REGIONAL LOCAL HEALTH NETWORKS

Protocol (clinical)

Title: Diabetes Assessment and Education

Author: Rural Support Service – Diabetes Service

Sponsor: Chief Clinical Advisor, Rural Support Service

Approved by: BHF LHN Clinical Council Governance Committee on 23/11/2021:
EFN LHN Universal Care Governance Committee on 23/11/2021:
FUN LHN Operational Governance Committee on: 24/11/2021
LC LHN Safety, Quality and Clinical Effectiveness Council on: 16/02/2022
RMC LHN Clinical Oversight Committee on: 17/02/2022
Y&N LHN Operational Clinical Governance Committee on: 12/01/2022

Next review due: 8/12/2023

Summary This protocol outlines responsibilities and actions required by diabetes specialist nurses to ensure the safety and quality of patient care.

Policy/procedure reference This protocol supports the SA Health, South Australian Medical Record Documentation and Data Capture Standards, SA Health, Clinical Handover Guidelines and SA Health, Recognising and Responding to Clinical Deterioration Guideline.

Keywords Clinical, Protocol, LHN.

Document history Is this a new LHN protocol? **N**

Does this protocol *amend or update* an existing protocol? **Y**

Documentation guide for diabetes services 2019-13020

Does this protocol *replace* an existing document? **N**

Applies to This protocol applies to all diabetes specialist nurses working in the regional LHN diabetes services.

Objective file number 2021-02643

Version control and change history

Version	Date	Amendment	Amended by:
1.0	01/04/2014	Original version	Jane Giles
2.0	08/12/2020	Continuous subcutaneous insulin infusion and continuous glucose monitoring updated	Jane Giles
3.0	25/08/2021	Paediatric pathway updated	Jane Giles

Table of contents

1. Purpose and scope of use

Clear, relevant and accurate documentation provides a summary of the assessment, on-going care and education of the person with diabetes. It is also a method of communicating details about the care with other health care professionals and is a medico legal requirement.

Documentation refers to all forms of information that has been recorded in a professional capacity and is a fundamental part of clinical practice. It demonstrates a clinician's accountability for the service they provide and a record of their professional practice.

The aim of this document is to improve clinical communication, provide a structured and standardised approach to documentation for diabetes services and to ensure consistency across all regional local health network (LHN) hospital and health services sites.

Effective documentation should be;

- clear, concise and accurate
- contemporaneous with the events recorded in chronological order
- complete
- comprehensive
- collaborative and person-centred
- confidential.

Documentation can be made up of;

- written and electronic health records including email and faxes
- audio and video tapes
- images such as photographs and diagrams, tables and downloads
- observation charts and checklists
- communication books
- incident reports
- clinical anecdotal notes or personal reflections (e.g. held by clinicians personally).

Appropriate documentation promotes;

- a high standard of care
- continuity of care
- improved communication
- an accurate description of the care provided
- goal setting and evaluation of care
- early detection of problems and changes in health status
- evidence of care provided.

Documentation should be able to demonstrate;

- a full report of the clinical assessment, the care provided and future care planning
- information related to the persons condition and any interventions/actions taken to achieve health outcomes

- evidence that the clinician has met their duty of care and has taken reasonable actions to provide the highest standard of care.
- a record of all communications with relevant health professionals.

1.1 Minimum standards for documenting diabetes education

The following minimum standards for documenting a diabetes service have been developed to assist diabetes specialist nurses (e.g. credentialled diabetes educators (CDE) or diabetes educators (DE)) to produce high quality nursing notes. There are clinical and corporate risks if the diabetes service documentation is not adequate.

- Clinical risks such as inadequate or incomplete documentation about the persons' occasion of service impede communication and, also diminish the specialist nursing role. This may lead to errors in assessment, and/or delays in treatment which adversely affects the outcome for the person with diabetes.
- Corporate risks such as poor or inadequate documentation could affect outcomes of legal proceedings.

Standard 1

To maintain accurate and confidential records of clinical care including;

- documenting the outcomes of the clinical assessment and ongoing care recommendations for each person
- providing the assessment and care plan information to the person with diabetes and/or their family/carer.
- ensuring that persons information is made available in a timely manner to all relevant health professionals
- safe and appropriate storage.

Standard 2

Written education entries should be timely, objective, person centred and include;

- a description of the assessment, problems areas, patient priorities and services provided
- the method(s) used for education (e.g. written, visual, verbal, auditory and any instructional tools that were used as part of the session)
- information about the involvement of and interaction between the person and/or their family/carer during the education process
- evaluation of the learning objectives (e.g. evidence of the person's comprehension and learning, attainment of behavioural goals)
- a documented education plan for follow up visits
- explanation of any referrals made.

Standard 3

Documentation provides evidence that the person's needs were assessed, and that the education plan was documented in collaboration with the person. It should demonstrate that education was tailored to the person's intellectual, social, psychological, spiritual, and cultural status.

Standard 4

Documentation must fulfil legal requirements;

- consultations need to be written ‘defensively’ (e.g. written in a way that explains the decisions that were made)
- ensure that documentation gives an accurate account
- documentation should be a continuous narrative that describes how the CDE/DE has dealt with the various issues
- outcomes of the occasion of service should be documented.

Standard 5

Evidence that the CDE/DE worked collaboratively with the referring practitioner, other members of the diabetes care team and the person to establish agreed clinical targets.

Diabetes Service documentation will support the process;

1. patient assessment
2. plan of care
3. subsequent visit/s and progress
4. discharge (e.g. type 2 diabetes).

1.2 Documenting the patient assessment

As a minimum the following information should be documented at an initial appointment:

- date and time of occurrence of service
- relevant history of the illness
- relevant physical examination, assessment findings and diagnosis
- treatment options and treatment given e.g. clinical observations results of treatment, and medication prescribed
- diagnostic and therapeutic orders/plan
- signature, surname and initials, and designation of the clinician.

Key aspects of the initial diabetes assessment can be documented using the *Diabetes Assessment Form (MR-DAF)* or the *Diabetes in Pregnancy Assessment Form (MR-DIP)*. Alternatively, documentation in long hand in the case notes (see below for examples of headings that can be used in the notes) can be made. Note: If an assessment form is used it is still a requirement to make an entry in the case notes.

Initial consult – case note entry

Diabetes service assessment

- referral source and reason
- preferred name and age
- type of diabetes
- date of diagnosis

- current signs and symptoms
- recent illness/hospitalisation.

Concerns

- person with diabetes understanding of purpose of the appointment
- how are they feeling about their diagnosis? Do they have concerns, questions?
- accompanying family members and/or carers.

Diabetes management

- management – prior and current (including diabetes medication)
- previous diabetes services and education.

Psychosocial

- mental health
- marital status, social supports/significant others
- living arrangements
- independence level with ADLs/ community services
- driving
- occupation or school year level
- cultural considerations
- barriers to learning (e.g. language, memory deficits, religion)
- areas of concern (e.g. financial).

Relevant medical and surgical history

- include relevant history including mental health, family history of cardiovascular and / or early death (<60 years)
- pregnant, planning a pregnancy
- immunisations
- allergies/alerts
- hearing or visual deficits, immobility and/or limitations to physical activity.

Diabetes complications/cycle of care

- micro – retinopathy, nephropathy, neuropathy
- macro – CHD, CVA, PAD
- oral health and sexual health.

Medications

- prescriptive
- over the counter and complementary medications
- illicit substances.

Anthropometry

- weight, height, BMI, goal weight
- pathology tests (e.g. HbA1c/ lipids/microalbumin/eGFR/AER/liver function)
- blood pressure
- blood glucose (BG) level
- blood ketone (BK) level.

Foot assessment (refer to *regional LHN Diabetes foot assessment chart)*

- circulation and sensation
- self-care and footwear.

Lifestyle

- smoking
- alcohol
- nutrition (e.g. meals/snacks, carbohydrate intake, special considerations)
- physical activity/sedentary behaviour (e.g. type, frequency, duration, weight loss goal)
- driving (e.g. car, heavy vehicle).

Focused assessment

- fingers used for capillary blood monitoring
- sites used for continuous glucose monitoring (CGM) and flash glucose monitoring (FGM)
- injection or continuous subcutaneous insulin infusion (CSII) site used (e.g. site rotation, evidence of lipodystrophy)
- specific body system(s) relating to the presenting problem or other current concern(s).

Self-care assessment, management and education planning (based on risk factors and current need

- pathophysiology of type 1/type 2/gestational diabetes mellitus (GDM)
- management requirements/options
- oral hypoglycaemic agents (e.g. metformin/sulfonylurea/thiazolidinedione/DPP4 inhibitor/acarbose/SGLT2 inhibitor) profile
- GLP1 profile
- insulin profile
- carbohydrate intake (e.g. meals/snacks, type/s, carbohydrate: insulin ratio, additional requirements)

- physical activity (e.g. specific considerations, pregnancy, +/- diabetes medication adjustment)
- commencement/update of blood glucose monitoring (e.g. blood glucose monitoring action plan)
- commencement/update of blood ketone monitoring (e.g. hyper/sick day action plan)
- application and removal of continuous glucose monitoring or flash glucose monitoring
- commencement/update of oral hypoglycaemic agents, GLP1 and/or insulin
- commencement/update of injectables/check technique/devices (e.g. insulin action plan)
- commencement/update of CSII/check technique/devices/troubleshoot
- titration of basal/bolus/premixed insulin (e.g. specific considerations, insulin sensitivity factor, correctional)
- hypoglycaemia] Hypo Action Plan
- severe hypoglycaemia] " " "
- hyperglycaemia] Hyper Action Plan
- ketones/diabetic ketoacidosis (DKA)] " " "
- sick day management] Sick Day Action Plan
- driving
- pre-school/day care/kindergarten/school visit and care plan
- health checks (cycle of care)
- complications of diabetes (micro and macro)
- coping skills
- rights and responsibilities
- decision making/behaviour change
- ambulance cover
- medic alert
- travel/school camps.

Problem areas identified

- identified from above listing.

Patient priorities

- identified from above listing
- SMART goals (e.g. specific, measurable, achievable, realistic and time framed).

1.3 Plan of care

The management and/or education plan should be documented in the case notes. See *Rural Support Service (RSS) Diabetes Service Education Pathways (Appendix 1, 2, 3, 4 & 5).*

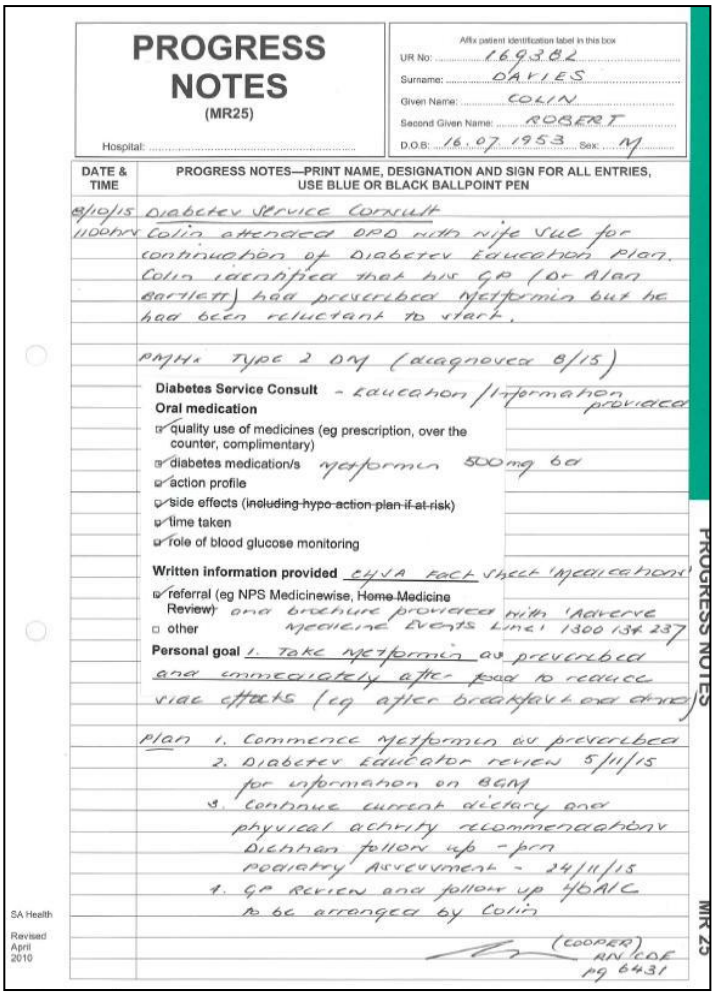
Management plan

Once a management plan is agreed with the person with diabetes and/or the family/carer, the problem area covered at this time is documented. Outstanding problems areas are to be listed and to be addressed at a future date.

Education plan

Once an education plan is agreed with the person with diabetes and/or the family/carer, the problem area covered at this time is documented. Outstanding problems areas are to be listed and to be addressed at a future date. Most aspects of the management and education plan can be documented using the *regional LHN Diabetes Educator Stickers*. The following management and education scenario stickers are currently available:

- introduction to diabetes
- nutrition
- physical activity
- monitoring (e.g. BGM and BKM)
- professional or personal CGM or FGM application and removal
- oral diabetes medications
- exenatide (Byetta®) and injectables
- insulin and insulin titration service
- insulin pump troubleshooting
- hypoglycaemia
- hyperglycaemia
- reducing risks
- GDM - diagnosis, BG targets and postnatal review plan
- discharge planning
- paediatric transition to adult services.



PROGRESS NOTES
(MR25)

Hospital:

Affix patient identification label in this box
UR No: 169382
Surname: DAVIES
Given Name: COLIN
Second Given Name: ROBERT
D.O.B: 16.07.1953 Sex: M

DATE & TIME	PROGRESS NOTES—PRINT NAME, DESIGNATION AND SIGN FOR ALL ENTRIES, USE BLUE OR BLACK BALLPOINT PEN
8/10/15 1100hrs	Diabetes Service Consult Colin attended OPD with wife Sue for continuation of Diabetes Education Plan. Colin identified that his GP (Dr Alan Bartlett) had prescribed Metformin but he had been reluctant to start. PMHx: Type 2 DM (diagnosed 8/15) **Diabetes Service Consult** - Education / Information provided **Oral medication** ☑ quality use of medicines (eg prescription, over the counter, complimentary) ☑ diabetes medication/s Metformin 500mg bd ☑ action profile ☑ side effects (~~including hypo action plan if at risk~~) ☑ time taken ☑ role of blood glucose monitoring **Written information provided** CHVA Fact sheet 'Medications' ☑ referral (eg NPS Medicinewise, ~~Home Medicine Review~~) and brochure provided with 'Adverse Medicine Events Line' 1300 134 237 ☐ other **Personal goal** 1. Take Metformin as prescribed and immediately after food to reduce side effects (eg after breakfast and dinner) Plan 1. Commence Metformin as prescribed 2. Diabetes Educator review 5/11/15 for information on BGM 3. Continue current dietary and physical activity recommendations Dietitian follow up - prn Podiatry Assessment - 24/11/15 4. GP Review and follow up HbA1c to be arranged by Colin (COOPER) RN/CDE PG 6431

SA Health
Revised April 2010
MR 25
PROGRESS NOTES

The regional *LHN Diabetes Educator Stickers* are photocopied onto adhesive labels and used in individual patient medical record's to assist in the documentation of the occasion of service. The stickers can be placed on the left hand side of the patient's progress note and additional information can be added on the right hand side to provide individualised information relevant to the person's circumstances (if required). See adjacent example.

Alternatively, documentation in long hand in the case notes (using the example headings identified) can be made

Insulin pump basal rates and advanced settings can be documented on the *CSII Inpatient Rate Record (MR-CIR)* or *CSII Outpatient Rate Record (MR-COR)*. Copies can be provided to the patient and/or their carer for reference and to use in the event that the insulin pump is misplaced or malfunctions.

Referrals

What referrals did you provide (to allied health) or recommend at this appointment?

Resources provided

What written or other resources did you provide at this appointment?

Follow Up

To be used to document what is planned for subsequent appointments.

1.4 Subsequent visit/s and progress

The method used to document the management and/or education will vary depending on the preferences of the CDE/DE. However, it is useful to use headings and try to avoid writing in narrative sentences.

Narrative charting refers to documentation that follows a chronological framework rather than grouping the information into categories. It can result in a lot of writing, can be time consuming and repetitive. This method of writing case notes is still commonly used but nursing is now using a problem oriented approach, clinical pathway or focus chart.

ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the assessment and transfer of critical information pertaining to a patient.

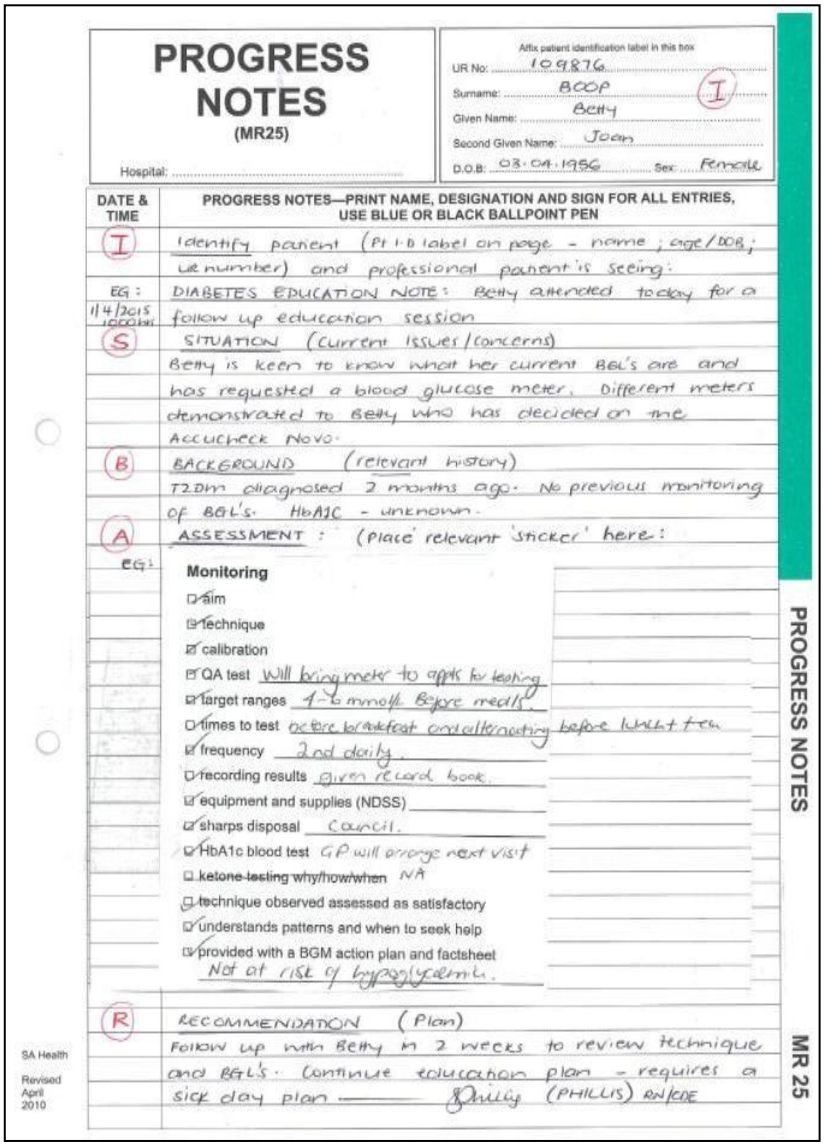
- **Identify** – patient with diabetes (at least 3 identifiers) and as the role of the CDE/DE.
- **Situation** – what is going on with the patient with diabetes?
- **Background** - what is the clinical background/context?
- **Assessment** - what is the problem?
- **Recommendation** - what is recommended? Are there patient/occupational health and safety risks? Assign and accept responsibility/accountability.

Guiding principles;

- document any amendments to education plan
- document clinical care and/or education given
- document plan for next appointment including client goals
- complete any outstanding assessment areas.

Most aspects of the subsequent visit/s and progress can be documented using the *RSS Diabetes Educator Stickers*. The stickers are photocopied onto adhesive labels and used in individual patient medical record's to assist in the documentation of the occasion of service. The stickers can be placed on the left hand side of the patient's progress note and additional information can be added on the right hand side to provide individualised information relevant to the person's circumstances (if required).

An example is provided below.



PROGRESS NOTES
(MR25)

Hospital:

Affix patient identification label in this box
UR No: 109876
Surname: BOOP
Given Name: Betty
Second Given Name: Joan
D.O.B: 03.04.1956 Sex: Female

DATE & TIME	PROGRESS NOTES—PRINT NAME, DESIGNATION AND SIGN FOR ALL ENTRIES, USE BLUE OR BLACK BALLPOINT PEN
I	Identify patient (Pt I.D label on page - name ; age/DOB ; UR number) and professional patient is seeing:
EG: 1/4/2015 1000hrs	DIABETES EDUCATION NOTE: Betty attended today for a follow up education session
S	SITUATION (Current issues/concerns) Betty is keen to know what her current BGL's are and has requested a blood glucose meter. Different meters demonstrated to Betty who has decided on the Accucheck Novo.
B	BACKGROUND (relevant history) T2DM diagnosed 2 months ago. No previous monitoring of BGL's. HbA1C - unknown.
A	ASSESSMENT : (Place relevant 'sticker' here:
EG:	**Monitoring** ☐ aim ☑ technique ☑ calibration ☑ QA test Will bring meter to appts for testing ☑ target ranges 4-6 mmol/L Before meals. ☐ times to test before breakfast and alternating before lunch + tea ☑ frequency 2nd daily. ☐ recording results given record book. ☑ equipment and supplies (NDSS) ☑ sharps disposal Council. ☑ HbA1c blood test GP will arrange next visit ☐ ~~ketone testing~~ why/how/when NA ☐ technique observed assessed as satisfactory ☑ understands patterns and when to seek help ☑ provided with a BGM action plan and factsheet Not at risk of hypoglycaemia.
R	RECOMMENDATION (Plan) Follow up with Betty in 2 weeks to review technique and BGL's. Continue education plan - requires a sick day plan ——— Phillis (PHILLIS) RN/CDE

PROGRESS NOTES MR 25

SA Health
Revised April 2010

The review tool can be used at any time to document the persons understanding, knowledge and self-management skills. The CDE/DE must draw on critical thinking and problem-solving skills to make clinical decisions and plan management and education for the patient with diabetes. If any abnormal findings are identified, the CDE/DE must ensure that appropriate action is taken.

Evaluation of plan

- coping skills
- concerns
- attended referrals
- techniques assessed
- knowledge assessed

> behavior changes assessed.

1.5 Discharge

The general practice system provides Commonwealth funding for diabetes cycle of care. Cycle of care has an education assessment included as an item and thus is a requirement. The CDE/DE assists with appropriate management and education assessment within cycle of care systems by providing the medical practitioner with advice on the self-care issues and specific self-management behaviours to support and review people with all types of diabetes.

Type 2 diabetes

Adults with type 2 diabetes are to be discharged to their treating medical practitioner for ongoing care. A letter to the medical practitioner should detail aspects of self-care that require monitoring and re-assessment.

Re-referral is appropriate when the person has treatment changes, develops a co morbidity or diabetes complication.

Children and adolescents with type 2 diabetes require ongoing specialist input thus remain active patients within the diabetes service, and diabetes management and education is reviewed and updated based on individual need.

Type 1 diabetes

Type 1 diabetes is a complex chronic disease requiring ongoing multidisciplinary specialist input. Clinical care and education/training is provided in a shared care model with the general practitioner (GP) and or endocrinologist.

Children, adolescents and adults with type 1 diabetes remain active patients within the diabetes service, and diabetes management and education is reviewed and updated based on individual need.

Child, adolescents and adults on insulin pump therapy require a copy of the current insulin pump rates to refer to. See *CSII Inpatient Rate Record (MR-CIR) or CSII Outpatient Rate Record (MR-COR)*.

Transition from paediatric to adult services

The regional LHN diabetes services play an integral role in ensuring the transition from Paediatric care to adult care is undertaking in a supportive manner.

For Paediatric patients with type 1 diabetes, transition to an adult type 1 diabetes service is required, and the expectations as outlined above apply. Paediatric patients with type 2 diabetes will also require transition to an appropriate adult type 2 diabetes service based on the complexity of diabetes management, clinical risk and patient need. The local medical practitioner works with the regional LHN or metropolitan diabetes service as the primary health care provider.

Diabetes in pregnancy

According to the RSS Maternal and Neonatal Clinical Network, women with pre-existing diabetes and those diagnosed with GDM are [C] coded. This code requires referral of care to a medical practitioner and discussion to continue with the midwifery team. Transfer to GP care or transfer to tertiary care.

In the ante natal period, women with pre-existing diabetes or GDM may have their care transferred from the local diabetes service to a higher graded maternity facility within regional LHN or to a private or public diabetes service within a metropolitan LHN (e.g. Women's and Children's Hospital, Flinders Medical Centre or Lyell McEwin Hospital). The CDE/DE is to provide written information on transfer of medical care to the receiving diabetes service that confirms a local role in the remaining antenatal period. Local access to the diabetes service is to be maintained if possible.

In the postnatal period, women with pre-existing type 1 diabetes will continue as an active patient within the diabetes service, and diabetes management and education is reviewed and updated based on individual need.

Women with pre-existing type 2 diabetes are to be discharged to their treating medical practitioner for ongoing care.

Non attending

People with diabetes who fail to attend the assessment and subsequent visit/s are to be contacted. Please refer to the regional LHN Non Attending Patient Procedure for further information regarding discharge to their treating medical practitioner for ongoing care.

1.6 Communicating with the referring medical practitioner

It is important the CDE/DE communicate with the referring doctor after the initial appointment to identify the negotiated management and/or education plan. The CDE/DE is to communicate further if circumstances change or there are concerns and when the person is discharged from the diabetes service. *The regional LHN Diabetes Service Communication templates* (Appendix 6, 7 and 8) can be used to format a concise letter.

Education Pathways Appendix 1

Rural Support Service - Diabetes Service
T1D Education Pathway

Newly diagnosed

Note:
- Endocrinology
- Paediatric team
  - Centrelink
- Dietitian

Cycle of care
Nutrition – CHO education & counting
Insulin action plan & self-adjustment
Blood glucose monitoring & targets
Blood ketone testing
Sick day action plan
Hypo action plan
Driving action plan
Exercise action plan
Foot care action plan
Dental care
Pre-pregnancy counselling
Anxiety / depression screening
NDSS

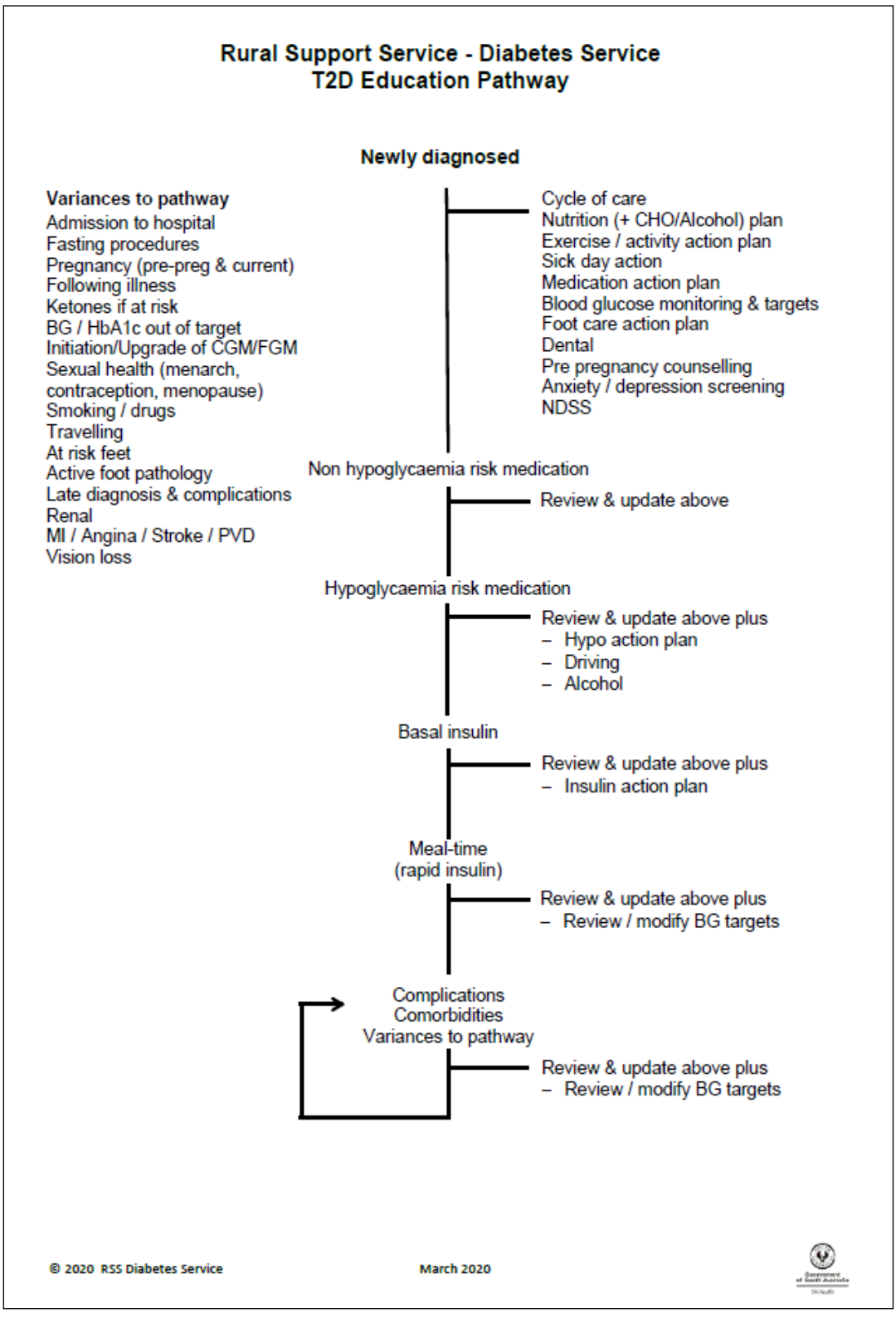
Review

Review & update above
- complications
- comorbidities
- variances to pathway

Variances to pathway
Childcare / school
Transition to adult care
Admission to hospital
Fasting procedures
Pregnancy (pre-preg & current)
Sexual health (menarch, contraception, menopause)
Smoking / drugs
Following illness
Psychosocial issues/mental health
Elevated BG / HbA1c
Travelling
Initiation of CGM & FGM
Initiation / Upgrade of CSII
At risk feet
Active foot pathology
Renal
MI / Angina / Stroke / PVD
Vision loss

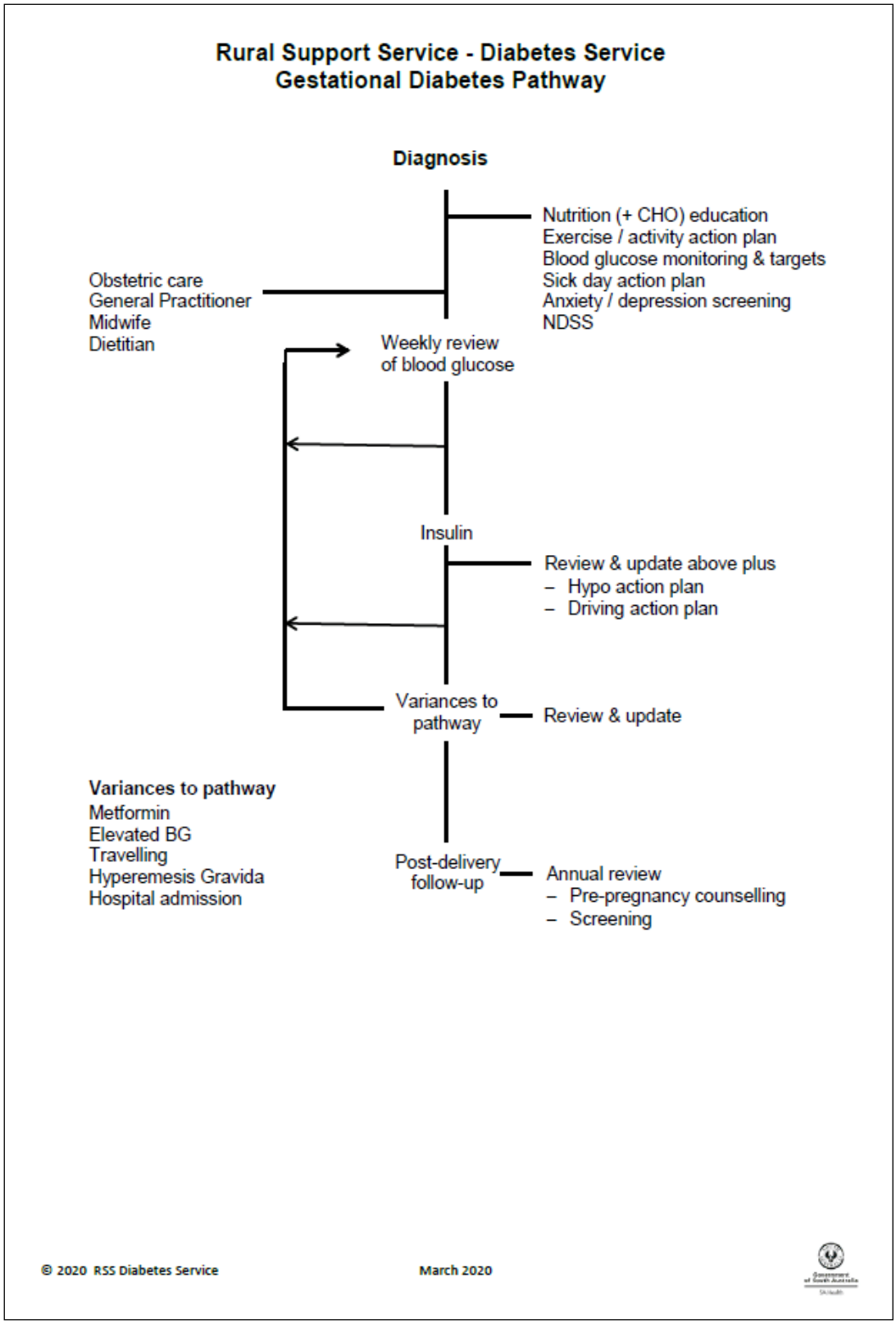
March 2020

Education Pathways Appendix 2

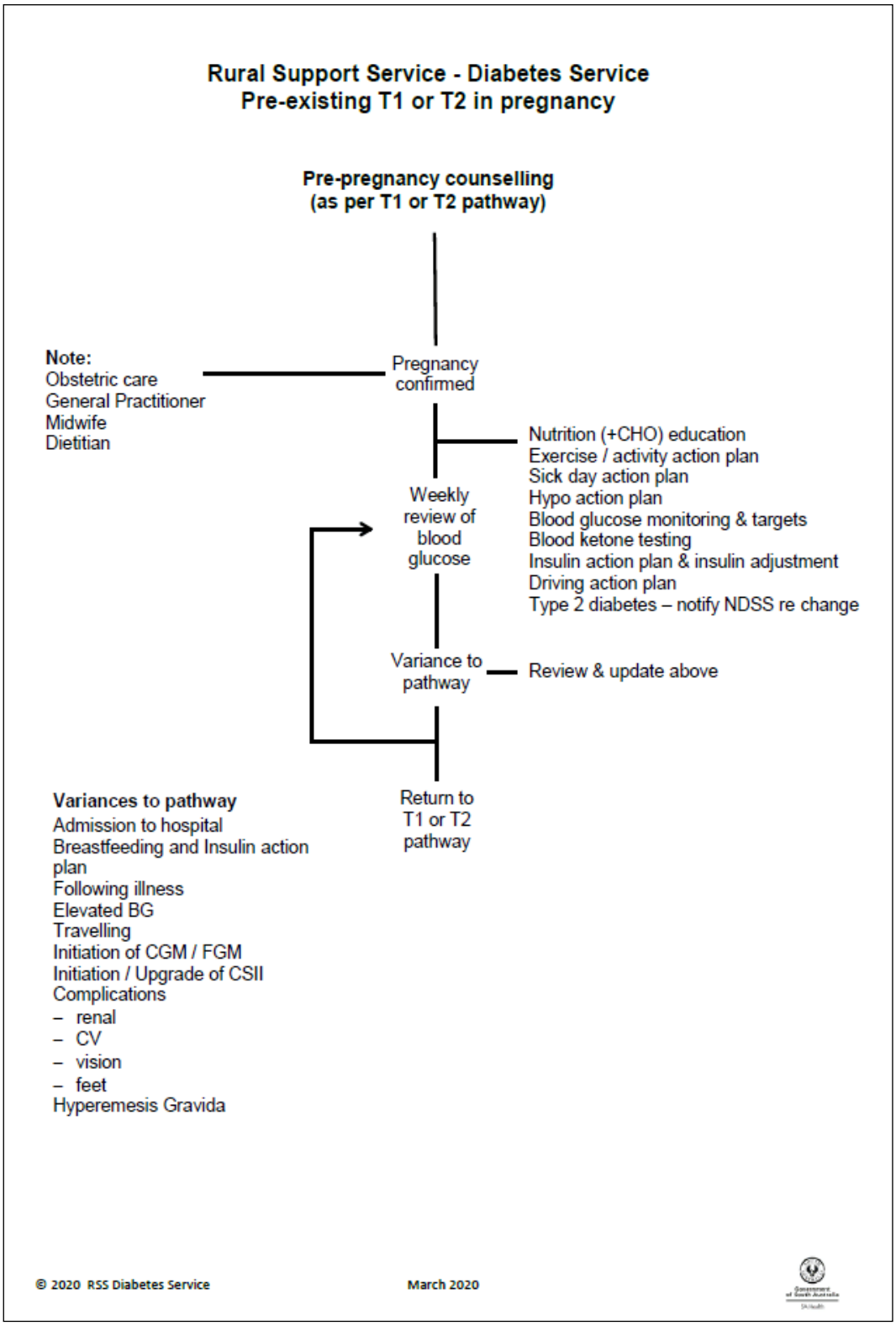


Education Pathways

Appendix 3



Education Pathways Appendix 4



Education Pathways

Appendix 5

Rural Support Service - Diabetes Service
Regional LHN Paediatric Diabetes and DECD Pathway

Referral via the Country Referral Unit should include:

- Discharge summary
- Prescribed medications
- Equipment provided (e.g. CGM, BGM and insulin injection device/s)
- Diabetes action plan for early childhood or school setting
- Medication authorisation form.

Step 1: Phone parents/carers

Discuss

- Referral received and your local role (if new to your service)
- Resources received
- Any immediate clinical concerns and educational areas that require follow up
- Child's capacity to participate and take responsibility for aspects of self-management
- Follow up appointment based on clinical need
- National Diabetes Services Scheme (NDSS) Diabetes in Schools program https://www.diabetesinschools.com.au/training-and-support and access by school staff to level 1 (Introductory) and level 2 (Intermediate) training online
- NDSS Diabetes in Schools program level 3 training (individualised skills training) for designated school staff. Adaption of NDSS Diabetes in Schools program for early childhood staff
- Parent/carer responsibility to contact the early childhood centre or school to arrange a meeting onsite or via videoconference to facilitate your delivery of the NDSS Diabetes in Schools program level 3 training (individualised skills training) for designated school staff or an adaption of the program for early childhood centre staff.

Step 2: NDSS Diabetes in School program level 3 (individualised skills training) with designated school staff, child and parents/carers or adaption of the program for early childhood centre staff, child and parents/carers (onsite or via videoconference).

Discuss

- Child's diagnosis and treating medical team
- Your local role and local services
- NDSS Diabetes in Schools program https://www.diabetesinschools.com.au/training-and-support and access by school staff to level 1 (Introductory) and level 2 (Intermediate) training online
- NDSS Diabetes in Schools program level 3 training (individualised skills training) for designated school staff or adaption of the program for early childhood centre staff including reference to:
  - Diabetes action plan for early childhood or school setting
  - Medication authority, and
  - Equipment required
- Staff responsibilities of the early childhood centre or schools
- Parent/carer responsibilities (e.g. emergency contacts, any changes/updates to diabetes action plan, medication authority, equipment)
- Child's capacity to participate and take responsibility for aspects of self-management
- Location of equipment to be provided (e.g. blood glucose / ketone monitoring, continuous glucose monitoring / insulin administration devices, hypo kits)
- Assistance / supervision required for blood glucose / ketone monitoring, continuous glucose monitoring / insulin administration and where this will take place
- Assistance / supervision required for meals and snacks and assistance with insulin dose calculations
- Assistance / supervision required for physical activity and additional planning for excursions/camps/ activities.

Step 3: Follow up and maintenance

- Follow up (either phone or in person) with child, parent/carer and school in 2-4 weeks (or as negotiated) to identify any diabetes action plan implementation issues or general concerns
- Communicate with referring team regarding outcomes of child, parent/carer and school visits
- Annual review to provide local support and review / update diabetes action plan and medication authority as required.

May 2021

Guiding document and checklist

The NDSS Diabetes in School program level 3 (individualised skills training) with designated school staff, child and parents or adaption of the program for early childhood centre staff, child and parents/carers, to include:

Explain

Children with both type 1 and type 2 diabetes need:

- Emergency treatment, supervision and support in the event of a low blood glucose level
- Unrestricted access to emergency treatment for low blood glucose
- To eat meals (carbohydrate) and snacks on time
- To eat carbohydrate snacks at additional times if involved in vigorous physical activity for more than 30 minutes
- Unrestricted toilet privileges and access to drinking water
- Additional planning with parents/carers to accommodate changes in school routine (e.g. excursions, camps and other activities)
- Extra supervision if blood glucose is elevated
- Support, encouragement and privacy (if requested) when blood glucose / ketone monitoring, continuous glucose monitoring and administering insulin (e.g. insulin syringe/insulin pen/insulin pump).

Discuss:

- DECD Diabetes Action Plan and Medication Authority
- hypo/hyper management +/- Glucagen Hypo Kit
- blood glucose / ketone / continuous glucose monitoring (e.g. assistance/supervision required and location of resources)
- insulin storage / administration (e.g. assistance/supervision and location of resources)
- meals and snacks (e.g. assistance/supervision with insulin dose calculations)
- physical activity (e.g. specific instructions for additional carbohydrate / insulin alteration)
- additional plans required (e.g. excursions / camps / swimming lessons/ other activities).

Encourage

- the designated early learning centre or school staff, child and parents to use a communication book or diary
- access to further information and resources via the NDSS website at https://www.diabetesinschools.com.au/resources-and-information/

May 2021

Communication Template for Admission Appendix 6

Government of South Australia
SA Health

Name of Regional Local Health Network

Name of Hospital and Health Service
Diabetes Service

Address

Tel 08 8888 8888
Fax 08 8888 8888

Date:

Dear Dr

RE: Diabetes Service Referral Response

Thank you for referring _____ DOB ___ / ___ / ___ for assessment and education regarding management of their _____.
was accompanied by _____.

Situation

Background/Tests and Results

I note that current treatment is:

☐ Nutrition and Physical Activity

☐ Oral Hypoglycaemic Agents (OHAs) (Name & Dose) _____

☐ Injectables including insulin (Name & Dose) _____

Assessment/Key Issues/Risks/Client Goals

Recommendations/Education Plan/Action Plans and Resources provided

Referrals required/arranged

Next CDE/DE Appointment/Request for GP follow up (if applicable)

Please feel free to contact me at any time to discuss your patient's management and education. I will keep you informed if any new issues arise and on the completion of their education.

Kind regards

Signature: _____ Print Name: _____ Title: _____

Communication Template for Interim Update Appendix 7

Government of South Australia
SA Health

Regional Local Health Network

Name of Hospital and Health Service
Diabetes Service

Address

Tel 08 8888 8888
Fax 08 8888 8888

Date:

Dear Dr

RE: Diabetes Service Review

_____ DOB ____ / ____ / ____ was reviewed today regarding management of their _____. _____ was accompanied by _____.

Situation

Background/Tests and Results

I note that current treatment is:

☐ Nutrition and Physical Activity

☐ Oral Hypoglycaemic Agents (OHAs) (Name & Dose) _____

☐ Injectables including Insulin (Name & Dose) _____

Assessment/Key Issues/Risks/Client Goals

Recommendations/Amendments to Clinical Care, Education Plan and Action/Resources provided

Referrals required/arranged

Next CDE/DE Appointment/Request for GP follow up (if applicable)

Please feel free to contact me at any time to discuss your patient's management and education. I will keep you informed if any new issues arise and on the completion of their education.

Kind regards

Signature: _____ Print Name: _____ Title: _____

Government of South Australia
SA Health

Name of Regional Local Health Network

Name of Hospital and Health Service
Diabetes Service

Address

Tel 08 8888 8888
Fax 08 8888 8888

Date:

Dear Dr

RE: Diabetes Service Discharge

_____ DOB ____ / ____ / ____ was referred to the Diabetes Service regarding management of their _____ on the _____. _____ was seen by the _____ Diabetes Service on _____ occasions. My last contact was on the _____. At that time, the patient was accompanied by _____.

I note that current treatment is:

☐ Nutrition and Physical Activity

☐ Oral Hypoglycaemic Agents (OHAs) (Name & Dose) _____

☐ Injectables including insulin (Name & Dose) _____

Situation

Background/Test and Results

Education/Action Plans/Instructions/Resources provided

Assessment/Competency

The patient will benefit from ongoing review of their diabetes management and self care. I have encouraged a partnership with you and his/her attendance at the 3-6 monthly reviews and annual reviews for the opportunity to receive an ongoing assessment, review of priority lists and goals and confirming arrangements for management.

While I am discharging this patient from the Diabetes Service at this time, they are welcome to return if their situation changes (eg commencement of diabetes medication, hypoglycaemia risk, sub optimal glycaemic control, pre pregnancy planning).

Kind regards

Signature: _____ Print Name: _____ Title: _____

Government of South Australia
SA Health

Name of Regional Local Health Network

Name of Hospital and Health Service Department

Address

Tel 08 8888 8888
Fax 08 8888 8888

Date:

Dear Dr

RE: Diabetes Service Discharge

_____ DOB ____ / ____ / ____ was referred to the Diabetes Service regarding management of their _____ on the _____. _____ was seen by the _____ Diabetes Service on _____ occasions. My last contact was on the _____. At that time, the patient was accompanied by _____.

I note that current treatment is:

☐ Nutrition and Physical Activity

☐ Oral Hypoglycaemic Agents (OHAs) (Name & Dose) _____

☐ Injectable including insulin (Name & Dose) _____

Situation

Background/Test and Results

Assessment/Competency/Education/Action Plans/Instructions/Resources provided

Recommendations

The patient will benefit from ongoing review of their diabetes management and self care. I have encouraged their attendance at the 3-6 monthly and annual cycle of review for the opportunity to receive an ongoing assessment, review of priority lists and goals and confirming current management.

While I am discharging this patient from the Diabetes Service at this time, they are welcome to return if their situation changes (eg commencement of diabetes medication, hypoglycaemia risk, sub optimal glycaemic control, pre pregnancy planning).

Kind regards

Signature: _____ Print Name: _____ Title: _____

Acronyms

The abbreviations used in the Diabetes Assessment Form (MR-DAF) and Diabetes in Pregnancy Form (MR-DIP) are offered alphabetically below:

Acronym	Word
ANRQ	Antenatal Risk Questionnaire
BG	Blood Glucose
BGM	Blood Glucose Monitoring
BK	Blood Ketone
BMI	Body Mass Index
BP	Blood Pressure
CGM	Continuous Glucose Monitoring
CHD	Coronary Heart Disease
CHO	Carbohydrate
COAD	Chronic Obstructive Airways Disease
COPD	Chronic Obstructive Pulmonary Disease
CSII	Continuous Subcutaneous Insulin Infusion
CVA	Cerebrovascular Accident
DAF	Diabetes Assessment Form (MR-DAF)
DIP	Diabetes in Pregnancy Assessment Form (MR-DIP)
DOB	Date of Birth
ED	Erectile Dysfunction
EDD	Expected Delivery Date
eGFR	Estimated Glomerular Filtration Rate
EPDS	Edinburgh Postnatal Depression Scale
Ex	Exchanges
FGM	Flash Glucose Monitoring
GDM	Gestational Diabetes Mellitus
GLP-1	Glucagon-like peptide -1
HbA1C	Haemoglobin A1C
HDL	High Density Lipoprotein
LDL	Low Density Lipoprotein
LGA	Large for Gestational Age
NDIS	National Disability Insurance Scheme
No.	Number
OGTT	Oral Glucose Tolerance Test
OSA	Obstructive Sleep Apnoea
PAID	Problem area in Diabetes Scale
RAC	Residential Aged Care
SN	Serial Number
SNAP	Smoking, Nutrition, Alcohol and Physical Activity

Acknowledgements

We would like to thank and acknowledge the SA Health Diabetes Nurse Leaders Group and the RSS Diabetes Specialist Nurse Network for sharing their documentation resources for the purpose of developing this documentation guide and tools.

2. Attached documents (Links)

Diabetes Assessment Form (MR-DAF)
Diabetes in Pregnancy Assessment Form (MR-DIP)
CSII Inpatient Rate Record (MR-CIR)
CSII Outpatient Rate Record (MR-COR)
Diabetes Foot Assessment Chart

3. References

Rural Support Service; Diabetes Service Share Point page https://sagov.sharepoint.com/sites/CHSA/clinical/diabetes/Pages/Protocols-%26- Procedures.aspx
Australian Diabetes Educators Association, 2017, *National core competencies for credentialled diabetes educators*, Australian Diabetes Educators Association, Canberra. Accessed 21/08/2020. Available from; https://www.adea.com.au/wp-content/uploads/2020/07/National-Competencies-for-Credentialled-Diabetes-Educators.pdf
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Australian Diabetes Society and Diabetic Foot Australia 2020. *Clinical Triage Guide*. Accessed Online 24/08/2020. Available from: https://www.diabeticfootaustralia.org/wp-content/uploads/COVID19-Australian-Clinical-Triage-Guide-for-DFD-V1.0.pdf

National Diabetes Services Scheme (2021) Diabetes in schools; Training for schools. Accessed online 25.08.2021. Available from: https://www.diabetesinschools.com.au/resources/training-for-school-staff/

4. Accreditation standards

National Safety and Quality Health Service Standards ***(2nd edition)***

1	2	3	4	5	6	7	8
☒	☐	☐	☐	☒	☒	☐	☐
Clinical Governance	Partnering with Consumers	Preventing & Controlling Healthcare Associated Infection	Medication Safety	Comprehensive Care	Communicating for Safety	Blood Management	Recognising & Responding to Acute Deterioration

Aged Care Quality Standards ***(includes home care clients)***

1	2	3	4	5	6	7	8
☒	☒	☒	☒	☐	☐	☐	☐
Consumer Dignity & Choice	Ongoing Assessment & Planning with Consumers	Personal Care & Clinical Care	Services & Supports for Daily Living	Organisation's Service Envorinment	Feedback & Complaints	Human Resources	Organisational Governance

National Disability Insurance Scheme (NDIS) Practice Standards

CORE MODULE				SUPPLEMENTARY MODULES	
1	2	3	4	1	2
☐	☒	☒	☐	☐	☐
Rights and Responsibilities	Governance and Operational Management	Provision of Supports (to participants)	Provision of Supports (environment)	High Intensity Daily Personal Activities Module	Early Childhood Supports Module

5. Consultation

Version	Consultation
1.0	Metropolitan Diabetes Services, CHSA Diabetes Specialist Nurse Network.
2.0	Metropolitan Diabetes Services, Regional LHN Clinical Governance Committees, RLHN Diabetes Specialist Nurses & Nurse Practitioners and Executive Director Medical Services and Endocrinologist LCLHN.
3.0	Regional LHN Diabetes Specialist Nurses & Nurse Practitioners.