

JBDS-IP Generic Approach to Managing Diabetes (type 1 and type 2) and Frailty Detected at Admission

Functional Assessment

- Establish history of any prior loss in function
- Liaise closely with OT and physio
- Undertake ADL/IADL scores
- Measure CFS or FRAIL score at admission and at 3 days
- Align IP glucose target levels with frailty category

Glucose Management

- Categorise Mild Frailty
- Categorise Moderate - Severe Frailty
- Acute illness
- Random Glucose - Mild F 7.5 - 10 mmol/l
ModF-SF 7.5-12 mmol/l

- Promote IP self-diabetes care if possible
- Measure HbA1c and gauge control over previous 2 months
- Avoid BGL <4.0 and >15 mmol/l
- Measure ketones in acute illness and be alert to DKA
- Consider DPP4-I as a first choice for treatment if necessary
- Consider basal insulin plus bolus correction for persistent BGL >12 mmol/l
- Consider CGM for acute

Managing Comorbidities

- Dementia / delirium
- Falls
- CKD
- Acute Stroke

- Assess cognitive function to ensure compliance with therapy and reduce risk of 'hypos' – see Appendix 3
- History of falls requires liaison with geriatric medicine service and/or physiotherapy to have a falls risk assessment
- Refer to Acute Care Toolkit 3 (RCP) for acute care advice in comorbid illness - see Appendix 2
- Liaise with DIT in the presence of stage 3b or above CKD; assess 'hypo' risk from existing GLT
- Frailty is present in 1 in 4

Preventing / Managing Hypoglycaemia

- Assess nutritional status using MUST tool
- Monitor BGL at least 2x daily
- Review pre-existing GLT
- Consider CGM if frequent 'hypos'

- Optimise treatment of acute illness
- Avoid GLT with a high risk of hypoglycaemia
- Simplify insulin regimen
- Avoid overtreatment and consider de-escalation using STOPPFRAIL – see Appendix 1
- Liaise with inpatient dietitians for meal planning
- Examine CGM traces to identify out of range glucose levels and

Pre-Operative Care

- Elective surgery or Emergency surgery
- DIT to agree target levels of glucose with surgical team for each stage of surgery
- Immediate referral to DIT if HbA1c >69 mmol/mol or if on insulin pump or CSII
- Liaise with DIT and pharmacist for any pre-op medication/GLT

- Be aware of JBDS-03 document and CPOC/Academy of Medical Royal Colleges document*: [CPOC-Diabetes-Guideline2021_0.pdf](#)
- Involve diabetes IP team at all stages of surgery: immediate referral if HbA1c > 69 mmol/l or on insulin pump or CSII
- The aim is to optimise glucose control at all stages of surgery
- Pre-op and post-op medication plans in place

Managing functional status

- Physiotherapy and OT assessment
- Optimise nutritional status/prevent weight loss
- IP exercise including RT and balance training
- Prevent de-conditioning

- After acute illness, agree an IP exercise and rehabilitation plan with PLWD/nursing and OT/Physio
- Exercises based on strength training including resistance training, and stretching/flexibility training should be considered
- Focus on maintaining nutritional status, preventing weight loss and lower limb muscle loss
- Avoid deconditioning which can increase the severity of frailty
- Be aware that deconditioning

Discharge Planning

- Start procedure early
- Arrange social needs assessment
- Repeat functional assessment before discharge
- Agree glucose BP targets with patient and home requirements