables them to maintain

good quality of life and remain safe and avoid predictable problems like dangerous highs and lows.

Many older Australians with diabetes are at risk of low blood glucose levels or hypoglycaemia ("hypos"). Hypoglycaemia can occur for a number of reasons, including food intake or lack of it, or activity, and dosage of insulin and other medications. Despite this, many aged care services do not undertake or document a hypoglycaemic risk assessment and plan for each person. This is essential to providing appropriate monitoring and timely care to individuals.

'Hypo' treatment kits are often not readily accessible for staff throughout the whole facility, or when the person goes on excursions, or during activities.

Many non-clinical staff are not trained in hypo management.

Many facilities do not have ready access to glucagon, an essential medication. Glucagon is an injectable medicine used to treat severe hypoglycaemia. Common excuses for not having glucagon available include "it goes out of date" and "if we need it, we get it from the pharmacy". This is unacceptable care - when a person with diabetes needs glucagon for severe hypoglycaemia, they need it immediately.

Glucagon should be a standing order on medication charts for all residents with type 1 diabetes and for those with type 2 diabetes assessed as high risk for hypoglycaemia. It should be readily available with a clear hypo management pathway clarifying when it is indicated.

Too often, in aged care services, GPs adopt the approach of maintaining an older person's blood glucose levels consistently in a high range under the mistaken belief that it is better for the person "to run a little bit high rather than too low". This is very poor practice and often means the person consistently feels unwell and has a poor quality of life.

Too often in aged care services, GPs set a 'reportable range' in relation to blood glucose levels. These ranges are often very wide and it is not unusual to see ranges set between 3.5mmol/L and 20mmol/L. This is poor practice and not recommended in any evidence based guidelines. The McKellar Guidelines recommend a reportable range between 6-15mmol/L.

The practice of intentionally letting the older person's blood glucose levels run high often results in the older person feeling consistently unwell and also leads to largely preventable incidents such as falls, poor wound healing and infections.

> "I was asked to consult on a patient admitted to hospital whose aged care facility had included his care plan in the admission. It stated insulin to be administered when BGL is greater than 20mmol. [this is very high]. This man was admitted with an infected foot ulcer and was facing amputation. This was particularly upsetting as

> this was very poor management of his diabetes and would have been a major contributing factor to amputation and death post-operative."
>
> Endocrinologist

'Reportable' blood glucose ranges like that outlined above are not recommended and are not appropriate. Evidence based practice supports adopting a 'target range' that supports good health and wellbeing, not a 'reportable range' that promotes ill health for convenience of the service provider.

Using a blood glucose 'target range' for each individual would enable staff to respond to blood glucose readings outside this target range in a timely fashion, therefore preventing a person becoming very unwell before a GP is contacted. This will also prevent an older person having to experience unacceptably high blood glucose levels for a long period of time.

Too often there is no monitoring or inappropriate blood glucose monitoring in residential aged care and again, too often, there is no action taken when glucose monitoring has revealed dangerously high or low levels.

> "As a credentialed diabetes educator working in an acute facility, I was frustrated by the admission of patients from aged care with poorly managed diabetes resulting in distress and in unnecessary complications when dangerously high or low BGLs were sustained over long periods of time"
>
> Credentialed Diabetes Educator (CDE)

> "Staff in the units I see are very diligent in taking BGLs. However they do not use this information to have the meds reviewed or looked at, as I am told - 'that is what they always sit at."
>
> Credentialed Diabetes Educator (CDE)

Lack of proactive and preventive action in regard to blood glucose management in older people appears to be common practice with many GPs and aged care facilities. This should not be acceptable and is not consistent with evidence based clinical guidelines.

When an older person with diabetes gets sick with another illness, for example with an infection or gastrointestinal problem/vomiting, they are at increased risk of having high or low blood glucose levels and it is very important that they are assessed and monitored regularly, as this can quickly become a serious event. This might mean the person will be transferred to an acute care hospital, which can be enormously stressful particularly for those with dementia or cognitive issues.

Too often in aged care services there is no plan for dealing with concurrent illnesses. This is despite the fact that this is predictable, and many problems are preventable if timely action is taken.

Too often there are no documented protocols in place as to what assessment, monitoring and treatment should take place for that older person with diabetes if they become unwell, or at what point to call the GP.

Instead, there is reactive care – as though this is a surprise event!

There should be a simple, documented plan, prepared in advance in consultation with the GP and the person/family, for what actions are needed when a concurrent illness or problem occurs. This would not only prevent hospital transfers and escalation of distressing problems for older people, it would save time and stress on both the resident and staff dealing with the situation.

Too often, the decisions on actions taken, or not taken, are made by the staff who happen to be working at the time, and in the absence of a plan. There is wide variation in staff knowledge including agency staff. At night, when access to the GP is often problematic, it is highly likely that the person may be transferred to hospital due to lack of staff training and lack of a plan.

The aged care system desperately needs a change in approach towards proactive and preventative care that enhances quality of life. Currently an enormous amount of energy and time is spent reacting to situations that, with forward planning with the GP, staff and the older person/family, could be prevented.

Healthy Eating

Healthy eating options for older people with diabetes should be no different from older people without diabetes.

Too often in aged care services there are outdated and restrictive dietary practices and language. People with diabetes are often referred to as 'diabetics', labelled by their condition, and often provided with limited dietary options.

People with diabetes should not be labelled as "diabetics" and their diet/eating should not be labelled and restricted in this way. Each older person with diabetes should have an individualised healthy eating plan that suits them and their diabetes.

Many services lack contemporary understanding of suitable healthy eating for older people with diabetes, often providing a limited menu, labelled as a 'diabetic diet'. It is not uncommon for a person who does not follow their 'diabetic diet', to be referred to as 'non-compliant'.

Sometimes older people forget to eat or eat very little at some meals and might have 'extra treats' at others. This needs to be monitored and considered by staff. The impact of timing and the amount of food eaten is important in relation to medications such as insulin and some oral medications, and avoidable low blood glucose levels and poor quality of life.

Refer recommendations 8, 11-16.

Leadership and Accountability within the Aged Care Sector

It is a reasonable expectation for older people living with diabetes and their families that all aged care facilities will provide quality diabetes care.

Every aged care facility or service should have plans, policies, protocols, medications, equipment and trained staff in place to ensure the highest standard of care is delivered.

This is currently not the case, despite all aged care facilities operating under the same regulatory and funding models. Some providers deliver a high standard of diabetes care, yet far too many do not. What we often hear, when standards of care are clearly poor and problems very obvious, is that more trained staff are needed. We agree! More staff and better training are needed.

However, increased staffing and training are only part of the way to address and ensure the delivery of quality diabetes care for older Australians. What must occur, as matter of priority, is that diabetes must be taken more seriously and governance and management systems put in place to ensure accountability in the delivery of optimal diabetes care.

There is a desperate need for stronger leadership, management and planning skills within aged care services if the current reactive culture is to change. The focus must shift to one where planning, proactive and preventive care, and continuous review of an individual's diabetes care and wellbeing is the priority.

There is a tendency in many facilities to see planning for care in diabetes as something "we just don't have time for".

Planning for diabetes care needs must be prioritised, undertaken and reviewed regularly as a fundamental clinical activity. This has to be a deliberate change in culture, driven and modelled by senior management with the necessary skills to support staff at the coalface.

There are too many instances of poor communication, a lack of plans, protocols and systems and little commitment to training.

With little effort put into ensuring appropriate clinical plans, protocols and systems are in place for people with diabetes, and limited understanding of the importance of clinical governance, it is no wonder that care outcomes for older people with diabetes are suboptimal.

It appears that in many aged care facilities 'being busy' is the main business – with little recognition that planning care and a systematic approach can reduce 'busy' and deliver far better outcomes for people.

Senior managers need to be accountable for the care provided and they need the management skills to deliver it.

Refer recommendations 9, 10.

Workforce Education and Training

Personal care staff

Whether a person is residing in an aged care facility or is being supported in the community, personal care staff are often the ones with whom they have the most contact. These staff are the eyes and ears and in close contact with residents and as a result in a unique position to notice things that will impact on a person's wellbeing. In the case of diabetes, this might be observing the type or quantity of food and drink eaten, seeing signs that the resident is acting 'out of character', thirst, giddiness or noticing a red mark on their foot when assisting in the shower. All these are important signs that the resident's diabetes management should be investigated.

The role of a personal carer for someone living with diabetes is a crucial one. It is vital that these staff understand and recognise how diabetes may affect people and know how to respond and report issues of concern. This will have a significant impact on improving quality of care for people living with diabetes and helping to prevent adverse events such as falls and complications such as foot ulcers.

There is an urgent need for providers to prioritise training for these staff. We have heard many instances where personal care staff are expected to attend training in their own time and in so many instances this comes back to the value that is placed on their contribution in caring for the elderly. In addition, we have a carer workforce where 60% of personal care workers are born overseas, with English not being their first language.

Registered and Enrolled Nurses

Enrolled and registered nurses in the aged care sector need to be a supported to access regular training opportunities and these should include topics such as managing low blood glucose levels, looking after a person with diabetes when they are sick, medication management and healthy eating.

Registered nurses need regular training and updates on insulin, glucagon and their administration as part of mandatory medication training. This training must also include

insulin action profiles, timing of doses and consideration of blood glucose monitoring to assess effect. If this training is not mandated, we will continue to see the poor and sadly avoidable adverse incidents which so commonly occur.

GPs

Provision of training opportunities for GPs in diabetes management in older people is needed, as clinical management of diabetes can be variable. Providing GPs with opportunities to develop their skills and knowledge in diabetes management of the older person may help dispel some the myths which appear to be guiding some current practice. Allowing older people to remain at totally unacceptable blood glucose levels for extended times under the mistaken belief that it's "better to be high", is an area needing urgent education and attention for some GPs.

Impact of technology

New technology to support people living with diabetes is developing at a rapid rate. There are less intrusive blood glucose monitoring devices and access to technology such as insulin pumps and Continuous Glucose Monitoring devices is becoming more widespread.

Aged care providers are beginning to see new residents using technology that is unfamiliar to many staff caring for them. This is very concerning as simple devices such as insulin pens are often misused, so something more complex such as an insulin pump, if not used correctly, can have disastrous consequences. This has implications for education and training for both facility and community staff and GPs, as this new technology will become much more common.

Refer recommendations 3, 11, 12, 13, 14, 15, 16.

Access to Diabetes Health Professionals

Diabetes is a serious, progressive and complex condition and a person with diabetes needs a team of people to support them to manage their condition. This support can have a significant impact on quality of life, prevent complications and reduce unnecessary transfers to hospital.

With diabetes, care needs to be individually tailored. It is important, especially for an older person who may have multiple comorbidities, to have regular reviews by diabetes health professionals.

Nurses in aged care are not the best equipped to carry out more complex diabetes management. People may not be able to access their GP in a timely way and as noted, GP skills in diabetes management are sometimes variable.

Timely access to a team of skilled diabetes health professionals is necessary to support GPs and clinical staff to provide quality diabetes care for the elderly. Sadly, the well evidenced team approach to diabetes management is not generally seen in the aged care sector.

Input from a skilled diabetes health professional such as a credentialed diabetes educator, when planning or reviewing care, assists aged care staff to deliver consistent, best practice and individualised care. Early input helps providers move to planned rather than reactive care, with better health outcomes. Like pharmacist medication reviews, there is an opportunity to have credentialed diabetes educators involved in the development and review of diabetes care plans.

While many aged care facilities have ongoing arrangements with allied health professionals, such as physiotherapists, occupational therapists and podiatrists to assess and review residents, the involvement of credentialed diabetes educators is very limited.

This is surprising given the prevalence of diabetes in this age cohort. Again, this is a clear example of where diabetes management sits in the hierarchy of care and the lack of understanding of the implications of diabetes.

GPs can make a referral to a credentialed diabetes educator as part of a Chronic Disease Management Plan. However, this referral is limited to 5 sessions annually and is often used to access podiatry services. Even if this was not the case, GPs and facilities often are unaware of where and how to access credentialed diabetes educators and then limited by their availability and cost.

In residential care, there is a desperate need for access to skilled diabetes health professionals, to support GPs and clinical staff to deliver quality care.

In consultation with the GP, access to diabetes health professionals such as credentialed diabetes educators, nurse practitioners and GPs with specialised skills in diabetes management could greatly contribute to better care in instances, where complex clinical issues arise and timely advice is needed or to arrange access to endocrinologists, geriatricians and palliative care specialists as needed for specialist advice.

Refer recommendations 17, 18.

Undiagnosed diabetes in aged care facilities

Increased age is a risk factor for type 2 diabetes. Undiagnosed diabetes accounts for approximately 30% of all people living with diabetes. Type 2 diabetes can be largely asymptomatic when it first develops. We know these three things and yet routine screening for type 2 diabetes on admission to aged care, or routinely after admission, is not common practice.

These older people are at an increased risk of falls, infections and a poorer quality of life which could be reduced if this relatively simple screening (and appropriate management) occurred as part of standard care offered.

This again reiterates the limited understanding of diabetes and its implications by staff and ultimately providers.

Refer recommendations 19, 20.

Recommendations

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