End of Life Care for People With Diabetes

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The size of the problem…

- 15 million living with a long term condition
  (DH, 2010)
- Nearly 3 million people with diabetes
  (Diabetes UK, 2011)

The size of the problem…

- More than half a million people die each year (DH,2008)
- 6-9% have diabetes (Rowles et al, 2011)

Preferred place of care

- Most deaths occur in institutional settings
  - 58% hospital
  - 18% home
  - 17% care homes
  - 4% hospices
  - 3% elsewhere

Palliative care for all?

- Equitable (DH, 2008)
- An international human right

  (Gwyther et al, 2009)

Palliative care for all (2)?

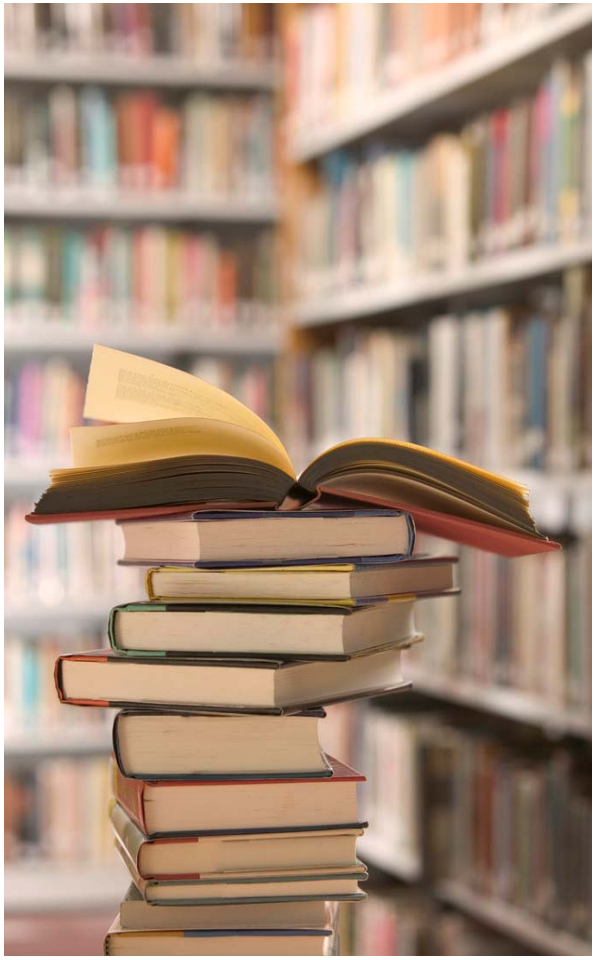
- Over half of complaints associated with end of life care (CHAI, 2007)
- Only 5% SPC provision patients with non-cancer diagnosis
  (Payne et al, 2004)

Palliative & end of life care

- An approach to improve quality of life - not restricted to end of life
- Care of the dying

Palliative and end of life care and diabetes mellitus

- ‘Challenge’ (Budge, 2010)
- ‘Complex’ (McCoubrie et al, 2005)
- ‘Inconsistent’ (Ford-Dunn et al, 2006)
- ‘Different’ (McPherson, 2008)
- Uncertain (Angelo et al, 2011)



Case studies – group work

The ‘surprise’ question

‘would I be surprised if this patient died in the next year?’

Type 1DM

- Continue insulin with preferentially simplified regimen
- Refer to specialist diabetes team

Type 2 DM

- Avoid hyperglycaemia
- Note affect of steroids and infection
  - Correcting hyperglycaemia justified
- If anorexic
  - discontinue oral hypoglycaemic medication
- Insulin may be discontinued
  - Reinstate if symptomatic

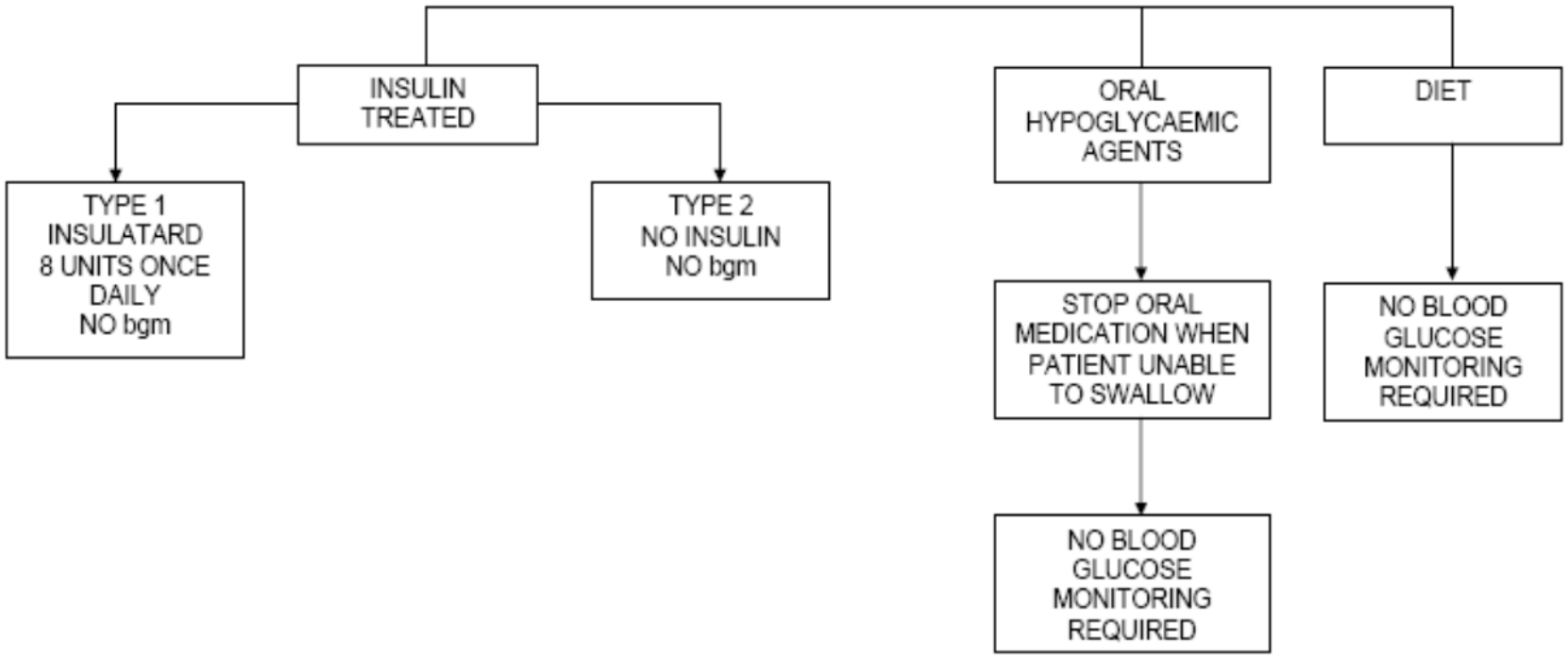
DKA / Hyperosmolar hyperglycaemic state

- DKA occurs in T1DM & T2DM
- Hyperosmolar hyperglycaemic state
  - Older patients T2DM
  - Associated with significant mortality
  - Good teamwork essential
- Change focus of hope and coping to QoL

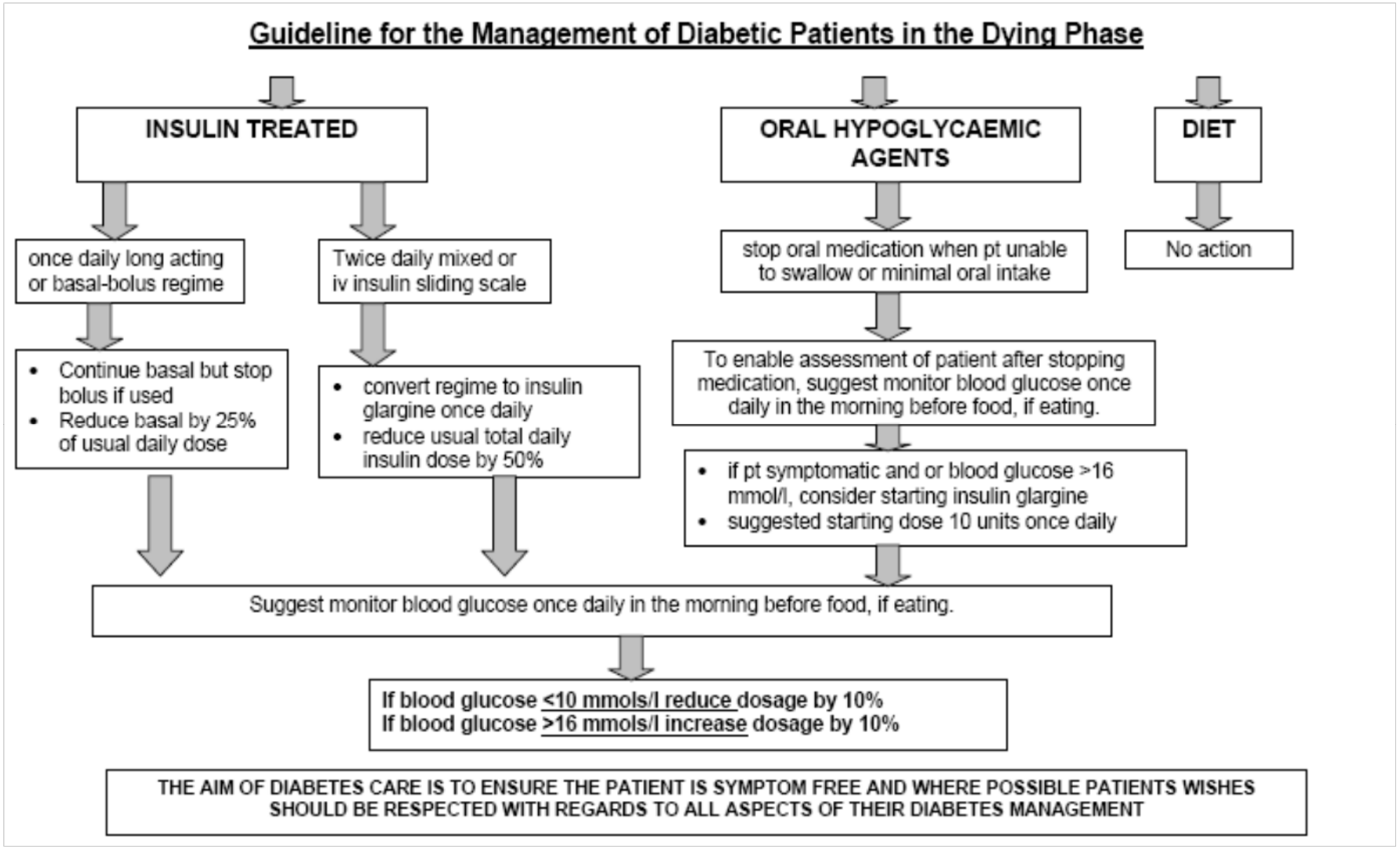
Control

- ? Daily blood glucose monitoring
- ?Aim for 5 – 15 mmols
- Relaxing control, may be difficult for:
  - Patient
  - Relatives
  - Staff

GUIDELINES FOR THE MANAGEMENT OF DIABETES FOR PATIENTS ON Liverpool Care Pathway



Luton adapted pathway



Bullet Points for New Clinical Solutions

- Advanced disease but relatively stable
  - Continue current regimen, if possible
  - Prevent hypoglycaemia & hyperglycaemia
  - Cease HbA1c
  - Reduce frequency BG monitoring
  - ‘Pleasure based’ diet
- Impending death
  - Reduce medication
  - Cease BG monitoring (T2DM), decision-making tool only (T1DM)
- Actively dying
  - Lack of consensus
  - Open realistic communication, anticipation, preparation for preferred place of care