a TEAM approach TO...

Care of the Elderly

The American Association of Diabetes Educators combines a diversity of professions and practices in its membership. To focus on the special contributions of each discipline a common diabetes management or educational problem will be addressed periodically, using a team approach.

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Case Description

Mrs. M is an 80-year-old widow with diabetes mellitus, organic brain syndrome, arteriosclerosis, and osteoarthritis. She was placed in a nursing home three years ago because she was unable to care for herself and her children could not provide her with the supervision and care that she needed. Over the past six months, Mrs. M has had a weight gain of ten pounds and required both a gradual increase in her insulin dose and diet changes to maintain her blood glucose between 200-300 mg/dL. Yesterday her fasting blood glucose was 410 mg/dL. She has signs of increased appetite, urinary frequency, and increased confusion. She is 5'3" tall and currently weighs 160 pounds. Her treatment orders are for 20 units NPH and 10 units Regular insulin every morning, 1000 Calorie ADA diet, and urine glucose testing once daily.

Problem Identification

This is an elderly diabetic nursing home resident who shows signs of poor diabetes control despite recent changes in her medical management. Since Mrs. M is dependent upon others for her care, a plan of action for staff and family is needed to improve her diabetes control.

Team Planning

The nursing home staff has convened a patient care conference. The team attending the conference consisted of a staff nurse, social worker, consulting dietitian, and nurse consultant. All team members have previously assessed Mrs. M during her nursing home stay. Following the discussion by nursing home personnel, Mrs. M's physician will be contacted.

Staff Nurse (Doris Hanan, RN, Asbury Circle Nursing Home, Denver, Colorado)

The nursing staff is concerned about Mrs. M's increased appetite and subsequent weight gain over the past six months. We are having difficulty in limiting the amount of Mrs. M's food intake to her 1000 Calorie ADA diet. She usually eats 80% of her meals and evening snack. In addition, the nurse aides report that she begs them for food and frequently "trades" food with other residents. Efforts to discuss her diet with her have been unsuccessful due to her confusion. Over the past few months she appears to be less in touch with reality and often recalls her early life in her native country, northern Italy.

Mrs. M's children and grandchildren visit her regularly, usually in the early evening. They often bring in Italian pastries which Mrs. M seems to enjoy. When the staff remind the family about her diabetes and special diet, they comment that, "She is 80-years-old and food is one thing she enjoys."

Mrs. M's urine sugar has been fluctuating between negative and 1/2%. We test her urine in the morning when we can get a specimen.

Consulting Dietitian (Suzanne Pecoraro, RD, MPH, Diabetes Control Program, Colorado Department of Health)

Past records show that Mrs. M's diet was reduced to 1000 calories (from 1500) when she began gaining weight. Perhaps this change did not take into account her likes and dislikes. A consultation with Mrs. M and her family to identify some of her favorite foods (especially ethnic) to be worked into her diet is the first step. The diet can also be changed to small servings with a calorie range of 1000-1200 and include an afternoon snack and evening snack. The diabetic diet should meet the patient's social and psychological needs as well as provide therapy for the disease entity. Providing the diet in small servings, with calorie reductions in fat calories, rather than carbohydrate and protein, is often more flexible than adhering to strict serving sizes and may improve patient acceptability of the therapeutic regimen.

Nurse Consultant (Sharon L. Michael, RN, MS, Diabetes Control Program, Colorado Department of Health)

I recommend more frequent monitoring to identify Mrs. M's blood sugar fluctuations throughout the day in relation to her inconsistent eating habits. This information is critical for modifying her medication or diet. Ideally, monitoring should be done by capillary blood glucose testing so that the nursing staff will have immediate results. These are more accurate than urine tests in an elderly person with a high renal threshold. If capillary blood monitoring cannot be done, her urine sugar should be tested at least four times daily. However, this could be a problem if specimens are difficult to obtain.

An inserfice for the nursing staff would also be useful. The nurse aides are responsible for observing and recording Mrs. M's food intake and may have some effect on controlling her eating between meals. The aides should be taught the role of the diet in diabetes control and to observe and record the composition and timing of food intake.

Clinical Social Worker (Carol M. Lewis, MSW, LSWI, Westside Neighborhood Health Center, Denver, Colorado)

I would focus attention on Mrs. M's family. Their regular visits tend to revolve around food; particularly, Italian pastries. The cultural issue regarding the importance of food, as well as the fact that centering their visits around food, seems to make the time spent more tolerable and less depressing.

A meeting with the family to explore their feelings about Mrs. M's condition, her placement, and their visits is needed. Several alternatives to bringing in pastries could be suggested. On occasion, they could schedule their visits at meal times so that food they bring can be substituted for her regular meal. The staff should be available to assist them in selecting foods that would be more in line with her diet. At times, Mrs. M would benefit by being taken out for a walk, to the park, or to their home for a visit. They could even bring small gifts, e.g., flowers or candles, to Mrs. M. For these changes to occur, the entire staff will need to offer the family encouragement and support.

Plan of Action

At the end of the conference, the following plan of action was formulated: The staff nurse will: 1) contact the physician to discuss the plan of action and request orders for capillary blood monitoring; 2) initiate frequent monitoring. The dietitian will: 3) assess Mrs. M's likes and dislikes; 4) modify the diet to small servings with two snacks. The nurse consultant will: 5) present inserfices for the nursing staff. The social worker will: 6) meet with family to discuss alternative approaches; 7) offer the staff suggestions for providing support to the family.

Follow-up

The physician agreed with the plan of action and ordered capillary blood glucose monitoring. Testing was done four times daily until her blood sugar was stabilized.

By providing some of her favorite foods in the diet and an additional snack, Mrs. M's adherence to the diet improved. Inserfices were held for the nursing staff covering diabetes management with emphasis on the importance of the diet. The nurse aides began recording their observations.

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