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Diabetes Care in Schools

SWCCAC Guideline

Guiding Principles for the SWCCAC and CCAC Agency Nursing:

The SWCCAC supports students living with diabetes to develop skills in self-management of diabetes within school health support services in partnership with parents/guardians, school personnel and other health care organizations such as Children's Hospital Diabetes Program and Public Health Units. Using the principles of Client-Driven Care, the SWCCAC supports the student in developing skills in managing their own condition and provides a consistent and collaborative approach to care with system partners including those in health care and education.

This guideline enables the CCAC to be a good steward of resources by identifying appropriate support for the student and a process to transition from CCAC support to self-management.

The SWCCAC will work with system partners in using a consistent evidence informed model of care for students with diabetes in the school system to support individual needs of student using clear communication and shared understanding of all partners. It is important that all have knowledge and education about diabetes. The SWCCAC will support education of school personnel using available resources as identified in the "Diabetes in School - Information Flow Sheet" developed through partnership of the Children's Hospital Diabetes Team, Public Health Unit Nurses and CCAC nursing service providers. The CCAC nurses can provide specific education for school personnel as part of the transition plan for a specific student. Generalized education is supported by Public Health and Trillium Health resources.

The SWCCAC will provide School Health Support Services Nursing on a temporary basis, for students with diabetes who require insulin injections on a sliding scale or use an insulin pump during school hours, while the student is unable or requires hands on support to administer the insulin or use the insulin pump. For a student needing support in developing skills in blood glucose monitoring, the care coordinator will work with the team to develop a plan, with training and education. For students that require only nursing support for blood glucose monitoring, this will be in place by exception and will require review with the Client Services Manager.

The SWCCAC supports the development and maintenance of a school safety plan in place, specific for the student, which will include an emergency plan for episodes of hypoglycemia or hyperglycemia and a back-up plan for periods of time when the agency nurse is unable to be present. The student's parent is pivotal in the development of the plan of care and is first point of contact. The SWCCAC supports use of the "Diabetes Independence Assessment Tool" to determine the amount of support the student requires at school and the student's progress toward self-management of various aspects of diabetes care. When the student is able to perform the tasks related to self-management of diabetes at an overseeing/cueing level, a transition plan will be developed through a care conference involving all members of the care team.

Roles and Responsibilities of CCAC Care Coordinator and Nursing Agency

The CCAC Care Coordinator will:

- Receive a referral from the Children's Hospital Diabetes Team (or from other medical centre Diabetes Teams). The referral (Request and Treatment Order form) will include the reason for the referral to CCAC, and specific instructions about the insulin administration including sliding scale information.
- Complete the assessment/reassessment of the student, determining eligibility for School Health Support Services and update the DIAT with the parent(s). The DIAT will be forwarded with the Request and Treatment Order form to the service provider.
- Initiate the Diabetes Independence Assessment Tool (DIAT), completing instructions for blood glucose checking, management of hypoglycemia and hyperglycemia, meals and snacks to be eaten at school, insulin administration and insulin pump settings; use available information from the Diabetes team and parents. The parents will be provided a copy of the DIAT.
- Arrange a care conference with parent/ student, school personnel, agency nurse (and other team members) to identify the plan to support information sharing and training to facilitate student achievement of self-management. The conference will assist in the development of a school safety plan specific to the student, including an emergency plan for episodes of hypoglycemia and hyperglycemia and a back-up plan when the agency nurse is unable to be present. The student's parent is the first point of contact.
- Provide Diabetes in School – Information Flow Sheet to school and parents. It is intended that the family share this flow sheet with the school when the student is newly diagnosed and additionally when the student progresses to the next grade.
- Arrange training for school personnel, through Public Health Unit for general education and Children's Hospital and CCAC Agency Nursing for education related to a specific student. For students requiring education and support with blood glucose monitoring, the care coordinator will work with the team to develop a plan to accomplish this.
- Receive PSPRs from agency nurse, initial and change of status, along with updated DIAT(s), to review progress of the student toward goals of self-management.
- Arrange additional care conference(s) for planning to facilitate the student's transition through the oversight and cueing phase and transition from support of nurse with objective of school personnel providing follow through and reminders to student and moral support for student to develop confidence and independence.

The CCAC agency nurse will:

- Review the DIAT with the parent at the initial visit. If the DIAT has not already been initiated, the nurse will start the tool with the parent. The tool helps identify the amount of support the student requires at school and the progression toward self-management in various aspects of diabetes care.
- Complete review of DIAT which can correlate with submission of provider reports as part of the August visit and reporting at midway during the school year. This comprehensive tool is completed by family/ caregivers and the health care team and will be reviewed every 6 months or as needed. A student new to School Health Support Services may start at any time in the year but should still be reassessed every 6 months. This review will identify the student's progress toward independence and identifies obstacles. The completion of the levels of independence for each skill area will assist in determining expectations and needs of the individual student. It is recommended that a copy of the DIAT be given to the parent at the end of the school year and can be reviewed with the parent prior to the student returning to school the next school year.
- Forward a copy of the completed or updated tool to the CCAC and Diabetes Clinic or give to the parent to share with the Diabetes Clinic whenever the student is reassessed.
- Provide education and training to the student according to level of independence determined in each skill area identified on the DIAT, to progress toward self- management.
- Provide education and training to school personnel and students within the classroom as part of the transition plan for a specific student.
- Support use of the School Kit for students and school personnel to help in understanding of diabetes, available from the Public Health Unit.
- Identify need for a care conference by linking with the care coordinator when student is ready to begin transition from nursing support to self-management.