REGIONAL LOCAL HEALTH NETWORKS

Protocol (clinical)

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Author: Rural Support Service – Diabetes Service
Sponsor: Chief Clinical Advisor, Rural Support Service

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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.

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Clinical, Protocol, LHN.

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Applies to
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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.
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?

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.

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.
Rural Support Service - Diabetes Service
T1D Education Pathway

Newly diagnosed

Note:
- Endocrinology
- Paediatric team
  - Controlink
- 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 (menarche, 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

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Rural Support Service - Diabetes Service
T2D Education Pathway

Newly diagnosed

- Cycle of care
  - Nutrition (+ CHO/Alcohol) plan
  - Exercise / activity action plan
  - Sick day action
  - Medication action plan
  - Blood glucose monitoring & targets
  - Foot care action plan
  - Dental
  - Pre pregnancy counselling
  - Anxiety / depression screening
  - NDSS

- Non hypoglycaemia risk medication
  - Review & update above

- Hypoglycaemia risk medication
  - Review & update above plus
    - Hypo action plan
    - Driving
    - Alcohol

- Basal insulin
  - Review & update above plus
    - Insulin action plan

- Meal-time (rapid insulin)
  - Review & update above plus
    - Review / modify BG targets

Complications
- Variances to pathway

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Rural Support Service - Diabetes Service
Gestational Diabetes Pathway

Diagnosis

- Nutrition (+ CHO) education
- Exercise / activity action plan
- Blood glucose monitoring & targets
- Sick day action plan
- Anxiety / depression screening
- NDSS

Weekly review of blood glucose

Insulin

- Review & update above plus
  - Hypo action plan
  - Driving action plan

Variances to pathway

Review & update

Variances to pathway

- Metformin
- Elevated BG
- Travelling
- Hyperemesis Gravida
- Hospital admission

Post-delivery follow-up

Annual review
  - Pre-pregnancy counselling
  - Screening
Rural Support Service - Diabetes Service
Pre-existing T1 or T2 in pregnancy

Pre-pregnancy counselling (as per T1 or T2 pathway)

Pregnancy confirmed

Weekly review of blood glucose

Variance to pathway

Return to T1 or T2 pathway

Notes:
Obstetric care
General Practitioner
Midwife
Dietitian

Nutrition (+CHO) education
Exercise / activity action plan
Sick day action plan
Hypo action plan
Blood glucose monitoring & targets
Blood ketone testing
Insulin action plan & insulin adjustment
Driving action plan
Type 2 diabetes – notify NDSS re change

Variance to pathway
Admission to hospital
Breastfeeding and insulin action plan
Following illness
Elevated BG
Travelling
Initiation of CGM / FGM
Initiation / Upgrade of CSII
Complications
- renal
- CV
- vision
- foot
Hyperemesis Gravid

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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 devices)
> 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. Adaptation 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 adaptation 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 parent/carer or adaptation of the program for early childhood centre staff, child and parent/carer (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 adaptation 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/uploads 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.
Guiding document and checklist

The NDSS Diabetes in School program level 3 (individualised skills training) with designated school staff, child and parents or adoption 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 +/- Glucagon 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 NDIS website at https://www.diabetesinschools.com.au/resources-and-information/
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

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: __________________________
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: ________________
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:

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

<table>
<thead>
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<td>CSII Outpatient Rate Record (MR-COR)</td>
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<td>Diabetes Foot Assessment Chart</td>
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3. References

Rural Support Service; Diabetes Service Share Point page
https://sagov.sharepoint.com/sites/CHSA/clinical/diabetes/Pages/Protocols-%26-Procedures.aspx


4. Accreditation standards

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

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

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**National Disability Insurance Scheme (NDIS) Practice Standards**

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5. Consultation

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