

# Diabetes Network News



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Dear Readers,

Welcome to the 66th edition of Diabetes Network News. The theme for this edition is type 1 diabetes. We aim to raise the awareness of this condition in rural and remote SA. The prevalence of type 1 diabetes is increasing as demonstrated by the recent Australian Institute of Health and Welfare report which estimates an increase of 10% since 2008 in the 10-14 year old age group.

Whilst type 1 diabetes most commonly develops in childhood and adolescence it can have its onset at any time. It is incurable and as yet there is no way to prevent it. The management of type 1 diabetes requires a multidisciplinary health care approach which can be particularly challenging in rural areas.

We hope you enjoy reading about the health services, research and resources pertaining to type 1 diabetes that we have profiled in this edition.

Cheers

Jane Giles, Manager

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## Diabetes Outreach

Diabetes Outreach is a Country Health SA program, providing continuing education, support and assistance with service planning.

### Diabetes Outreach

- > Provides training and support for rural and remote health professionals.
- > Contributes to local and regional networks.
- > Promotes evidence based standards of care.
- > Facilitates access to information about quality assurance and documentation.
- > Facilitates access to information about population health needs.

### We offer:

- > Education resources for health professionals and people with diabetes.
- > Education programs conducted in rural and remote areas.
- > Distance education programs.
- > Peer support.

### The vision of Diabetes Outreach is:

**Better health for rural and remote South Australians by supporting health service providers towards best practice in diabetes care.**

The Diabetes Outreach team is located at 8 Woodville Rd, Woodville South SA 5011. Visit our website [www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au) for access to and information about education programs and free resources for both people with diabetes and health professionals.



L-R: Kathy Melino, Tracey Gerhardy, Jane Giles, Kate Visentin

Cover pict: Diabetes Department staff photo

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## Type 1 diabetes in South Australian health services

Type 1 diabetes is an autoimmune disease which results in the person requiring lifelong insulin injections for survival. To achieve target glycaemic control most people with type 1 diabetes will require four or five injections every day or an insulin pump which delivers continuous insulin over a 24 hour period. Type 1 diabetes can cause short and long term complications such as hypoglycaemia, diabetic ketoacidosis, nephropathy, retinopathy, neuropathy and cardiovascular disease. However, with adequate management, education and care, many of these complications can be either limited or avoided thus optimising the person's quality of life.

The management and care of the person with type 1 diabetes is different than the person with type 2. Type 1 diabetes can affect people at any age with 50% of diagnosis occurring in childhood or adolescence. Health services need to provide ongoing education and care for people with type 1 diabetes across the lifespan including:

- > children
- > adolescents
- > young adults
- > adults
- > pregnant women.

The draft national evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults state that individuals with type 1 diabetes should be reviewed regularly (3-4 times per year). Of these reviews, one should be a major review with the multidisciplinary team (including an endocrinologist). All people should also have a general practitioner who is kept informed of the diabetes management.

In this section we provide an overview of the current services being provided in South Australia for people with type 1 diabetes.

### Adelaide Women's and Children's Hospital



The Diabetes and Endocrine Department at the Women's and Children's Hospital care for over 1000 children and adolescents from the age of 0 years to 18 years.

Their team consists of:

#### Endocrinologist:

Professor Jenny Couper  
Dr Jan Fairchild  
Dr Elaine Tham  
Dr Alexia Pena

#### CPC-CDE:

Marianne Lambert

#### CPC-CDM:

Tania Kelly

#### CDE:

Louise Wilson

#### Dietitians:

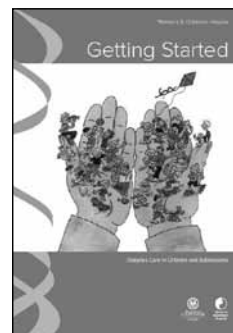
Bronwen D'Arcy  
Caroline South

#### Mental Health Nurse:

Pat Mead- CPC

#### The services include:

- > education for children/adolescents and family who are newly diagnosed with type 1 and type 2 diabetes
- > inpatient care and support
- > outpatient clinics – Tuesday, Wednesday and Thursday
- > continuous glucose monitoring system clinics
- > insulin pump therapy initiation and ongoing support.



#### Resources written by the Diabetes Team and available on the intranet:

'Getting Started' is a book for newly diagnosed families with type 1 diabetes. It introduces the families to the management of type 1 diabetes. New copies can be ordered for \$10 each by contacting the Endocrine and Diabetes Department, Women's and Children's Hospital, phone (08)

8161 6402 or downloaded (for SA Health employees only) from [http://inside.cywhs.sa.gov.au/webs/endocrine\\_diabetes/documents/GettingStartedOct2010.pdf](http://inside.cywhs.sa.gov.au/webs/endocrine_diabetes/documents/GettingStartedOct2010.pdf).

'Doing Diabetes 2011' is a newsletter full of stories about children/adolescents with diabetes, helpful hints in managing diabetes and research that is conducted in the department. The newsletter is sent to all families who are current patients of the service.

#### Carbohydrate exchange list

'Carbohydrate Exchange List' is a guide to common carbohydrate foods and their exchange values.



This resource is available from the Nutrition Department website at [www.wch.sa.gov.au/services/az/other/nutrition/nut\\_resources.html](http://www.wch.sa.gov.au/services/az/other/nutrition/nut_resources.html) then click on 'diabetes'. It can be downloaded for free, or print the order form to purchase a hard copy.

'Type 1 diabetes and healthy weight' is another colourful handout with nine quick tips to ensure children are eating well and keeping active.

### Standards available on the intranet:

- > Diabetes and Hypoglycaemia Management
- > Diabetes Insulin Administration
- > Diabetes – Management of a Patient Pre and Post Operatively (updating)
- > Diabetes - Hyperglycaemia (updating).

The other metropolitan diabetes health services provide a range of specialised services for people with type 1 diabetes. Some diabetes services also cater for children.

The services provided include:

- > inpatient care and support (adults and paediatric)
- > outpatient insulin stabilisation phone service
- > outpatient insulin pump clinic – adults/paediatrics
- > outpatient paediatric clinic
- > outpatient insulin clinic
- > continuous glucose monitoring systems (CGMS)
- > high risk foot clinic
- > outpatient endocrinology clinics
- > outpatient education.

For further information about metropolitan services for people with type 1 diabetes please contact the Clinical Services Consultant at the major centres below:

- > Flinders Medical Centre
- > Lyell McEwin Hospital
- > Royal Adelaide Hospital
- > The Queen Elizabeth Hospital
- > Repatriation General Hospital.

In country South Australia there are a wide range of services being offered and these depend on the resources available locally. Some services have visiting endocrinologists while others have no local access to specialty care. The Women's and Children's Hospital do regional visits to Whyalla, Pt Augusta, Mt Gambier and Pt Lincoln. In some of these towns multidisciplinary clinics have been set up where children can see the diabetes educator and dietitian at the same visit. The South East provides a Dose Adjusted for Normal Eating (DAFNE) program for people with type 1 diabetes. Some areas are also providing CGMS and commencement of insulin pump therapy.

For information about education and medical services in rural areas contact the local diabetes educator.

## Case study – How my patient managed insulin and exercise

**Diana Vine, Credentialed Diabetes Educator, Naracoorte Community Health Service, South Australia**

When Cassie came to see me last September to discuss her intention to take part in a 60km fundraising walk to be held in late November my first thought was it could be a recipe for disaster. I had known Cassie for six years and now at seventeen she was struggling more than most teenagers with numerous social and emotional problems while trying to complete her schooling and manage her diabetes. Over the previous twelve months Cassie's HbA1c had been between 10-11% and she had been admitted to hospital on several occasions with both DKA and hypoglycaemia.

Cassie was one of the students at the local Independent Learning Centre organising the fundraiser and although keen to complete the two day walk she was anxious about how she would manage her diabetes. Cassie had not been monitoring her blood glucose levels regularly and was prone to binge eating when feeling stressed or unhappy while also often forgetting to take her bolus insulin. Cassie was currently not playing sport and walked only occasionally when she had no other means of transport.

We talked about what she would need to do to succeed and I emphasised the importance of good preparation in terms of both physical fitness and improved blood glucose control. Together we devised an action plan that involved Cassie making significant changes to the way

she managed her diabetes. We started by going back to basics, checking injection technique, injection sites, blood glucose monitoring equipment, as well checking Cassie had blood ketone testing strips and an in date GlucoGen Hypo kit. We reviewed hypoglycaemia management and set realistic blood glucose targets. We made weekly contact and involved Cassie's GP who assisted with insulin adjustment over the weeks leading up to the walk. A meeting with Cassie's teacher was also arranged to ensure there was adequate support for Cassie before and during the walk weekend.

Expansion of my knowledge of exercise and type 1 diabetes was part of my ongoing professional development plan so as well as researching written resources and reading widely on this subject, I also subscribed to Allan Bolton's website eXT1D (<http://ext1d.com.au/diabetes/>). This interactive web-based education tool comprises five learning modules, and the 'Dashboard' section proved valuable when it came to working out Cassie's exercise carbohydrate requirements and insulin adjustment guide for the walk.

During the final weeks before the event Cassie prepared with daily walks, healthy eating as well as making a commendable effort in keeping her diabetes self-management on track, resulting in greatly improved blood glucose control. On the night before the walk Cassie's basal insulin dose was reduced by 10% and 20% the following night. We kept in phone contact but my advice was not needed as apart from one mild hypo on the first day Cassie managed the gruelling 60km walk without incident. Everyone, especially Cassie, was very proud of her success and the confidence she gained from the experience was wonderful to see.

## Introducing Nikola Thompson



Since Marg Daly retired at the end of 2010, Nikola Thompson (pictured) has now filled the position as Diabetes Nurse Educator at the Murray Mallee Community Health Service, based in Murray Bridge.

Nikola has a background in community nursing, respiratory nursing and diabetes chronic disease management. As a diabetes nurse educator she enjoys continually learning from other people, including other colleagues and her clients directly. Everyone's diabetes experience is different so she is continually learning from this and is able to expand her knowledge and experience to be able to more effectively help clients with their diabetes journey. Working in a rural area presents different challenges for people to deal with, so she is enjoying learning from them and helping them to self manage. Her role and the organisation she is working within also has a large health promotion focus, working towards improvements in primary health care and community health which she has found particularly rewarding to be able to work towards creating change rather than just 'treating' the client with diabetes.

Her interests and hobbies include horse riding, spending time with her family (three children and her husband), writing and drawing.

Expanding upon her experiences, knowledge, interests and love for her family she has written a book 'Maliki's Spirit'. See below for some information from Nikola.

### Maliki's Spirit

"The book was written to assist in encouraging children to eat healthily and be active. My daughter inspired me to write the book as when she was three years of age I encountered problems because she would only eat bread and butter. I read the story to my daughter who then wanted to be healthy like Maliki and began to enjoy eating a variety of foods particularly vegetables and fruit which made meal times a lot of fun.

The book is designed for parents, children, and professionals such as teachers, health workers, dietitians, nurses and allied health workers. I have used the book as an educational resource on well being in schools to encourage healthy living. Children enjoy the story and find that they want to know more about health. I have had comments such as I do not want to eat junk food because I do not want to be sick or I am going to play more outside rather than watch television. These are comments that children have stated.

The idea of the book is to promote well being and health literacy. Although the recipes were not reviewed formally by a dietitian they are based on healthy eating principles in accordance with Australian eating guidelines. I have had two dietitians look at the recipes informally.

People can get copies of the book by emailing [nikolathompson@bigpond.com.au](mailto:nikolathompson@bigpond.com.au) or phone 8389 8554 or 0488 088 838."

## Farewell to Di Barrie and Liz Bishop

On behalf of the Northern Diabetes Educators Network and Country Health SA we would like to acknowledge and farewell Di Barrie and Liz Bishop who were both dedicated diabetes educators within their respective communities. Di Barrie will still be working in health promotion but she has chosen to focus more on health promotion and will no longer be working in the diabetes area. We wish Liz well in her retirement.

Liz and Di have provided us with some background information about their journey in the world of diabetes.

Around 2003 the northern region (Booleroo Centre, Orroroo, Jamestown and Peterborough) was fortunate to be granted Commonwealth funding to promote Primary Health/Health Promotion in their delivery of health outcomes (Regional Health Services Program Funding which is known locally as the Rural Health Team). Both Liz Bishop and Di Barrie were employed by this team as Diabetes Educators, and Di also held the Health Promotion position at Orroroo. This has been one of the most rewarding aspects of their positions, being able to have the time and resources to promote healthy lifestyle programs for the prevention of chronic disease including type 2 diabetes, but also to support those with

type 2 diabetes in their management skills, and complication prevention. They have been able to work closely on many projects which have included school nutrition programs, Diabetes Support Groups in both Orroroo and Booleroo Centre, and a local Diabetes Newsletter.



*Pictured above: Liz Bishop and Di Barrie.*

One of the best supports for diabetes educators in rural areas are the network meetings, and the Northern Diabetes Educators Network meetings are no exception, meeting every 3 months, and well supported by Diabetes Outreach, and various diabetes equipment representatives. It is a very

proactive group who have achieved a great deal including:

- > local staff education
- > advocating for the development of online competencies for staff education
- > updates on clinic documentation and auditing requirements
- > ongoing information on new/improved management strategies via guest speakers, teleconference and videoconference
- > advocating on behalf of rural and isolated diabetes clients.

They have both been able to achieve:

- > Annual mandatory staff training at both the hospital and the aged care unit.
- > School nutrition programs for both reception/year 1 students and middle primary students each year.
- > Working with the dietitians on the 'Go 4 Green' label reading in the local supermarkets, to make healthier choices of food items easier to select.
- > Production of a local diabetes newsletter, with local clinic and group information, and management of skills and support.
- > Development of and continued support of the Diabetes Special Interest Group, in Orroroo. 'The Buzz Group' has run now for six years, and eight years for the Booleroo group, enjoying education sessions, and social outings - twice a year the two groups come together for bus trips and shared guest speakers.

Below are some words from Di on her background, experiences and individual achievements.

"I worked originally in neonatal nursing in Adelaide until I married and moved north to an isolated farm at Willowie in 1978. Initially, I conducted Infant Welfare Clinics for the old 'MBHA' until my own family came along, then I worked as an RN RM at the Orroroo Hospital for a number of years. I was asked to take on the Health Promotion position in 1999 as part of my responsibilities and then commenced as the Diabetes Educator at Orroroo in 2002. One of the great things about working in a small rural health unit is the ability to gain experience in such a wide range of nursing and health, and being flexible; as one door closes (obstetrics/ midwifery), another one opens (health promotion and diabetes education!).

I completed my Graduate Certificate in Diabetes Management at Flinders University in 2003 and enjoyed meeting a wonderful group of fellow students who catch up periodically at various study and refresher days.

Whilst I am reducing my hours, I will be continuing my work in health promotion, and will continue to promote healthy lifestyles and good nutrition across all ages in the Orroroo community. The rewards in working locally are enormous, and I am looking forward to maintaining this relationship with the

Orroroo community.

In Orroroo (apart from those listed above) I have achieved:

- > A half day clinic each fortnight, and half day of resident assessment each month at the residential aged care.
- > Promotion of diabetes information in the community to increase knowledge; medical centre displays, local community newsletter and posters etc.
- > Promotion of exercise and activity sessions at the Orroroo Community Gym for diabetes clinic clients."

Below are some words from Liz on her background, experiences and individual achievements.

"I started all my diabetes training in 1990 so I guess you could say I have been the diabetes educator at Booleroo for 20 years!

When I started I was doing a day a month working from an office in the hospital and I was making the appointments with a simple recall system that I set up at the time. This eventually progressed to the one day per fortnight where I now work out of the medical centre and work closely with the practice nurse and the doctors. Appointments are made by the medical centre practice nurse from a recall system and doing care plans.

Back in the 1990's it was definitely a tick box type of education and I can recall the doctor at the time saying "why do you need to go off and do all this education, you just have to tell them not to put sugar in their mouth"!!!

Some of my achievements (apart from those listed above) are:

- > helping set up a community garden
- > producing a quarterly newsletter and post this out to all known people with diabetes in the district for the past 4 years
- > running Wise moves exercise groups
- > working with community foodies
- > cooking programs."



*Pictured above: the Northern Diabetes Educators Network.*

## Farewell to Helen McNicol

Helen has been a diabetes educator at Port Lincoln Health Services for 12 years. During that time she completed the Graduate Certificate in Diabetes through Curtin University and graduated in 2008.

Helen's favourite areas of diabetes education are insulin pumps and type 1 clients, and she worked at establishing local support and education services in this area.

The Port Lincoln area has developed its service from no clients on insulin pumps to approximately 8 people at present. In addition there are now clients being assessed with continuous glucose monitoring systems (CGMS).

Helen helped establish the regional network and provided

ongoing support and help to the other regional educators. She has also been instrumental in developing and maintaining a diabetes support group and following Dr David Mills departure, Diana and herself have worked closely with Dr Natalie Giles and Hamish Eaton who both visit Port Lincoln 3 times a year.

Helen has decided to 'take a break' from full time work, assisting her husband on their property and spending more time with her family. The service has advertised the position and they hope to have someone step into Helen's position who is as passionate and forward thinking about diabetes, and have someone who can continue to develop the regional service to provide outstanding care.

Diana Pluker who also completed her Graduate Certificate in 2008 continues to provide diabetes education 2 days a week.

## Update from Diabetes Outreach

Since the last edition of Diabetes Network News, we have updated a number of the factsheets along with valued feedback from numerous health professionals across the state. These updated factsheets, useful for patient education include:

- > Gestational diabetes
- > Foot care for low risk feet
- > Foot care for high risk feet
- > Type 2 diabetes and exercise
- > Blood glucose monitoring
- > Insulin
- > Troubleshooting - being split into 'Low blood glucose in type 2 diabetes (hypoglycaemia)' and 'High blood glucose in type 2 diabetes (hyperglycaemia)'.

Some of the 'Dealing with Diabetes' PowerPoints have also been updated recently on the Diabetes Outreach website. Dealing with diabetes is a teaching and PowerPoint package to support health professionals providing inservice education. The updated presentations are:

- > Monitoring of diabetes
- > Diabetes and exercise
- > Oral hypoglycaemic agents
- > Insulin
- > Foot care
- > Hypoglycaemia.

To view and download the updated PowerPoint presentations including the presenters notes, visit <http://diabetesoutreach.org.au/professional/dealingwithdiabetes.asp>.

### Diabetes Fundamentals – an online self directed learning program (type 2 diabetes)

This program is designed as a basic introduction to type 2 diabetes and it has been designed for allied health professionals, nurses and Aboriginal health workers. The module introduces the reader to a range of diabetes teaching

resources, tools and organisations.

Whether one's interest in diabetes is incidental and informal or a chosen professional career pathway towards becoming a 'diabetes educator', this package is designed to give you a starting point from which to embark.

There are 11 modules that make up the 'Diabetes Fundamentals' program:

- > Understanding diabetes
- > Nutrition and diabetes
- > Lifestyle and diabetes
- > Monitoring and diabetes
- > Oral hypoglycaemic agents
- > Insulin
- > Hypoglycaemia
- > Hyperglycaemia
- > Long term complications
- > Pregnancy and diabetes
- > Diabetes education and support.

You will notice that each module consists of:

- > an introduction to the topic
- > suggested client evaluation questions
- > suggested teaching tools for consumer education and peer education
- > further reading
- > a case study for you to complete.

The program will be available in late August. Please contact Diabetes Outreach on 8222 6775 or email [diabetesoutreach@health.sa.gov.au](mailto:diabetesoutreach@health.sa.gov.au) if you require more information.

### Online Sick Day Education module

This program aims to provide an opportunity for health professionals to understand the principles that underpin self management of sick days for people with type 2 diabetes. The program also aims to highlight the evidence base for sick day management and the guidelines used in Australia that frame education provided to people with type 2 diabetes.

People with type 2 diabetes need assistance in developing

their action plan to help self manage their diabetes during illness. This program is designed to help you become familiar with and to use the Australian Diabetes Educators Association (ADEA) Sick Day Guidelines effectively in your education with people with type 2 diabetes.

Each module is framed to specifically identify self care issues under the following headings:

- > initial advice
- > blood glucose
- > medication needs and/or adjustment
- > hydration and food
- > when to attend a hospital or medical clinic
- > equipment/supplies needed at home to self care.

The program will be available in late August. Please contact Diabetes Outreach on 8222 6775 or email [diabetesoutreach@health.sa.gov.au](mailto:diabetesoutreach@health.sa.gov.au) if you require further information.

### Metropolitan contacts list

The contacts list for key diabetes educators, dietitians and podiatrists in the metropolitan area of SA has recently been updated. It is useful for health professionals working in regional areas who may need to contact other health professionals in the metropolitan area. It is now available on the Diabetes Outreach website on the 'Rural directory' page at <http://diabetesoutreach.org.au/directory>.



## National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults

Prepared by the Australasian Paediatric Endocrine Group and the Australian Diabetes Society for the Australian Government Department of Health and Ageing.

The draft National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults is the first national evidence-based clinical care guideline for type 1 diabetes across the lifespan. The guideline updates the Clinical practice guidelines: Type 1 diabetes in children and adolescents (APEG (Australasian Paediatric Endocrine Group) 2005), and extends the scope of that document to address the needs of adults with type 1 diabetes, including pregnancy.

The document was developed by an Expert Advisory Group (EAG) representing specialist societies and organisations, with the active participation of consumer groups and the community.

The document consists of an executive summary that includes:

- > a summary of the recommendations that were developed by the EAG, based on evidence from a systematic review of the relevant question; each recommendation is numbered according to the chapter to which it pertains.
- > a summary of the practice points that were developed by

the EAG through consensus decision-making, where the systematic review found insufficient high-quality data to produce evidence-based recommendations but clinicians require guidance to ensure good clinical practice; as with the recommendations, each practice point is numbered according to the chapter to which it pertains.

The guidelines outline current care in relation to:

- > blood glucose monitoring
- > insulin and pharmacological therapies
- > health care delivery
- > education and psychological support
- > nutrition
- > exercise
- > complementary and alternative medicines
- > pregnancy
- > contraception
- > transition and care across the lifespan
- > hypoglycaemia
- > diabetic ketoacidosis and sick day management
- > microvascular and macrovascular complications
- > foot ulcers and Charcot's arthropathy
- > other complications and associated conditions.

The draft document can be downloaded at

[www.diabetessociety.com.au/downloads/Type1guidelines\(7Feb11\).pdf](http://www.diabetessociety.com.au/downloads/Type1guidelines(7Feb11).pdf)

## National evidence-based guideline on prevention, identification and management of foot complications in diabetes

The recently released National evidence-based guideline on prevention, identification and management of foot complications in diabetes can be accessed at <http://t2dgr.bakeridi.edu.au/Home/FootComplicationsGuidelinesandTechnicalreport.aspx>.

### Key practice points from the guidelines

The assessment for foot complications needs to focus on identifying the risk factors. Prevention begins with identifying those who are at the highest risk.

The risk of foot ulceration and amputation is increased in people who have the following risk factors:

- > previous foot ulceration or previous amputation
- > peripheral neuropathy
- > peripheral arterial disease
- > foot deformity.

### Defining risk of foot complications and amputation

#### Tools for assessing neuropathy, circulation and foot deformity

##### Neuropathy

- > 10g monofilament sensitivity
- > vibration perception (tuning fork or biothesiometer)
- > Neuropathy Disability Score – ankle (Achilles) reflexes and the sensory modalities of pinprick, vibration and temperature perception

##### Circulation

- > palpation of peripheral pulses
- > ankle-brachial pressure index (ABPI)
- > toe-brachial pressure index

##### Foot deformity Score - 6 point scale (1 point for each characteristic)

- > small muscle wasting
- > Charcot foot deformity
- > bony prominence
- > prominent metatarsal heads
- > hammer or claw toes
- > limited joint mobility.

*Score of 3 or above indicates foot deformity.*

#### Stratify foot risk in the following manner:

- > 'low risk' - people with no risk factors and no previous history of foot ulcer/amputation
- > 'intermediate risk' - people with one risk factor (neuropathy, peripheral arterial disease or foot deformity) and no previous history of foot ulcer/amputation
- > 'high risk' - people with two or more risk factors (neuropathy, peripheral arterial disease or foot deformity) and/or a previous history of foot ulcer/amputation.

Until adequately assessed all Aboriginal and Torres Strait Islander people with diabetes are considered to be at high risk of developing foot complications and therefore will require foot checks at every clinical encounter and active follow-up.

#### Frequency of risk assessment

Expert opinion suggests:

- > In people stratified as having low risk feet, foot examination should occur annually.
- > In people stratified with intermediate or high risk feet (without foot ulcer) foot examination should occur every 3–6 months.

#### Foot protection program

In people with intermediate or high risk feet the guidelines suggest a foot protection program that includes:

- > foot care education
- > podiatry review (if there is no podiatrist available the review could be done by an appropriately trained worker)
- > hygiene maintenance – advice to inspect and wash feet daily
- > appropriate footwear and hosiery
- > protective shoes
- > clinic contact initiated by patient if concerned.

Footcare education should be provided to all people with diabetes.

Managing foot complications such as ulceration includes interventions such as:

- > wound debridement
- > dressings and other topical treatments
- > pressure reduction, redistribution of pressure or offloading the wound.

Best practice management of diabetes related foot ulceration requires coordinated and expert multidisciplinary care.

#### Reference:

National Health and Medical Research Council (2011) National evidence-based guideline on Prevention, identification and management of foot complications in diabetes: Evidence review. February. Baker IDI Heart & Diabetes Institute, The George Institute for International Health, Adelaide Health Technology Assessment, Melbourne.

## Diabetes counselling for men with diabetes living in rural Australia

Diabetes Counselling Online, Flinders University Rural Health School and Diabetes Outreach-CHSA are undertaking a study which looks at how extended counselling services for men living in rural and remote Australia can improve wellbeing. 'Widening the net – the impact of web based diabetes counselling on the wellbeing and diabetes related distress of men living in rural and remote regions in Australia' will investigate the impact of personalised online counselling for men who have sub-clinical depression and/or anxiety.

If you are interested in having participant information flyers available in your service, please visit [www.diabetescounselling.com.au](http://www.diabetescounselling.com.au) and follow the 'counselling and support' link to the 'men's shed' for further information and the participant flyer.



## Gastroparesis, food for thought

Barbie Sawyer MN(NP) CDE RN Diabetes Nurse Practitioner, South East Regional Community Health Services

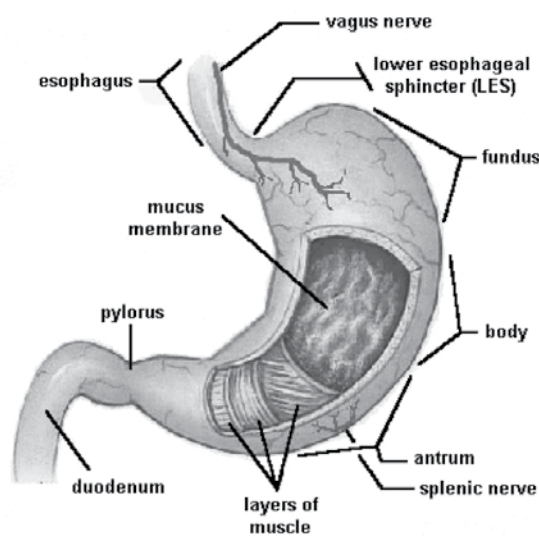
Normal gastric motility and function requires an integrated, systematic coordination between the sympathetic, parasympathetic, and (intrinsic-gut) enteric nervous systems, and the gastrointestinal smooth muscle cells. The autonomic (smooth muscle, involuntary) nervous system of the bowel comprises parasympathetic (stimulating motility) and sympathetic (inhibiting motility). The enteric nervous system is the internal nervous system of the gut itself. It has an essential role in the control of the motility, blood flow, water and electrolyte transport and acid secretion in the digestive tract. Disruption to any of these complex integrated systems has the potential to alter gastric function, and impact gastric emptying.<sup>2</sup>

Functionally the stomach is subdivided into two main regions; the proximal stomach consists of the cardia, fundus and body, comprising a thin layer of muscle capable of relatively weak contraction. The proximal stomach exhibits receptive relaxation upon ingestion of food and is responsible for storage. The distal stomach is comprised of the antrum and pylorus, the musculature is thick and capable of powerful contraction, mechanical and enzymatic digestion takes place in this portion of the stomach. The rate of passage of partly digested food particles, known as chyme, into the duodenum is regulated by the distal stomach.<sup>2</sup>

The digestive functions of the stomach include storage of food; the volume may vary between 50ml and 1500ml, mechanical and enzymatic breakdown of food, and a controlled delivery of chyme into the duodenum at a rate congruent with the digestive and nutrient absorption capacity of the small intestine.<sup>2</sup>

Gastroparesis is described by the American Gastroenterological Association (AGA) as 'a symptomatic chronic disorder of the

stomach characterised by delayed gastric emptying in the absence of mechanical obstruction'<sup>4</sup>

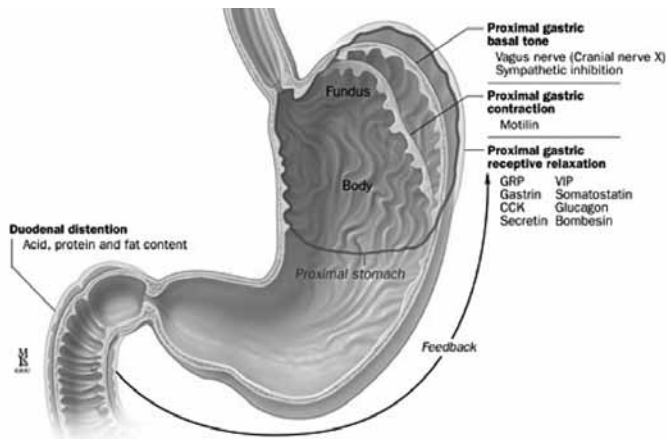


(source: Caryl Iverson)

Delayed gastric emptying of a modest extent is reported to have a prevalence of up to 50% in those with long standing diabetes and the pathophysiology is described as a combination of vagal neuropathy and increased gastrointestinal hormone levels such as glucagon. A history of long standing poor glycaemic control is usually evident. Hyperglycaemia itself has been identified as a cause of delayed gastric motility, and emphasises the importance of normalising blood glucose levels in those individuals with gastroparesis. The co-existence of other endocrine diseases such as hyper and hypothyroidism, both of which can cause altered gastrointestinal function, should be excluded.<sup>1</sup>

Gastroparesis often accompanies other symptoms and signs of autonomic neuropathy such as postural hypotension and is referred to as part of autonomic neuropathy. It comprises a range of gastrointestinal manifestations such as early satiety,

nausea, bloating, vomiting of undigested food hours after a meal, abdominal pain, gastro-oesophageal reflux, constipation and faecal incontinence. Constipation has been reported to affect 12-88% of patients with diabetes. However, there is debate as to whether there is a direct correlation with autonomic neuropathy.<sup>6</sup>



Upper gastrointestinal motility is the foremost determinant of postprandial excursions of blood glucose.<sup>5</sup>

The impact of gastroparesis on blood glucose control can result in delayed post-prandial hyperglycaemia in patients with type 1 diabetes, and in those with insulin requiring type 2 diabetes, however it is also the cause of otherwise unexplained hypoglycaemia. This hypoglycaemia tends to occur in the early postprandial period, especially in patients with type 1 diabetes. The time and action profile of exogenous insulin is unable to match the delayed absorption of nutrients from the small intestine in patients with gastroparesis, resulting in hypoglycaemia 1-2 hours post-prandially and hyperglycaemia several hours later.<sup>5</sup>

Gastroparesis can be episodic, with patients experiencing periods relatively symptom free interspersed with periods of hyperglycaemia, nausea and reflux. In the more advanced stages of gastroparesis the symptoms become more prevalent and nausea and vomiting can occur on a daily basis.<sup>2</sup>

Management of gastroparesis is aimed at improving nutritional status, quality of life and optimising blood glucose control. Patients with type 1 diabetes may benefit from continuous subcutaneous insulin infusion. Patients with type 2 diabetes may benefit from commencing exogenous insulin therapy. Matching the rate of carbohydrate delivery into the small intestine with exogenous insulin is the aim of therapy. Medications promoting gastric emptying rates may assist such as prokinetic agents erythromycin, metoclopramide and domperidone. The choice of pharmacological therapy to aid gastric motility and relieve symptoms will be influenced by potential adverse effects, coexisting disease states and physician preference.<sup>5</sup>

Conversely some medications/drugs delay gastric motility - opioid analgesics, tri-cyclic antidepressants, calcium channel blockers, nicotine, glucagon, proton pump inhibitors and H<sub>2</sub>-receptor antagonists, alcohol, marijuana and many others. It is therefore important to review medications with patients suspected of suffering from gastroparesis, and discuss changes

to medications that may be exacerbating dysmotility with the physician or general practitioner.<sup>4</sup>

Dietary recommendations are aimed at ensuring adequate nutrition and promoting gastric emptying. High fat and indigestible fibre tend to retard gastric motility. An increased liquid nutrient component may prove easier to mobilise from the stomach as liquid stomach emptying is often more functional than solids emptying in patients with gastroparesis. Minimisation of meal size may also assist, with 4-6 small meals per day required to enable adequate nutrient intake. Pured foods may also be beneficial. Smoking and alcohol should be avoided.<sup>4</sup>

Symptomatic improvement may be obtained with post-prandial walking, and chewing sugar free gum for 1 hour post-prandially,<sup>7</sup> anecdotally this has proven successful for several patients with gastroparesis who have reported less episodes of nausea and vomiting and improvements in bowel function with less constipation.

Gastroparesis is a distressing and sometimes debilitating condition which impacts greatly on the quality of life of people with diabetes. It therefore remains an imperative part of holistic care to enquire about bowel function, and consider the presence of gastroparesis in patients with unexplained post-prandial hypoglycaemia and those with hyperglycaemia at unexpected times.

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## Self-management experience for the person with type 1 diabetes in the hospital setting

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Type 1 diabetes mellitus (T1DM) is a chronic illness for which there is currently no cure. Individuals living with T1DM learn to manage their disease on a daily basis through a series of self management tasks. Not only does T1DM self management require the person to perform tasks it also requires decision making on many aspects of those tasks, making T1DM the most complex self management disease<sup>1</sup>. Previous research has identified the role of self management in the person with T1DM and the expertise an individual develops over a significant period of time in relation to their T1DM management<sup>2,3,4</sup>. However, on admission to hospital the person with T1DM is often required to alter or relinquish their daily self management responsibility<sup>5</sup>. While in some circumstances a patient with T1DM may be too unwell to continue self management the interest of this study was to explore the person with T1DMs ability to self manage their chronic illness while an inpatient when T1DM is not their primary admission diagnosis.

To explore the patients experience a qualitative case study was undertaken following ethics approval. Data was collected through semi structured interviews of patients and a nurse manager, periods of nurse patient observation and analysis of the large metropolitan hospital policies on diabetes management and the patient participants' case notes. All data was thematically analysed. The study found while the actual experience of individuals' self management of T1DM varied in the hospital setting there were some common themes.

### Participants' perspective of self management

For the patient participants their ideals of self management shaped their expectations of how their T1DM would be managed in hospital. The participants suggested self management of their T1DM involved a number of daily tasks, along with making numerous decisions. Over time the participants had learnt about their own bodies response to their illness, which enhanced their ability to independently self manage their T1DM.

*...Check your blood glucose level, make sure your insulin is coinciding with those, keep an eye on your diet but don't be strict, let your hair down occasionally, yeah basically you know look after your health (Participant 1)*

*...living with it you tend to know a fair bit and living in this body I tend to know what this body will cope with (Participant 2)*

### Expectations of self management in hospital

The patient participants had expectations of management of their T1DM in the hospital setting which was shaped by their previous hospital experience, their perceived level of knowledge of health professionals on T1DM and their desire to be seen as knowledgeable. In relation to previous hospital experience the participants said

*...literally its quite obvious their reading the book cause they are going diabetes you should have a blood sugar of... (Participant 2)*

*...but you expect people to know what they're doing for diabetics ...And I just hoped like hell they knew what they were doing...(Participant 1).*

On knowledge of the health professional the participants said:

*...I just think they've got such a poor understanding of diabetics, they have got a good understanding of diabetes but a bad understanding of diabetics (Participant 2)*

*...they (nurses) should sort of have a bit of an idea of what diabetes is all about (Participant 1)*

*I think that in the hospital we're still getting to the point of getting people to think that the patients have some knowledge (Participant 3)*

Lack of recognition of their own knowledge of T1DM by health professionals tainted the patient participants' perception and further shaped expectations of their current hospital admission.

*...I probably know the equivalent to most of the nurses and probably the Drs too and I might not be able to quote all the technical stuff but living with it you tend to know a fair bit (Participant 2)*

The participants wanted their knowledge and ability to manage their T1DM recognised and validated in the hospital setting. They also wanted to contribute and negotiate with health professionals about their T1DM management in the hospital setting.

### Impact of the environment

In addition to the management of daily tasks the participants discussed the impact of the hospital environment on T1DM management. The impact of the rules within the hospital on T1DM management along with the issue of communication between patient and health professional were identified.

In relation to communication one participant said

*The nurses looking after you a bit of a discussion with them about the diabetes just so they can gauge how much you know and how much they do need to be involved... listen to the patient, what the patient says (Participant 2).*

Numerous factors within the hospital setting impacted on the patient participant's self management experience. These identified factors included a change of routine from home to hospital and lack of recognition of the knowledge level and ability of the T1DM patient to self manage their condition.

In relation to change of routine the participants said

*...timing of insulin in here is different to home...(Participant 1)*

*...Diet in hospital messes up your home management. It's different at home... (Participant 2)*

*...not following their home routine their blood sugar levels do change... (Participant 3)*

### Current experience of T1DM management in hospital

The three previous themes all impacted on the actual experience of T1DM management in hospital in relation to the daily tasks of T1DM; BGM, insulin administration and dietary intake. In relation to whether the participants would prefer

nurses to manage their T1DM or to self manage in hospital the participants said:

*That's a definite no...to me it's like cleaning your teeth, you do it every day (Participant 1)*

*...[I] would rather do it [T1DM management] myself or at least have a say in doing it (Participant 2)*

### Summary

People with T1DM who independently self manage in the context of their lives have their own ideal of self management. When admitted to the hospital setting patients with T1DM want their ideal of self management to continue. Furthermore patients with T1DM want recognition of their knowledge and abilities to manage their illness when admitted to hospital. As well as being recognised, patients with T1DM want to be able to actively self manage or be invited to collaborate with health professionals in regard to their T1DM management. The patient with T1DM has the knowledge and ability to be an active participant in their T1DM management in the hospital setting.

### Recommendations

The study recommends that health professionals consider:

#### 1. *Understanding the patient's perspective of T1DM management*

If nurses understand the ideal of day to day management for a patient with T1DM, including normal practices and timing of these practices, instead of attempting to have the patient fit the hospital regime, patients may be more satisfied with their care. In addition, minimal disruption to the self manager's normal routine can lead to better glycaemic control and less complications on discharge.

#### 2. *Recognising the expert self manager*

Health professionals need to recognise that people with T1DM who self manage at home have their own ideal of T1DM management and recognise their expertise in this area<sup>1</sup>. In order to support the patient to self manage and further enhance patient care this study recommends the patient's expertise needs acknowledgement by health professionals in order to ensure the provision of appropriate care.

#### 3. *Collaborating with the patient to plan care and employ a holistic patient centered approach*

What patients consider as preferences in their care needs to be taken into consideration by the health professionals in order to meet the needs of the patient in hospital<sup>6,7</sup>. This study recommends health professionals listen to the patients' understanding of their symptoms and the management of those symptoms in order to provide appropriate care for the

patient. In addition it is suggested that at initial consultation the health professionals negotiate care provisions with the patient to determine the level of involvement the patient wants while in hospital. Chronic illness requires care that is patient orientated, proactive and planned which is difficult to provide through the acute care model<sup>8</sup>.

### Conclusion

In summary, it is recommended that health professionals acknowledge patients with T1DM ideals of self management, along with acknowledging the patient as a valuable resource in their T1DM management. Health professionals need to consider the impact and barriers that exist in the hospital setting for those who have an underlying chronic illness to ensure patients have a positive and supported experience in the hospital setting. Further research is required to better understand the requirements of those in hospital who self manage T1DM independently in their own environment. The plan is to continue to research the requirements of patients with T1DM in hospital in a PhD study.

*No conflict of interest declared.*

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## A Child's Voice is one that needs to be heard!

Lorraine Pitman, Chair, Family Voices

Any parent caring and supporting a child or teenager with a chronic condition like type 1 diabetes knows all too well that diabetes has a significant impact on all areas of their life and that of their family.

Since coming together over six years ago, Family Voices continues to address, express and advocate the health, social and quality of life needs for both the child, young adult and the families living with type 1 diabetes in our community.

Family Voices is grateful for the continued support from Children, Youth and Women's Health Services (CYWHS), The Department of Education and Children's Services (DECS), Diabetes SA, Juvenile Diabetes Research Foundation (JDRF), Diabetes Counselling Online, Diabetes Wellbeing Services, and Diabetes Outreach – Country Health SA. These organisations welcome and encourage Family Voices to continue to share the views of families and to express our views in areas that may need further support or change in how they are managed.

In April of this year, Family Voices held a 'Transition Workshop' engaging health care professionals from the Women's and Children's Hospital along with the incredibly valuable guidance and input of our young adults.

The workshop was extremely insightful and the conclusions reached deliver a clear message to our health care professionals; just what it is our young adults really need to support them and what obstacles they encounter during the transition from paediatric to adult care.

It was an open forum, which allowed the teens to consider and work through the issues they face outside the world of diabetes. Highlighting the very real situations a young person encounters as they finish their final years of school, establishing social outlets and just generally endeavouring to engage equally with their peers. As they explore and grow in this period of change there are so many aspects of their daily life to manage and they consider that their type 1 diabetes should be aligned with their life situations, rather than controlled and governed.

One of the significant outcomes was identifying the need to connect, support and align support services for our rural and remote families. Accessibility and connectivity to health services and up-to-date information was key to a successful transition and ongoing quality of life for the young adult as they pursue their own personal goals and aspirations.

Understanding the challenges families face in the rural and remote centres brought us to exploring ways in which services and the availability of those significant support networks could be provided effectively and proactively.

Availability, accessibility and education are seen as being pivotal to establishing a foundation that could be tapped into by health professionals, educators, family and friends and, critically, those young adults themselves. The very notion of bringing those services to the rural and remote centres and engaging the community would remove some of the prevalent social hurdles as well as provide the support platform they and their families need.

Family Voices along with Diabetes Outreach and, most

importantly, affected families living in the rural and remote pockets of our State need to come together to harness their collective thinking and efforts and drive the necessary change to give our young adults the support and future they so richly deserve. This can only be done by sharing and understanding the wants, needs and desires that could bring that element of normality to the lives of people living with type 1 diabetes.

One particular family, living in a rural area less than 200kms from Adelaide, are typical of many others and know all too well the frustrations of managing, explaining and educating the people they come in contact with daily. It can be exhausting, but if there is a positive outcome to be had from this, then it is worth every bit of energy it takes to make life better...

"Sarah has type 1 diabetes", five little words that I never knew how much would change our lives. Life has seen many challenges since Sarah was diagnosed three years ago. Living in a country area seems to add some interesting factors, especially when it comes to hospitalisation. I guess I should explain! Sarah is on an insulin pump, which is like being from another planet when it comes to a hospital visit. Sarah is like a sideshow, everyone wanting a look, how does it work, where does it feed from, how is it inserted, etc. Sarah found this quite annoying after the first ten times! The worst part was when we had an older nurse insisting that she be given an insulin injection after eating, even though she had already triggered her pump to administer the required bolus. Blood ketone testing, we were told that it was impossible for them to be accurate and being made to do it the old way. Our doctor is fantastic, communicating with WCH constantly but left the actual handling of the diabetes solely with me, as even for him it was a bit of the unknown. Just for interest ask a country hospital kitchen to tell you the estimated carb serves for what they are serving!!!

Another challenge we find is the lack of support for Sarah in the country. Getting supplies in under a week is near impossible unless we drive to Adelaide. There is a major lack of resources in the area for us and also for people wanting to know more and trying to help. It is extremely hard for me to have any time out as I have, since diagnosis, become a single parent on a very limited income. Holding down a full time job is impossible due to the expectation that I will be on call 24/7 and constantly needed at sporting events, school, etc. Arriving at work/even getting out of bed sometimes after nights on end of constant monitoring is a real challenge.

Centrelink never cease to amaze me, we have been asked to prove each year that she still has type 1 diabetes. Getting the Carer's Allowance is becoming more and more difficult as she gets older but they don't understand the level of care she requires or the amount it costs simply having this disease.

Type 1 diabetes has changed the lives of both my girls and myself but we ALWAYS LOOK TO THE FUTURE NOT BACK! We're living in the hope that with more awareness and resources the hope of a cure will become a reality for us and others living with this rotten disease."

Despite the very best efforts of the professionals working in our hospitals and communities, the situation described above is sadly not unique. It is therefore our collective responsibility to ensure the 'humanity' of this condition be understood and considered and that our efforts are redoubled in ensuring the availability and accessibility of services and the education of all health care professionals in our rural and remote areas.

## NDSS Diabetes School Pack

The NDSS is providing packs to schools at no cost. The pack is designed to assist teachers and staff in schools to understand type 1 diabetes and to assist them in managing the student with diabetes in a school setting.

Included in the pack is:

- > Diabetes Basics: A teacher's guide to type 1 diabetes DVD – This DVD/CD ROM package aims to give a basic understanding of type 1 diabetes, provides important information about the day-to-day management of diabetes, including blood glucose monitoring, insulin delivery, balancing food intake and exercise and the management of emergency situations that may occur.
- > Diabetes Information flip chart – This flip chart is a comprehensive booklet which includes specific issues surrounding the management of diabetes such as: hypoglycaemia (low blood glucose level – BGL), food, exercise, exams and high blood glucose levels. It is designed to be handy and easy to read in a colourful flip chart.
- > Diabetes Emergency poster – This colourful poster is a step by step guide for treatment of hypoglycaemia or

hypo. Schools are encouraged to display this in their staff room so that all staff know what to do in an emergency situation.

- > Diabetes in Education and Children's Services booklet – this booklet contains the guidelines for diabetes in education and children services.

This school pack has been developed to provide general information to compliment the specific training delivered to schools by the Royal District Nursing Service or other health professionals upon a child's diagnosis of diabetes.

School packs can be obtained from Diabetes SA on 8234 1977.



## Type 1 Diabetes Network and Reality Check

The Type 1 Diabetes Network is an Australian organisation founded in 1997 and run by a dedicated team of volunteers, all of whom have type 1 diabetes. They provide a number of useful online resources that can be valuable to health professionals working with people who have type 1 diabetes.

One of the central resources is Reality Check, an online community of people with type 1 diabetes. Every day hundreds of messages are posted through the online community on the Reality Check website, topical issues are discussed and experiences shared. Anyone can read the discussions that take place. A simple, free registration process is required to participate. Topics range widely from media coverage of diabetes to new treatments and general troubleshooting.

In addition to their online activities, the Type 1 Diabetes Network holds informal seminars and social events, produce educational materials and represent the interests of people with type 1 diabetes to government, health professional forums and the media.

The Type 1 Diabetes Network has also conducted research into the way people with type 1 diabetes use, and their experience of, health services and presented abstracts and papers at national and international conferences. These abstract and research papers are available to download from the website ([www.d1.org.au/resources.htm](http://www.d1.org.au/resources.htm)) and could prove to be valuable resources for health professionals.

The Type 1 Diabetes Network's website has an extensive section dedicated solely to health professionals that includes professionally-endorsed educational resources such as:

A Starter Kit for Newly-Diagnosed Adults

([www.d1.org.au/starterkit/](http://www.d1.org.au/starterkit/)), a pregnancy and diabetes booklet and a collection of fact sheets that are free to download on topics such as 'ketones and diabetic ketoacidosis' and 'alcohol and drinking.'

Another resource that the Type 1 Diabetes Network provides is their free email newsletter, Yada Yada, which is sent to more than 4,000 people every month. This newsletter provides news and views for and by young adults with diabetes, additions to the website and upcoming events. The newsletter is written predominately for people living with type 1 diabetes but health professionals are encouraged to subscribe. The discussions and news can often help health professionals relate to their patients.

### Links

The Type 1 Diabetes Network [www.d1.org.au](http://www.d1.org.au)

Reality Check online community [www.realitycheck.org.au](http://www.realitycheck.org.au)

Online community for parents [www.muntedpancreas.com](http://www.muntedpancreas.com)



## Flexible insulin therapy: for type 1 diabetes booklet

Baker IDI have produced a booklet written for people with type 1 diabetes who are using, or intend to use, intensive insulin therapy. Medical practitioners, diabetes educators, other health professionals and students may also find it useful.

To view and download a free copy visit [www.bakeridi.edu.au/Assets/Files/Type1\\_booklet.pdf](http://www.bakeridi.edu.au/Assets/Files/Type1_booklet.pdf) or hard copies can be ordered for \$10 via the BakerIDI website by visiting [www.bakeridi.edu.au/online-store](http://www.bakeridi.edu.au/online-store) and clicking on 'Books'.

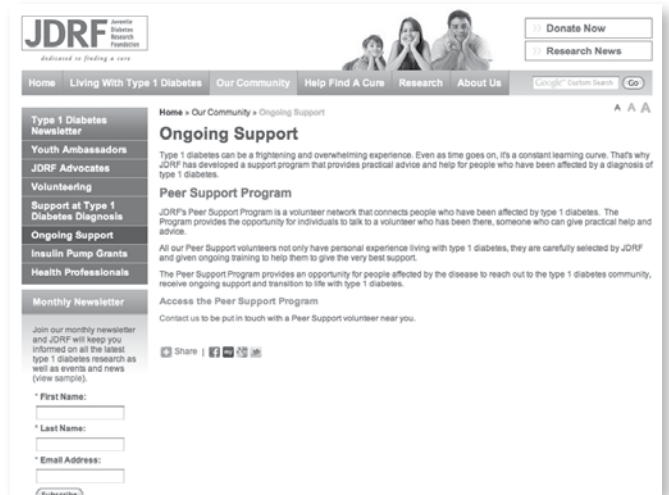


## Peer Support Program for children with type 1 diabetes

JDRF's Peer Support Program is a volunteer network that connects people who have been affected by type 1 diabetes. The program provides the opportunity for individuals to talk to a volunteer who has been there, someone who can give practical help and advice.

According to JDRF all Peer Support volunteers have personal experience living with type 1 diabetes and are given ongoing training to help them to give the very best support.

The Peer Support Program provides an opportunity for people affected by the disease to reach out to the type 1 diabetes community, receive ongoing support and transition to life with type 1 diabetes. To access the Peer Support Program go to [www.jdrf.org.au/our-community/support](http://www.jdrf.org.au/our-community/support).



## healthdirect Australia

healthdirect Australia is a FREE\* 24-hour telephone health advice line staffed by Registered Nurses to provide expert health advice. They can also help with general health information and direct the person to local health services. Call 1800 022 222 or for other information visit [www.healthdirect.org.au](http://www.healthdirect.org.au).

The 24-hour telephone health advice line is currently available to residents of the Australian Capital Territory, New South Wales, the Northern Territory, Tasmania, South Australia and Western Australia.

- \*Calls from landlines are free.
- \*Mobile charges may apply.

## Rural Health Education Foundation

### Smoking: An Indigenous Health Issue

Tobacco use is a major preventable contributor to the gap in life expectancy between Indigenous Australians and other Australians. Much of this gap is due to smoking related diseases such as cardiovascular disease, respiratory disease and cancer.

Nearly half of all Aboriginal and Torres Strait Islander adults smoke compared to less than one fifth of other adults. Smoking prevalence is higher in remote areas. The challenge

for health practitioners and communities is to develop innovative and effective ways of addressing tobacco use in Indigenous communities. Research is still needed to ascertain the most appropriate interventions for Aboriginal and Torres Strait Islander people.

Strategies to combat smoking need to acknowledge the historical, cultural, and socio-economic factors influencing its use, as well as the individual psychological, physical and behavioural factors.

View the webcast at [www.rhef.com.au/programs/program-1/?program\\_id=563](http://www.rhef.com.au/programs/program-1/?program_id=563) or the audio CD for this presentation is offered free to those working in Indigenous health. To download the order form visit [www.rhef.com.au/free-dvds](http://www.rhef.com.au/free-dvds).

## Resources to support transition of adolescents to adult health services

The American Society for Adolescent Medicine defines transition as 'the purposeful planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-orientated health care systems'.<sup>1</sup>

The recently released draft 'National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults'<sup>2</sup> provide an excellent overview of the main elements of transition.

### The key elements required for effective transitional care<sup>2</sup>

- > flexible timing of transfer
- > flexibility in provision of health services
- > a 'transition case manager' for each person
- > a preparation period
- > a choice of adult provider
- > a coordinated transfer
- > joint consultations
- > accessible medical documentation
- > maintaining contact after transfer
- > psychosocial support.

### Adult diabetes health service

The guidelines recommend the following strategies to better meet the needs of young people when they transition from a paediatric model of health care<sup>2</sup>:

- > ensuring that the young person sees the same staff at each consultation or clinic visit
- > providing definite appointment times
- > providing capacity for 'drop in' visits
- > holding clinics and consultations out of working hours (including weekends)
- > providing specific clinics for young adults
- > encouraging questions during clinics and consultations
- > taking an interest in the patient as a person
- > providing information relevant to the young person
- > providing resources (eg list of appropriate websites, booklets, videos)
- > providing regular updates (eg through a newsletter)
- > encouraging telephone or email contact with staff
- > sending SMS reminders for appointments
- > implementing a patient feedback process.

### The role of the general practitioner

The guidelines also highlight the important role of the general

practitioner (GP) in the management of the young person with type 1 diabetes. The GP should be the primary point of contact for the young person and their family for day-to-day health issues and needs to be kept in the communication loop. The GP has a critical role in ensuring continuity of care, particularly during transition.<sup>2</sup>

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### Useful resources to assist with transition

Queensland Health has developed a comprehensive guideline that covers all aspects for planning transition. To view the guidelines go to

[www.health.qld.gov.au/cpic/documents/dbtran\\_bpguide\\_hp2.pdf](http://www.health.qld.gov.au/cpic/documents/dbtran_bpguide_hp2.pdf).

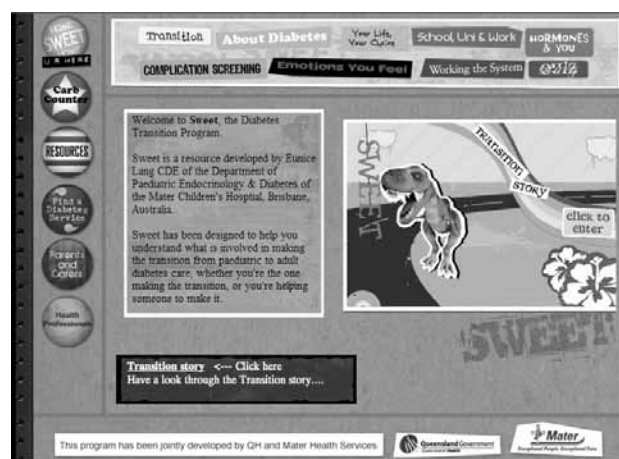
### Sweet, the Diabetes Transition website

The sweet website can be a useful resource for adolescents who are preparing for transition. It has been specially designed to provide the young person with information about the different issues that they may face along the way.

It has:

- > an interactive tool called the 'Transition Story' to assist young people to understand the transition process
- > fact sheets, resources and relevant links for young people, their families and health professionals
- > an interactive tool called the 'Carb Counter' which assists young people identify the amount of carbohydrate contained in a variety of foods
- > a program called 'find a diabetes service'
- > knowledge based diabetes quizzes for young people with type 1 and type 2 diabetes.

To view this website go to: [www.sweet.org.au](http://www.sweet.org.au).



**NDSS Diabetes Youth Transition Project**

The project has been looking at ways to increase the number of young people with diabetes who stay connected with adult diabetes health care when they transfer from paediatric (child) to adult diabetes services. The project is funded by the Department of Health and Ageing through a NDSS Strategic Development Grant and delivered through state and territory NDSS Agents.

NDSS sends a birthday card to every NDSS Registrant aged 12 to 20 each year on their birthday. In addition a series of letters is sent to parents/carers every year from age 12 to 18. Each letter has been developed so that the information is relevant to the parent and their child at that age. To view examples of each of the letters go to [www.myd.net.au](http://www.myd.net.au).

The aim of the birthday cards and letters is to:

- > remind young people and their parents to continue to think about diabetes care as the young person matures through adolescence
- > help maintain the teenager's and parents' connection with a diabetes health team pre, during and post transition
- > promote teenagers independence.



To view information about this project go to [www.ndss.com.au/en/MyD/Transition/](http://www.ndss.com.au/en/MyD/Transition/).

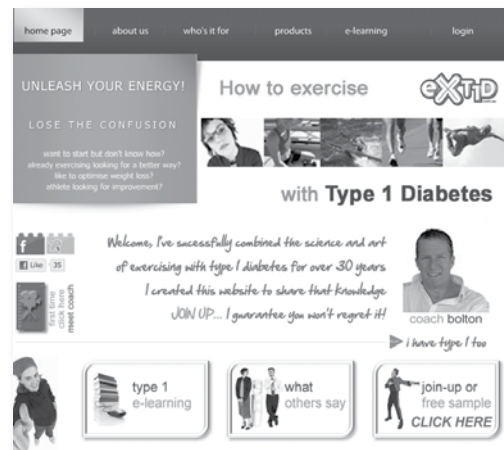
**Ext1d.com website**

Exercising with type 1 diabetes isn't simple. This website [ext1d.com.au](http://ext1d.com.au) is providing practical direction on 'how to' exercise successfully and with confidence to people with type 1 diabetes.

The author suggests that there are literally thousands of websites, books and assorted publications telling people with type 1 diabetes about the 'health benefits' and why they 'should' exercise but few on 'how to'. Much of the information available on 'how to exercise' is either too academic to be understood or, it simply scratches the surface avoiding the meaningful issues that can help make exercise and participation in sport part of everyday life.

People can access information for a free trial, but there is a cost for ongoing use. Best to check it out and see if it is useful before spending any money.

[www.ext1d.com.au/diabetes/index.html](http://www.ext1d.com.au/diabetes/index.html)



**Glucagen® HypoKit brochure**

The leaflet answers some common questions about Glucagen HypoKit such as:

- > What Glucagen HypoKit is used for
- > Before you use Glucagen HypoKit
- > How to use Glucagen HypoKit
- > While you are using Glucagen HypoKit
- > Side effects
- > Storage
- > Product description
- > Instructions for use.

For more information on the Glucagen HypoKit contact Novo Nordisk on 1800 668 626 or visit [www.novonordisk.com.au](http://www.novonordisk.com.au).

**Straight to the Point: A guide for people living with type 1 diabetes**

This booklet is a fantastic resource for adults with type 1 diabetes. Written by a diabetes nurse practitioner and two adults with type 1 diabetes, it is a practical and an informative resource.

The personal excerpts throughout the book help people with diabetes get a sense that they are not alone.

This book especially if used in conjunction with [www.diabetescounselling.com.au](http://www.diabetescounselling.com.au) will assist the person to have access to ongoing support and resources.

To receive a free copy of this book you can place an order by phoning JDRF Adelaide office on 8338 3677.

## Parent and Teens Education Day

The Women's and Children's Hospital's Diabetes and Endocrine team are planning a Parent and Teens Education Day on **Sunday 14 August**. The Plenary speaker is Kate Gilbert who founded the Type 1 Diabetes Network. Kate will share her journey with type 1 diabetes. Workshops will be age specific for the parents/family while the teenagers program will be interactive to support and update on topics including transition to adult services, parties, drugs and rock n roll. Contact Marianne Lambert on 8161 6347 for further details.

## ESA/APEG Combined Annual Scientific Meeting

The Annual Meetings of the Endocrine Society of Australia (ESA) and the Australian Paediatric Endocrine Group (APEG) are being held together at the Perth Convention Centre from **28th to 31st August 2011**.

For more information or to register visit <http://esaapeg.asnevents.com.au/>.

## The Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) and Australasian Diabetes in Pregnancy Society (ADIPS) Joint Meeting

24th September, 2011	Abstract Submissions Deadline
30th September, 2011	Early Bird Registration Deadline
4th-7th November, 2011	The Sebel & Citigate, King George Square, Brisbane

For further details visit [www.adips-somanz.org](http://www.adips-somanz.org).

## The Australian and New Zealand Obesity Society (ANZOS) Annual Scientific Meeting

Theme: 'The Obesity Challenge: physical, psychosocial and environmental'

National Wine Centre of Australia, Adelaide  
**20th - 22nd October 2011**

For further details visit [www.anzos2011.com](http://www.anzos2011.com).

## Walk to Cure Diabetes

The Walk to Cure Diabetes brings the type 1 diabetes community together on **30th October** in Adelaide.

Type 1 diabetes doesn't affect just one person, family and friends are involved too. The Walk to Cure Diabetes gives everyone the chance to get involved and make a difference.

The funds raised at the Walk to Cure Diabetes support the best and brightest Australian researchers working to find a cure for type 1 diabetes.

The Walk to Cure Diabetes website will be open for registrations in July 2011 at at <http://walk.jdrf.org.au/>.



## ADS/ADEA Annual Scientific Meeting

The Australian Diabetes Society (ADS) and Australian Diabetes Educators Association (ADEA) Annual Scientific Meeting will be held on **31st August to 2nd September 2011** at the Perth Convention & Exhibition Centre, WA. For more information or to register visit [www.ads-adea.org.au](http://www.ads-adea.org.au).

## 30th State Diabetes Refresher Day

### 'Coaching for Success'

**When:** 9th December 2011  
**Where:** AAMI Stadium,  
105 West Lakes Boulevard  
West Lakes SA 5021

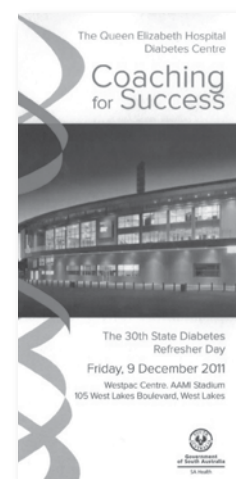
Hosted by the Diabetes Centre,  
The Queen Elizabeth Hospital

The theme of the refresher day is coaching for success.

Some of the topics include;

- > If not dieting, then what?
- > Targets and medications
- > Acute coronary syndrome
- > Developing self management education competence
- > Positives around amputations
- > Consumer view on achieving personal goals
- > Exercise in diabetes

Registration forms are now available. Contact Lesley Roberts via email [lesley.roberts2@health.sa.gov.au](mailto:lesley.roberts2@health.sa.gov.au).



## Health Events Calendar

### August

- |      |                                  |  |
|------|----------------------------------|--|
| 2-8  | Dental Awareness Week            | <a href="http://www.ada.org.au">www.ada.org.au</a>                             |
| 7-14 | National Healthy Bones Week      | <a href="http://www.healthybones.com.au">www.healthybones.com.au</a>           |
| 9    | Day of World's Indigenous People | <a href="http://www.un.org/events/indigenous">www.un.org/events/indigenous</a> |
| 12   | International Youth Day          | <a href="http://www.un.org/youth">www.un.org/youth</a>                         |

### September

- |       |                      |  |
|-------|----------------------|--|
| 12-18 | National Stroke Week | <a href="http://www.strokefoundation.com.au">www.strokefoundation.com.au</a> |
| 26    | World Heart Day      | <a href="http://www.heartfoundation.com.au">www.heartfoundation.com.au</a>   |

### October

- |                   |                                    |  |
|-------------------|------------------------------------|--|
| Foot Health Month |                                    | <a href="http://www.apodc.com.au">www.apodc.com.au</a>                       |
| 1                 | International Day of Older Persons | <a href="http://www.un.org/observances/days">www.un.org/observances/days</a> |
| 1-7               | Seniors Week                       | <a href="http://www.cotasa.org.au">www.cotasa.org.au</a>                     |
| 4-11              | Amputee Awareness Week             | <a href="http://www.limbs4life.com">www.limbs4life.com</a>                   |
| 7                 | R U OK? Day                        | <a href="http://www.ruokday.com.au">www.ruokday.com.au</a>                   |
| 9-15              | Mental Health Week                 | <a href="http://www.mentalhealth.org.au">www.mentalhealth.org.au</a>         |
| 10                | World Mental Health Day            | <a href="http://www.mentalhealth.org.au">www.mentalhealth.org.au</a>         |
| 13                | Stress Less Day                    | <a href="http://www.stressdown.org.au">www.stressdown.org.au</a>             |
| 16-22             | National Nutrition Week            | <a href="http://www.nutritionaustralia.org">www.nutritionaustralia.org</a>   |
| 16                | World Food Day                     | <a href="http://www.un.org.au">www.un.org.au</a>                             |

### November

- |          |                                     |  |
|----------|-------------------------------------|--|
| Movember |                                     | <a href="http://www.movember.com">www.movember.com</a>                       |
| 4        | World Diabetes Day                  | <a href="http://www.worlddiabetesday.org">www.worlddiabetesday.org</a>       |
| 7-11     | Community Health Nursing Week       | <a href="http://www.anf.org.au">www.anf.org.au</a>                           |
| 21       | 25th Birthday of the Ottawa Charter | <a href="http://www.who.int/healthpromotion">www.who.int/healthpromotion</a> |

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Country Health SA  
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Telephone: (08) 8222 6775  
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[www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au)



<http://www.gilf.gov.au/>

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