

Diabetes Outreach

# Diabetes Management Portfolio

3rd Edition

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By  
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SA Health

## Acknowledgements

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## Contents

Introduction

Planning your education process

Forms

- A. Client registration and diabetes assessment .....
- B. Education program outline and care planning .....
- C. Goal setting and evaluation of learning outcomes .....
- D. Reply to referring GP .....
- E. Discharge letter to GP .....
- F. Record summary of clients .....
- G. Basic foot screening checklist .....
- H. Referral for diabetes education .....
- I. Insulin education check list .....
- J. Gestational – history and assessment checklist .....

Appendix

- 1. Community Education flow chart .....

# Diabetes Management Portfolio

## Introduction

### **Aim:**

The package aims to provide tools for diabetes health care providers to:

- > keep appropriate records
- > undertake an assessment and education process
- > track client's progress in diabetes education and self management
- > maintain an effective and efficient working relationship within the team
- > develop and maintain an accurate system for the collection of statistics.

## The diabetes education process

In your role as a diabetes health care provider you will be concerned essentially with enhancing your clients' ability to self manage their diabetes through a process of information, self care education, counselling and behaviour change.

## Initial individual assessment

Refer to the Diabetes Manual; Section 3 'Diabetes Education' for further information regarding: client assessment, planning a teaching session, (group and / or individual) implementing a plan and evaluating the effectiveness of the teaching.

### **Lifestyle assessment**

- > nutrition history
- > weight/waist
- > exercise/activity history
- > smoking, alcohol use
- > psychological considerations
  - acceptance of diagnosis
  - preparedness to modify lifestyle behaviours
  - belief that lifestyle behaviour change will help.
  - healthy coping
  - depression / anxiety.

If you wish to use a screening tool to see if a person is at risk of psychological distress, the Kessler psychological scale (K10) consists of 10 questions that can detect depression and other related psychological disorders. Go to

[http://www.beyondblue.org.au/index.aspx?link\\_id=89.678](http://www.beyondblue.org.au/index.aspx?link_id=89.678) and the person can fill out the form online. The program will then generate a score. This screening tool only provides a rough guide and further steps are required to obtain a full diagnosis of depression. The Diabetes Manual, Section 9 'Maintaining a healthy lifestyle' has more information about screening tools ([www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au)).

## Examination

- > weight (kg) and height (cm) to calculate body mass index (BMI), and / or
- > waist circumference
- > blood pressure: lying and standing
- > eyes: history, visual impairment, need for referral to ophthalmologist / optometrist
- > feet: circulation, sensation, skin and nail condition, pressure areas, abnormal bony architecture, footwear, self care, signs/symptoms of neuropathy
- > oral health: need for regular dental review , signs and symptoms of oral health problems (dry mouth, bleeding gums, bad breath)
- > sexual health: erectile dysfunction, vaginal dryness, thrush.

NB: you may wish to discuss sexual health once you have established rapport with your client.

## Self-care assessment

- > medication, self management (understanding of medications)
- > blood glucose monitoring and glycaemic control – method, technique, regularity, recording, targets and response plans.

## Clinical investigations

To assist in planning future education and care seek the following results:

- > HbA1c
- > lipid profile – total cholesterol, LDL, HDL, triglycerides
- > microalbuminuria
- > fundal report (eye examination)
- > previous blood pressure, weight.

Consider referral to other health professionals and services such as endocrinologist, oral health professional, ophthalmologist, optometrist, dietitian, podiatrist & pharmacist as needed.

## Risk factors for complications

### Fixed

- > family history of cardiovascular and / or early death (<60 years).

### Modifiable

- > smoking
- > hypertension
- > hyperlipidaemia
- > medication
- > alcohol
- > weight / nutrition / activity

## Housekeeping

- > registration with National Diabetes Services Scheme
- > motor vehicle registration notification
- > insurance company notification
- > medic alert (recommended for clients requiring insulin or at significant risk of hypoglycaemia)
- > ambulance fund.

## Planning your education process

You might want to use a Community Education Flow Chart (Appendix 1) as this can be used across a geographical area. The education pathway can be used by all health professionals as well as consumers. The flow chart clearly shows the cyclical nature of education, reinforcing that diabetes education is a lifelong journey. You can modify the flowchart so that it reflects the types of groups and programs that are run in your area.

Education can be conducted in a group setting or if needed, individual sessions. Group sessions are an effective, efficient way of communicating the general principles of diabetes management. Individual client consultations are generally reserved for managing complex management issues or for clients disadvantaged by group environment such as those with hearing, sight or communication difficulties.

## Implementing the education plan

It is important that your education plan be delivered with methods and materials that respect your client's cultural background, age, language, literacy level and special educational needs.

## Individual appointments

Allow 1 hour for an initial consultation. Don't forget to leave enough time to write your notes, make referrals and complete appropriate paperwork. Allow 30 - 60 minutes for a follow-up consultation.

## Group education

Conducting education with a group of clients is an effective way of communicating the general principles and concepts associated with diabetes management. A few issues can be addressed in one session or it may be necessary to conduct several sessions to communicate the range of issues related to diabetes self-management.

You will need to consider the individual suitability of clients to attend a group. Consideration should be given to your client's social and cultural background, age, level of literacy, prior knowledge and type of diabetes prior to them attending a group session.

Evaluating a group education program can be in the form of a participant questionnaire, which can contribute to the ongoing revision of the program objectives, curriculum, methods, materials, participation and resources. Also asking clients what behaviours they are prepared to change will give you feedback.

Refer to the resource titled 'Group Education: A training kit for health educators' for further information related to planning and conducting group education (see online resource catalogue).

Refer to the resource titled 'Diabetes Self Care Program' for a flexible education package that can be used for groups or 1:1 education. It is available on the Diabetes Outreach website [www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au).

Approach client education as an episode of care. Clients come to your group or individual sessions for an agreed number of times. After which they should be referred back to their general practitioner for ongoing management and review. In your initial letter to the GP (the one you send after your first contact with the client) outline the education plan with a time line. Don't forget to share this written plan with your client. In your discharge letter let the general practitioner know that the person can be re-referred at anytime. You can recommend seeing the person again in 1 year or 2 years, depending on the need & circumstances.

### **Education areas**

By no means an exhaustive list, but offers a framework for your education program and supports a common language for diabetes education:<sup>1, 2</sup>

- > healthy eating
- > being active
- > monitoring
- > taking medication
- > problem solving
- > reducing risk
- > healthy coping.

### **Documentation**

As you implement your education plan you will need to document your progress.

### **Evaluating your client's progress**

Evaluating the effectiveness of your education with your client will allow you to revise the education plan and the effectiveness of your own practice. You can do this by seeking

#### **Individual education**

You discussed 'hypoglycaemia' with Mr Isophane at his previous visit when he was commenced on insulin. He reports that his glycaemic control has been ideal apart from having experienced a 'hypo' every time he walks for more than an hour mid mornings. He recognises the symptoms you discussed previously. He treats himself appropriately, however doesn't fully appreciate that exercise is a possible contributing factor to hypoglycaemia. He hasn't learnt to ask himself, 'now why did the hypo happen'. You reiterate the need for him to question why the hypo occurred and preventative strategies, which he then restates to you as having understood. At his next visit he reports that he now walks after lunch and hasn't experienced any problems since.

## Further Reading

American Association of Diabetes Educators (2008) AADE7™ Self-Care behaviours. *The Diabetes Educator*, 34(3), p445-449.

Australian Diabetes Educators Association (2008) *Client centred care*, Australian Diabetes Educators Association, Canberra.

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## Forms

This package has been designed to be utilised in whatever setting diabetes care/education takes place whether it be in a community setting, within a hospital or nursing home or in a health clinic. The documents provided are a template that may be adapted to suit your needs or used as they are. They can be incorporated into existing client case files (ie hospital records) or initiate new client case files in a clinic setting. Forms are also available in electronic version and a disk is provided.

- A: client registration – part 1  
diabetes assessment – part 2
- B: education program outline and care planning
- C: goal setting and evaluation
- D: reply to referring GP
- E: discharge letter to referring GP
- F: record summary of clients
- G: basic foot screening checklist
- H: referral for diabetes education
- I: insulin education check list
- J: gestational diabetes check list

### Form A – Client registration – part 1

The client registration form – part 1 can be used if your clinic/service does not have its own form for database information for new clients. In some cases this form can be filled out by the person themselves. If you have your own form, this can be used in addition to form B to complete your assessment.

### Form A – Diabetes assessment – part 2

The diabetes assessment – part 2 is recommended for use at the client's initial consultation. It includes a comprehensive social and medical history, an assessment of risk factors and complications, a baseline for clinical observations and a record of specialist and allied health referrals.

Educational and personal considerations:

There are many factors that may contribute to management issues when negotiating lifestyle changes with a client. Issues you may need to consider are:

- > cultural background
- > educational background
- > socio-economic factors.

*Culture, for example, may influence diet and lifestyle practice, eg some cultures have high alcohol and high fat diets and consider these healthy and an important component of their lifestyle. Educating clients about the recommended nutritional requirements for diabetes management will require a good understanding of their preferences.*

*An Aboriginal client living in a traditional rural community may not have the structural support in the community for self monitoring therefore before recommending or arranging*

*for self monitoring equipment (even though clinically ideal) you should consider whether this is going to be effective. The Aboriginal health worker will be of great assistance in this situation and working together may achieve realistic goals for both you and the client.*

## **Form B – Education program outline and care planning**

The first flyer 'Diabetes Self care: The 7 steps to success' can be used to provide your client with an outline of a diabetes education program. It can be used as a way to open up discussion about the 7 steps and highlight that learning about diabetes occurs over a period of time and needs will change across the person's life span. They can tick off topics as they do them and it can assist clients to set priorities and be actively involved in the education process.

The DES brochure 'Your care plan' is also a useful tool to assist clients to prioritise their learning and medical needs.

## **Form C – Goal setting and evaluation of learning outcomes**

These forms provide you with the opportunity to develop goals with your clients. The form is designed so you can document barriers and enablers for each goal. You can then document evidence of learning or a summary of the education session. The evaluation gives an indication of whether or not the expected outcomes have been achieved and a documented basis for which to continue or change the agreed educational plan.

There are 7 of these forms which outline the 7 learning outcomes associated with each of the ADEA 7 steps;

- > healthy eating
- > being active
- > monitoring
- > taking medication
- > problem solving
- > reducing risk
- > healthy coping.

### **Goal setting**

S: Specific	Specific, concrete goals to describe what the aim is.
M: Measurable	Make sure there is an inbuilt measure so that it is clear when the goal has been accomplished.
A: Action oriented	Make sure there is a description of how the goal will be achieved.
R: Realistic	Set achievable and realistic goals that are geared towards success not failure.
T: Time-bound	Goals that have a time frame can be measured and reset.

Being Active example

Eg I'm going to start exercising. This does not meet the criteria for a SMART goal.

Instead try:

'I'm going to walk for 20 minutes on my lunch break three times a week for the next four weeks.'

This goal clearly states what the person will be doing, when they will be doing, and for how long. It seems realistic and after four weeks it can be evaluated and changed as required. The aim of the goal is to take small steps that will lead to the larger overarching goal of 'being active'. If the person wasn't reaching their goal then it is important to look at what the barriers are eg using the example above perhaps the person has been skipping their lunch break because they have too much work to do. Whatever the reason, it's an indication that the goal needs adjusting. The person might decide to walk after supper for twenty minutes instead. It is important to change the goals so that the person can succeed.

### **Evidence of learning**

Within your documentation it is important to be able to provide evidence that the person has understood the information that has been provided.

*Eg Bob states that he is aware that he should walk most days for 30 minutes. His current goal is 10 minutes a day and he is gradually working towards increasing this. He is aware that he should always carry some short and quick acting sugar in case of a hypo. I have provided him with written information about exercising safely.*

### **Form D – Reply to referring GP**

This reply acts as an acknowledgment and a thank you for a new client referral. It establishes a working relationship between you and the GP and immediately opens a channel for ongoing communication regarding the client's progress.

It provides the GP with a succinct outline of the education requirements and intended education topics agreed upon with the client. It also outlines a time frame within which the client will be provided with education and support from you and establishes a discharge date for which to commence pre-discharge planning.

This outline further enables you to structure appropriate education sessions (either group or individual) with the client (maintaining flexibility) and establish some achievable learning and behaviour goals.

A copy of this form should be kept in the client's file and the original sent to the referring GP.

### **Form E – Discharge letter to referring GP**

The discharge letter provides a summary of the client's attendance at the service and their knowledge and skills in self managing their diabetes.

The letter gives an overview of education provided to the client and other information that may assist the GP in continuing care and treatment, eg you may note in 'additional comments/issues' that community services have been arranged or may need to be arranged.

You may wish to accompany this letter with a phone call to the GP informing him/her of the client's discharge and outlining their progress. This could be an opportunity to remind the GP that the client can be re-referred back to the service at a later date if further education is needed (ie management change, commencement of insulin etc). Re-referral at 1-2 years for an educational update (group or 1-1) is a realistic time frame for most people with diabetes.

A copy of this form should be kept in the client's file and the original sent to the referring GP.

### **Form F – Record summary of clients**

The record summary of clients is a summary of all clients being seen by you and details the number of referrals / appointments and where they were seen. It provides a format for the maintenance of accurate statistics of the number of people with diabetes seen in the service. It further provides justification and support for funding for your service and establishes a register of people with diabetes known to you in your community.

The details of each client should ideally be recorded daily and collated on a monthly basis. The original should be kept on file in your clinic and a copy forwarded to your service manager (eg Director of Community Health Service / Director of Nursing).

### **Form G – Foot risk screening**

Foot complications in diabetes can largely be prevented by early identification and early intervention. Diabetes educators are well placed to; provide initial assessment when the client is first diagnosed with diabetes, teach the person how to care for their feet and refer client to the podiatrist, should they have active foot problems or are deemed to have at risk feet. The person's feet should be assessed at least 6monthly by a health professional who has had continuing education in this area, and referred to a podiatrist if problems are identified.

If a person is unable to take care of their own feet due to poor vision, lack of mobility or comprehension it is important that their carer is taught how to do this for them.

For further information please see the National Association of Diabetes Centres' *National Diabetes Foot Screening Project Manual (2004)*. A copy of the basic foot screening form is enclosed for your convenience.

### **Form H – Referral for diabetes education**

Can be used by other services including general practice as a referral form to your service.

### **Form I – Insulin commencement or review education**

Can be used to guide education about self administration of insulin.

### **Form J – Gestational diabetes assessment & education**

Can be used to guide education provided to women with gestational diabetes.

## **References**

1. American Association of Diabetes Educators (2008) AADE7™ Self-Care Behaviours - A position statement. *The Diabetes Educator*, 34(3): p445-449.
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