

Documentation guide for diabetes services

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Approved by: CHSA Clinical Governance Committee

Effective date: 23rd December 2016

Version: 1

Last reviewed:

Next review due: December 2019



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Background

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.¹

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 clinicians accountability for the service they provide and a record of their professional practice.²

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 Country Health SA Local Health Network (CHSA) hospital and health services sites.

Effective documentation should be,^{2 1}

- > 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,²

- > 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 (eg held by clinicians personally).

Appropriate documentation promotes,²

- > 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,²

- > 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.

Minimum standards for documenting diabetes education

The following minimum standards for documenting a diabetes service have been developed to assist diabetes educators to produce high quality nursing notes. There are clinical and corporate risks if the diabetes service documentation is not adequate.³

- > Clinical risks: inadequate or incomplete documentation about the persons' occasion of service impedes communication and also diminishes 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: poor or inadequate documentation could affect outcomes of legal proceedings.

Standard 1

To maintain accurate and confidential records of clinical care including;⁴

- > 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;⁵

- > a description of the assessment, problems areas, patient priorities and services provided
- > the method(s) used for education (eg 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 (eg evidence of the persons 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 persons intellectual, social, psychological, spiritual, and cultural status.⁴

Standard 4

Documentation must fulfil legal requirements;

- > consultations need to be written 'defensively' (eg 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 diabetes educator has dealt with the various issues
- > outcomes of the occasion of service should be documented.

Standards 5

Evidence that the diabetes educator worked collaboratively with the referring practitioner, other members of the diabetes care team and the person to establish agreed clinical targets.⁴

Diabetes Service documentation will support the process;

1. patient assessment
2. plan of care

3. subsequent visit/s and progress
4. discharge (eg type 2 diabetes).

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 eg clinical observations results of treatment, and medication prescribed
- > diagnostic and therapeutic orders/plan
- > signature, surname and initials, and designation of the clinician.

Some aspects of the initial assessment can be documented using the CHSA *Diabetes Educator Assessment Form* (for adults and paediatric patients) or the CHSA *Diabetes Educator Diabetes in Pregnancy (DIP) Assessment Form* (for women with pre-existing diabetes or those diagnosed with gestational diabetes mellitus (GDM)). 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 (eg language, memory deficits, religion)
- > areas of concern (eg 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 (eg HbA1c/ lipids/microalbumin/ eGFR/AER/liver function)
- > blood pressure
- > blood glucose level (BGL)
- > blood ketone level (BKL)

Foot assessment (refer to CHSA *Diabetes Service Foot Risk Assessment*)

- > circulation and sensation
- > self-care and footwear

Lifestyle

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

Focused assessment

- > fingers used for capillary blood monitoring
- > injection site used (eg 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/GDM
- > management requirements/options
- > oral hypoglycaemic agents (eg metformin/sulphonylurea/thiazolidinedione/DPP4 inhibitor/acarbose/SGLT2 inhibitor) profile
- > GLP1 profile
- > insulin profile
- > carbohydrate intake (eg meals/snacks, type/s, carbohydrate: insulin ratio, additional requirements)
- > physical activity (eg specific considerations, pregnancy, +/- diabetes medication adjustment)

- > commencement /update of blood glucose monitoring (eg blood glucose monitoring action plan)
- > commencement /update of blood ketone monitoring (eg hyper/sick day action plan)
- > application and removal of continuous subcutaneous glucose monitoring
- > commencement /update of oral hypoglycaemic agents, GLP1 and/or insulin
- > commencement/update of injectables/check technique/devices (eg insulin action plan)
- > commencement/update of continuous subcutaneous insulin infusion (insulin pumps) /check technique/devices/troubleshoot
- > titration of basal/bolus/premixed insulin (eg 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 (eg specific, measurable, achievable, realistic and time framed).

Plan of care

The management and/or education plan should be documented in the case notes. See *CHSA 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 *CHSA Diabetes Educator Stickers*. The following management and education scenario stickers are currently available:

- > introduction to diabetes
- > nutrition

- > physical activity
- > monitoring (eg BGM and BKM)
- > oral diabetes medications
- > exenatide (Byetta ®) and injectables
- > insulin and injectables
- > insulin titration service
- > insulin pump troubleshooting
- > hypoglycaemia
- > hyperglycaemia
- > reducing risks
- > GDM – diagnosis
- > GDM – BG targets dairy insert
- > GDM – post natal
- > discharge planning
- > transition to adult services
- > CGMS application
- > CGMS removal.

The CHSA 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 Diabetes Educator 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.

<h1>PROGRESS NOTES</h1> <p>(MR25)</p>		<p>Affix patient identification label in this box</p> <p>UR No: <u>169382</u></p> <p>Surname: <u>DAVIES</u></p> <p>Given Name: <u>COLIN</u></p> <p>Second Given Name: <u>ROBERT</u></p> <p>D.O.B: <u>16.07.1953</u> Sex: <u>M</u></p>
DATE & TIME	<p>PROGRESS NOTES—PRINT NAME, DESIGNATION AND SIGN FOR ALL ENTRIES, USE BLUE OR BLACK BALLPOINT PEN</p> <p>8/10/15 Diabetes Service Consult</p> <p>1100hrs 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.</p> <p>PMH: Type 2 DM (diagnosed 8/15)</p> <p>Diabetes Service Consult - Education / Information provided</p> <p>Oral medication</p> <p><input checked="" type="checkbox"/> quality use of medicines (eg prescription, over the counter, complimentary)</p> <p><input checked="" type="checkbox"/> diabetes medication/s Metformin 500mg b.i.d</p> <p><input checked="" type="checkbox"/> action profile</p> <p><input checked="" type="checkbox"/> side effects (including hypo-action plan if at risk)</p> <p><input checked="" type="checkbox"/> time taken</p> <p><input checked="" type="checkbox"/> role of blood glucose monitoring</p> <p>Written information provided CHSA Fact sheet 'Medication'</p> <p><input checked="" type="checkbox"/> referral (eg NPS Medicines, Home Medicine Review) and brochure provided with 'Adverse Medicine Events Line' 1300 134 237</p> <p><input type="checkbox"/> other</p> <p>Personal goal 1. Take Metformin as prescribed and immediately after food to reduce side effects (eg after breakfast and dinner)</p> <p>Plan 1. Commence Metformin as prescribed</p> <p>2. Diabetes Educator review 5/11/15 for information on BGM</p> <p>3. Continue current dietary and physical activity recommendations</p> <p>Diabetes follow up - per podiatry assessment - 24/11/15</p> <p>4. GP Review and follow up HbA1c to be arranged by Colin</p> <p>SA Health Revised April 2010</p> <p>(COOPER) RN, LDE p9 6431</p>	

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 CHSA *CSII Inpatient and Outpatient Record*. 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.

Subsequent visit/s and progress

The method used to document the management and/or education will vary depending on the preferences of the diabetes educator. 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.⁶

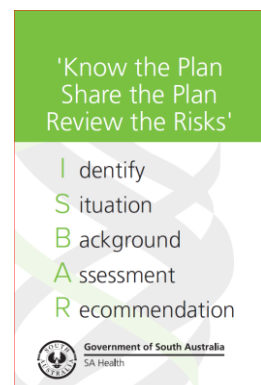
ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the assessment and transfer of critical information pertaining to a patient.⁶

- > **Identify** - patient with diabetes (at least 3 identifiers) and as the role of the Diabetes Educator
- > **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 CHSA *Diabetes Educator Stickers*. The CHSA 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 Diabetes Educator 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)		Affix patient identification label in this box	
Hospital:		UR No: 109876	
		Surname: BOOP	(I)
		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 (Print label on page - name, age/DOB; UR number) and professional patient is seeing:		
EQ: 11/4/2015 1000hr	DIABETES EDUCATION NOTE: Betty attended today for a follow up education session		
(S)	SITUATION (current issue/concerns) Betty is keen to know what her current BG'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 BG's. HbA1c - unknown.		
(A)	ASSESSMENT: (Place relevant 'sticker' here:)		
EQ:	Monitoring <input type="checkbox"/> aim <input type="checkbox"/> technique <input type="checkbox"/> calibration <input checked="" type="checkbox"/> QA test Will bring meter to appt for testing <input checked="" type="checkbox"/> target ranges 4-6 mmol/L before meals <input checked="" type="checkbox"/> times to test before breakfast and alternating before lunch + tea <input checked="" type="checkbox"/> frequency 2nd daily <input checked="" type="checkbox"/> recording results given record book <input type="checkbox"/> equipment and supplies (NDSS) <input checked="" type="checkbox"/> sharps disposal Council <input checked="" type="checkbox"/> HbA1c blood test GP will arrange next visit <input type="checkbox"/> ketone testing why/how/when NA <input type="checkbox"/> technique observed assessed as satisfactory <input type="checkbox"/> understands patterns and when to seek help <input checked="" type="checkbox"/> 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 BG's. Continue education plan - requires a sick day plan. <i>Phillips (PHILLIS) ENJOE</i>		

SA Health
Revised April 2010

PROGRESS NOTES
MR 25

The review tool can be used at any time to document the persons understanding, knowledge and self-management skills. The Diabetes Educator 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 Diabetes Educator must ensure that appropriate action is taken.

Evaluation of plan

- > coping skills
- > concerns
- > attended referrals
- > techniques assessed
- > knowledge assessed
- > behaviour changes assessed.

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. CHSA Diabetes Educators assist 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. Education is provided in a shared care model with ongoing medical care by the general practitioner 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 CHSA *CSII Inpatient and Outpatient Record*.

Transition from Paediatric to Adult Services

The CHSA Diabetes Service plays an integral role in ensuring the transition from paediatric care to adult care is undertaken 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 CHSA or Metropolitan Diabetes Service as the primary health care provider.

Diabetes in Pregnancy

According to the CHSA Maternal and Neonatal Clinical Network, women with pre-existing diabetes and those diagnosed with gestational diabetes mellitus (GDM) are [C] coded. This code requires referral of care to a medical practitioner and discussion to continue with Team Midwifery, 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 CHSA or to a private or public Diabetes Service within metro Adelaide (eg Women's and Children's Hospital, Flinders Medical Centre or Lyell McEwin Hospital). The Diabetes Educator 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.

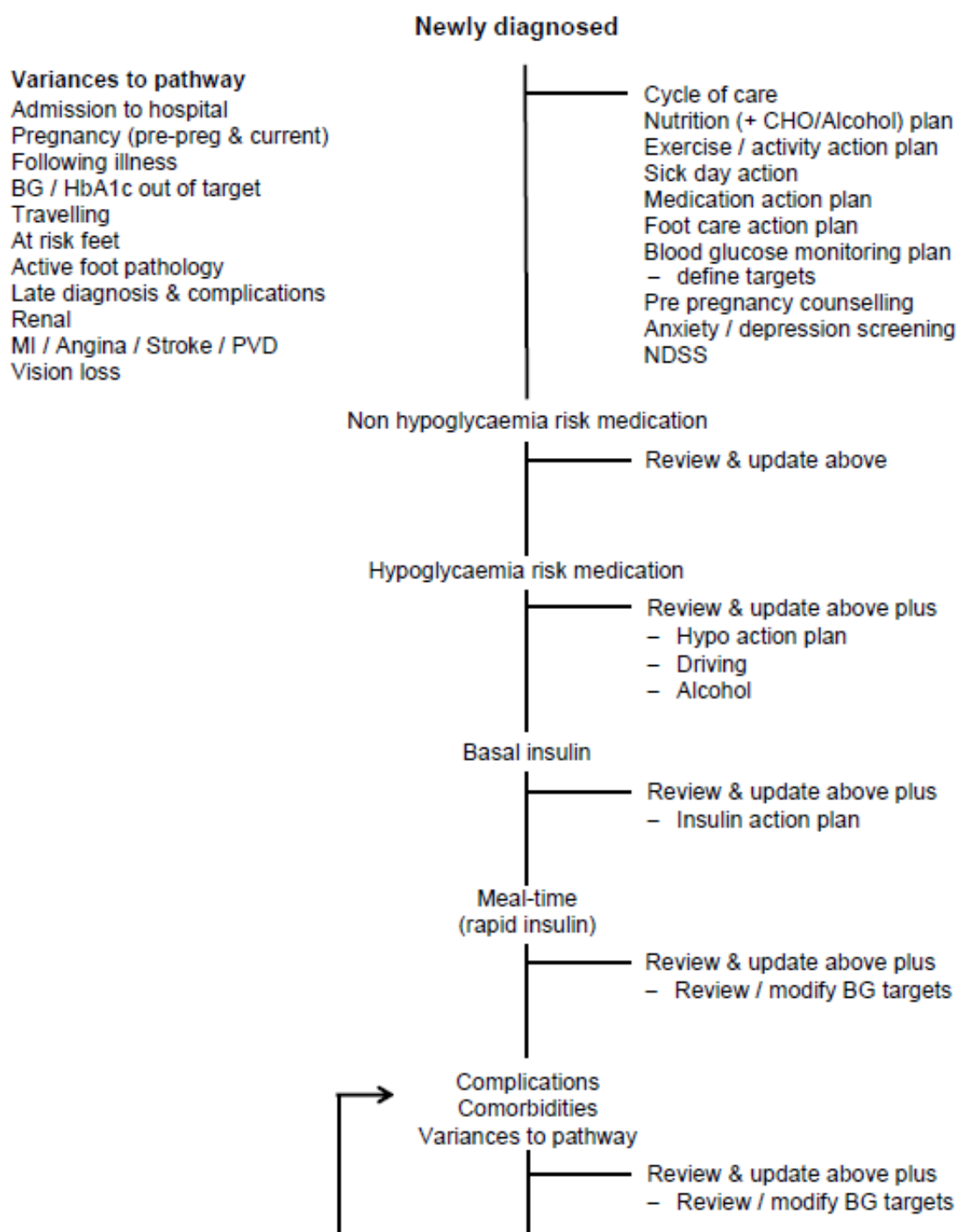
Non Attending

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

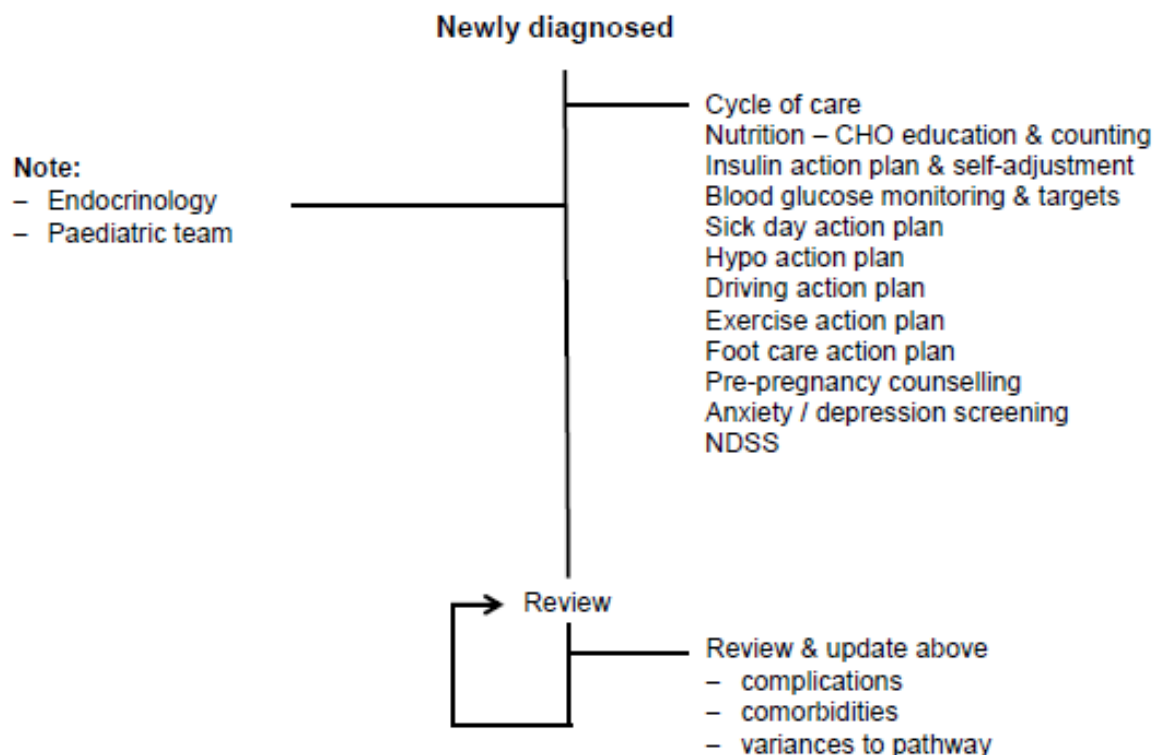
Communicating with the referring medical practitioner

It is important to communicate with the referring doctor after the initial appointment to communicate the management and/or education plan and potential completion date/s. Consider additional communication if circumstances change or there are concerns. Always communicate when the person is discharged from the diabetes service. The *CHSA Communication templates* (Appendix 6, 7 and 8) can be used to format a concise letter.

Country Health SA Diabetes Service T2D Education Pathway



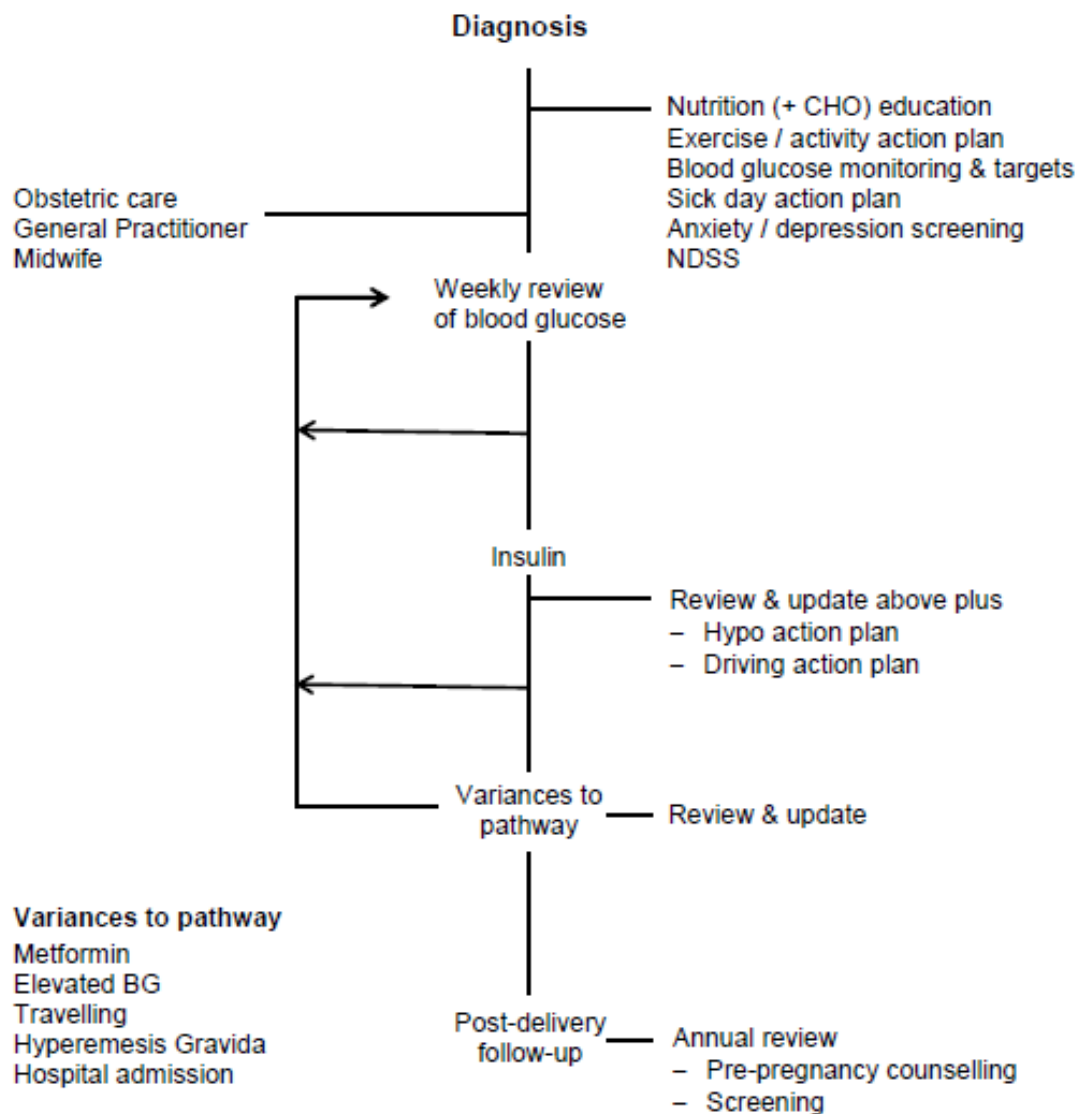
Country Health SA Diabetes Service T1D Education Pathway



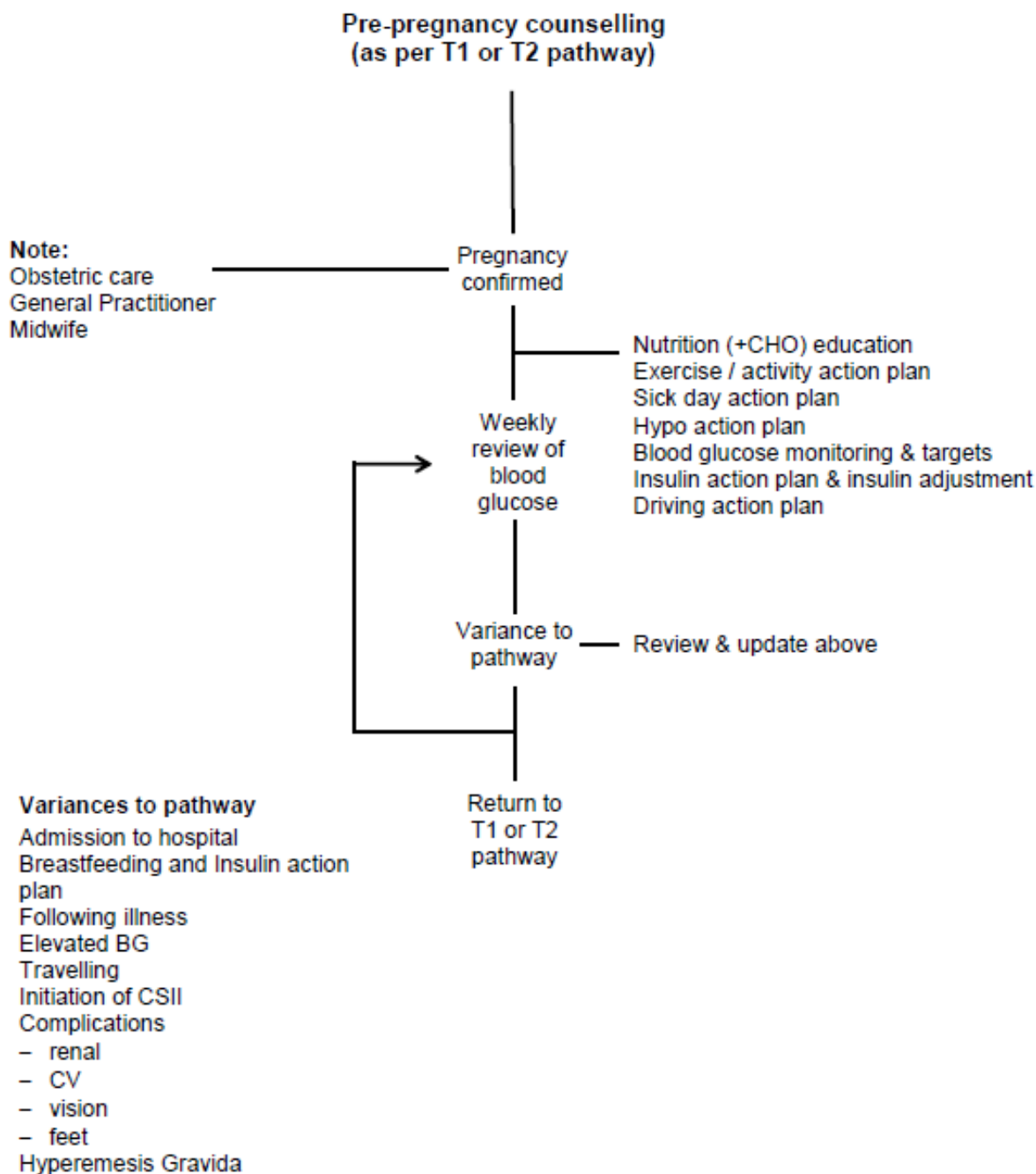
Variances to pathway

Childcare / school
 Transition to adult care
 Admission to hospital
 Pregnancy (pre-preg & current)
 Following illness
 Elevated BG / HbA1c
 Travelling
 Initiation of CSII
 At risk feet
 Active foot pathology
 Renal
 MI / Angina / Stroke / PVD
 Vision loss

Country Health SA Diabetes Service Gestational Diabetes Pathway



Country Health SA Diabetes Service Pre-existing T1 or T2 in pregnancy



Country Health SA Diabetes Service Paediatric Diabetes and DECD Pathway

Referral to CHSA Diabetes Service (by specialist team)

Referral should include

- > Contact details
- > Insulin regimen
- > Psychosocial issues
- > Equipment provided
- > Copy of school care plan



Step 1: Phone parents

Discuss

- > Your local role (if new to your service).
- > Organise an appointment time with parent/child.
- > Ask parents to contact the school/child care centre to set up a meeting time.
- > Advise parents that it may be beneficial for their child to attend the meeting with the school.



Step 2: Initial meeting with parents (may be scheduled immediately before school meeting)

- > Discuss child's DECD Care Plan, Medication Authority and First Aid Guides. Ensure any changes are dated and signed.
- > Identify any educational issues that require follow up.
- > Explain responsibilities of the school/child care centre staff.
- > Discuss parental responsibilities (eg provide emergency contacts, any changes/updates to care plan / first aid guides / medication authority, equipment (eg blood glucose / ketone monitoring, insulin administration devices, hypo kits)).
- > Identify child's capacity to participate and take responsibility for aspects of self -management.



Step 3: School meeting

Discuss with principal/class teacher/SSO/parent/child;

- > DECD Care Plan, Medication Authority and First Aid Guides.
- > Parental responsibilities and child's capacity to participate and take responsibility for aspects of self-management.
- > Location of equipment to be provided (eg blood glucose / ketone monitoring, insulin administration devices, hypo kits).
- > Supervision required for blood glucose / ketone monitoring, insulin administration and where this will take place.
- > Supervision of meals and snacks and assistance with insulin dose calculations.
- > Supervision of physical activity and additional planning for excursions/camps/ activities.



Step 4: Follow up and maintenance

- > Follow up (either phone or in person) with parent and school in 2-4 weeks (or as negotiated) to identify any care plan implementation issues or general concerns.
- > Communicate with specialist team re outcomes of parent and school visits via email or letter.



Contact family at least annually to provide local support and review/update Diabetes Care Plan, Medication Authority and First Aid Guides as required.



Government of South Australia
SA Health

Country Health SA Local Health Network

Name of Hospital
Department

Address

Date:

Tel 08 8888 8888
Fax 08 8888 8888

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) _____

☐ Insulin (Name & Dose) _____

Assessment/Key Issues/Risks/Client Goals

Recommendations/Education Plan/Action Plans and Resources provided

Referrals required/arranged

Next CDE 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

Country Health SA Local Health Network

Name of Hospital

Department

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) _____
- ☐ 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 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

Country Health SA Local Health Network

Name of Hospital
Department

Address

Date:

Tel 08 8888 8888
Fax 08 8888 8888

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) _____
- ☐ 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: _____

Acknowledgements

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

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