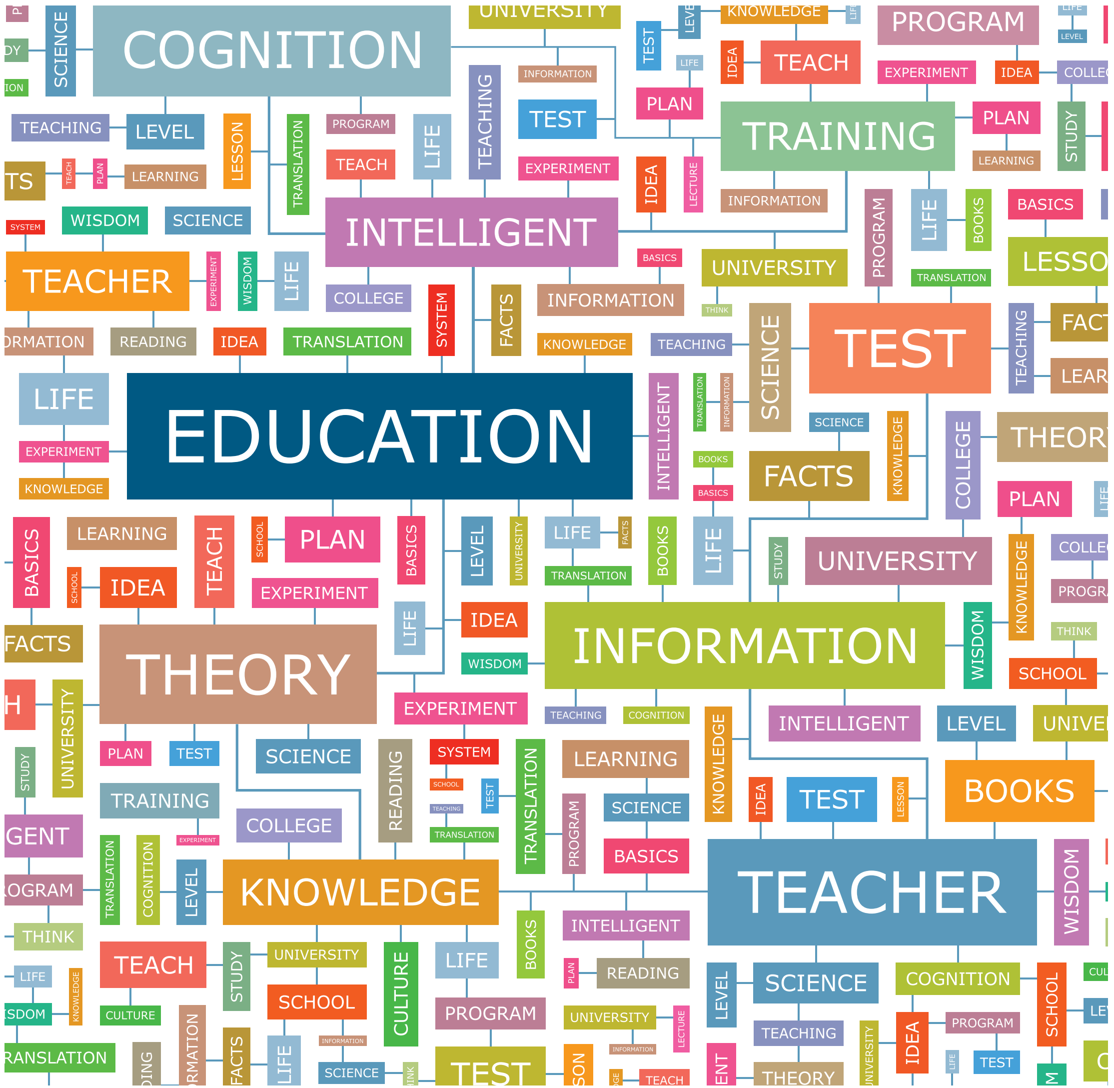
Canadian Diabetes Association, Diabetes Educator Section

Standards for Diabetes Education in Canada 2014



DIABETES EDUCATOR SECTION
SECTION DES ÉDUCATEURS DU DIABÈTE

Canadian Diabetes Association

Canadian Diabetes Association
Diabetes Educator Section

Belief Statements

As members of the Diabetes Educator Section (DES), we support the philosophy and goals of the Canadian Diabetes Association. We believe that diabetes is a disease that can affect all aspects of an individual's life, and we respect, value and encourage diabetes self-management. We furthermore hold the following beliefs:

We believe that individuals affected by diabetes:

- Have the right to access diabetes education and the diabetes healthcare team
- Are the primary members of their healthcare team
- Have varying potentials or desires for autonomy

We believe that diabetes education:

- Is a planned, individualized and evaluative process
- Focuses on the individual with diabetes and includes family, friends and the community
- Encourages individuals to modify lifestyle risk factors that may contribute to diabetes
- Takes into consideration physical, psychosocial, spiritual, cultural and socioeconomic needs
- Is best provided by an interdisciplinary team of healthcare professionals who collaborate to achieve patient-centred goals
- Enables individuals with diabetes to manage their diabetes-related health to the full extent of their abilities
- Enables individuals with diabetes to make choices and take actions based on informed judgement and understanding of possible outcomes
- Enhances general well-being, adaptation, acceptance and quality of life
- Is a continuous process in which the needs of the individual change throughout life

We believe that diabetes educators have a responsibility to:

- Continually strive to improve the quality of diabetes education
- Be current in their knowledge and skills regarding diabetes education
- Respect the choices made by individuals affected by diabetes

We believe that the DES has a responsibility to:

- Demonstrate leadership in diabetes education and in the professional development of diabetes educators
- Provide an organization that supports diabetes educators in their practice
- Advocate on behalf of diabetes educators and patients
- Support diabetes research related to the practice of diabetes educators

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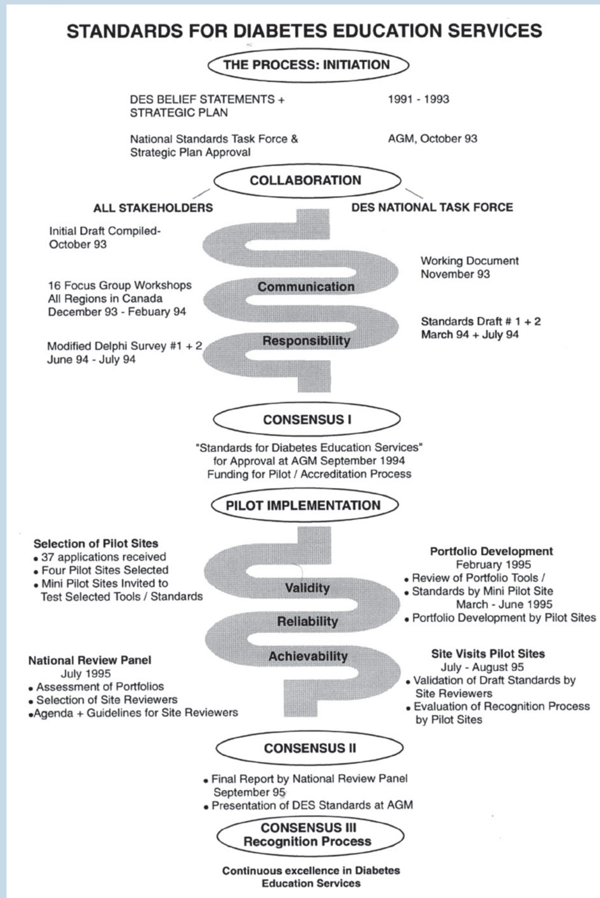
The Long and Winding Road of Standards for Diabetes Education in Canada:



2006 Standards Recognition Program Reviewed by independent panel
Helen Jones RN, MN, CDE; Ann Belton RN, BA, CDE; Lynn Edwards BSc, RD, MHSA

2009 Standards and SRP reviewed by Committee for compliance with 2008 Clinical Practice Guidelines

2014 Independent Review of Standards for Diabetes Education in Canada and the Standards Recognition Program
Ann Bowman RN, PhD, Pamela Osborne RD, CDE, Diana Sherifali RN, PhD, CDE

Structure Standards

STRUCTURE STANDARD 1

Human resources enable achievement of "Process" and "Outcome" standards.

Indicators:

1.1 Interprofessional teams for diabetes education services are consistently adequate, as defined by the client population and services required.

1.2 Staffing permits appropriate contacts, which may include individual assessments, group assessments and education, and sufficient time for education and ongoing follow-up when required.

1.3 Staffing permits timely access, according to individual needs and professional judgment (the following guidelines refer specifically to diabetes education and are based on the individual receiving appropriate medical assessment and treatment):

- Access to diabetes education is prioritized individually for all patients affected with diabetes
- Access to diabetes education is available within 48 hours for the following:

  a) Uncontrolled diabetes (BG >20 mmol/L, ketonuria >1.5 mmol/L)
  b) Newly diagnosed type 1 diabetes
  c) Pregnancy with pre-existing diabetes
  d) Recent treatment for ketoacidosis/nonketotic hyperosmolor hyperglycemia
  e) A crisis that drastically affects the individual's ability to manage their diabetes

- Access to diabetes education is available within 1-2 weeks for women with gestational diabetes mellitus

1.4 Individuals have timely contact with all of the following, who have diabetes expertise:

- Primary care provider
- Registered nurse
- Registered dietitian

1.5 Personnel involved in diabetes education have clinical expertise within a recognized profession.

1.6 Facilitators and volunteers have expertise in delivering learning events (e.g. Train the Trainer and signature programs).

1.7 Individuals have access, according to their needs, to the services of other specialists:

- Cardiologist
- Child and family services
- Child life specialist
- Dentist
- Dermatologist
- Clinical nutritionist
- Endocrinology/internist
- Exercise specialist
- Foot care specialist
- Internist
- Income security
- Long-term care services
- Home care
- Mental health professional
  (e.g. social worker, psychologist, psychiatrist, spiritual counselor)
- Neurologist
- Nephrologist
- Nursing
- Occupational therapist
- Ophthalmologist
- Optometrist
- Pharmacist
- Physical therapist
- Obstetrical care
- Chronic disease specialist

1.8 Relationships are fostered with available community resources:

- Canadian Diabetes Association/Diabetes Educator Section
- Canadian Mental Health Association
- Canadian National Institute for the Blind
- Community healthcare services
- Diabète Québec
- Health councils/boards
- Juvenile Diabetes Research Foundation
- National Aboriginal Diabetes Association
- Other relevant associations (e.g. Heart and Stroke Foundation of Canada, Kidney Foundation of Canada)
- Service organizations
- Support groups

1.9 Appropriate cultural resources are available in a language that is understood.

1.10 Chronic disease self-management (CDSM) programs (e.g. Stanford) are offered, or relationships with community-based CDSM programs are promoted.

STRUCTURE STANDARD 2

Physical resources enable achievement of "Process" and "Outcome" standards.

Indicators:

2.1 Physical space and education resources are conducive to learning and are based on individual/community needs, e.g.:

- Individual counseling space
- Sufficient classroom space relevant to the size of the group attending
- Comfortable seating
- Adequate lighting and air quality
- Privacy and confidentiality
- Audiovisual equipment and resources
- Literature
- Instructional equipment and supplies
- Washrooms
- Waiting area
- Accessibility for the physically disabled

2.2 Communication technology, appropriate equipment and information systems support the interprofessional team, e.g.:

- Effective communication services (phone/fax, computers/software, email/Internet)
- Office supplies and equipment
- Record-keeping system, including laboratory reports

2.3 There is clear indication of organizational support for diabetes education as reflected in the organization's

- Mission statement
- Strategic plan
- Resource allocation, including provision of continuing education

STRUCTURE STANDARD 3

Coordination and administration of diabetes education services enable achievement of “Process” and “Outcome” standards.

Indicators:

3.1 Responsibility for physical and human resource management is clearly defined. Appropriate support personnel and processes exist, e.g.:

- Program coordinators/managers
- Clerical staff
- Annual performance and program reviews
- Continuous quality improvement indicators

STRUCTURE STANDARD 4

Teamwork and communication are promoted among those who provide diabetes self-management education.

Indicators:

4.1 Teamwork is evident by:

- Collaborative decision making, problem solving, and priority setting
- Respect for interdisciplinary practice and skills
- Team meetings, which may include:
  a) Care conferences
  b) Service planning meetings
  c) Evaluations
  d) Journal clubs
  e) Extended team meetings (including referral sources)
  f) Meetings with board of directors

STRUCTURE STANDARD 5

The competence of diabetes educators is regularly assessed and promoted.

Indicators:

5.1 Orientation to roles, responsibilities and the work environment includes the following, as appropriate:

- Values
- Mission

- Strategic plan
- Goals and objectives
- Performance expectations
- Organizational structure
- Physical layout
- Accreditation standards
- Policies, procedures, standards and guidelines
- Relevant legislation
- Occupational health and safety training
- Continuous quality improvement
- Community partners and resources

5.2 Diabetes educators receive constructive feedback on their performance/professional practice from personnel such as supervisors, colleagues and clients.

5.3 Diabetes educators participate actively in ongoing professional development/education related to diabetes education, e.g.:

- Conferences (including conference calls)
- Audiovisual resources
- Workshops
- Certification as a diabetes educator
- College/university education courses or programs
- Self-directed learning, such as regular review of relevant theoretical, clinical, education and research publications, and participation in multidisciplinary discussions on topical issues
- A minimum of 16 hours per year of continuing health education related to diabetes

STRUCTURE STANDARD 6

Mechanisms are in place to ensure that community values are reflected in diabetes education.

Indicators:

6.1 Structures such as community liaison and advisory committees facilitate active community partnerships in diabetes education program planning, implementation and evaluation.

6.2 Representatives of communities report or demonstrate their involvement with diabetes education.

6.3 Where possible, a representative from the Canadian Diabetes Association is invited to be a member of the advisory committee.

Process Standards

PROCESS STANDARD 1

Diabetes self-management is based on ongoing patient-centred needs assessment of individuals with diabetes.

Indicators:

1.1 Initial and ongoing assessments are conducted, which recognize the diversity of client needs. These include needs assessments and analysis and interpretation of data.

1.2 The assessment is based on the participation of the individual, support persons and the interprofessional healthcare team members.

1.3 The assessment process is appropriate to communities served by one or more of the following strategies:

- Interviews with key informants in the community
- Focus groups
- Needs surveys/evaluations
- Community meetings

PROCESS STANDARD 2

Plans for diabetes education are ongoing and centred around the person with diabetes.

Indicators:

2.1 The individual and/or communities affected by diabetes actively participate with the interprofessional team in the development of an educational plan. This includes

- Collaborative goal setting
- Processes appropriate to culture
- Clear and full explanations of all options

2.2 The education plan reflects an effective integration of

- Current principles and practices for diabetes care
- Teaching/learning principles and practices
- Flexibility in approaches to teaching and learning
- Lifestyle and health beliefs that affect diabetes management
- Physical, psychosocial, spiritual, cultural and socioeconomic issues related to diabetes management

2.3 The education plan includes identification of resources needed to support healthy living with diabetes.

2.4 The education plan is client-focused and includes support persons and/or communities affected by diabetes.

PROCESS STANDARD 3

Diabetes self-management education is client-centred and facilitates behaviour change, problem solving and active participation by the individual living with diabetes.

Indicators:

3.1 The plan is implemented in a manner that reflects relevant principles of teaching and learning and the needs assessment of the individual and/or community.

PROCESS STANDARD 4

Diabetes education programs partner with services and utilize resources identified by individuals to support diabetes self-management.

Indicators:

4.1 Interprofessional team members function as resources and facilitators for learning.

4.2 Collaboration, as and when appropriate, is evident between healthcare professionals and others (e.g. community health representatives, health boards/councils, school personnel, allied health providers and caregivers).

4.3 Partnerships are developed and are ongoing to encourage learning opportunities (e.g. Living Well programs, chronic disease prevention and management initiatives).

4.4 Opportunities exist for support persons/systems to facilitate learning.

4.5 Processes are in place for appropriate follow-up and continuity of education.

4.6 Referrals to other services are facilitated, as needed (e.g. income security, child and family services).

PROCESS STANDARD 5

Diabetes self-management education is provided according to the practice standards of the health professions involved.

Indicators:

5.1 Practices are consistent with professional standards of care, codes of ethics and current knowledge, including the current Canadian Diabetes Association Clinical Practice Guidelines.

5.2 Interprofessional team members adhere to the codes of ethics of their workplaces and their respective professions.

PROCESS STANDARD 6

The effectiveness and quality of diabetes education program services are regularly evaluated and revised, as needed.

Indicators:

6.1 Education plans are evaluated regularly, based on current best practice guidelines.

6.2 Processes are in place for feedback between individuals and/or communities and diabetes educators regarding progress toward achievement of identified learning goals.

6.3 Modifications for education services are identified, planned and implemented jointly by the individuals and/or communities and the interprofessional teams.

Outcome Standards

OUTCOME STANDARD 1

Individuals affected by diabetes understand to the best of their ability how diabetes may affect them and the implications for healthy living with diabetes.

Indicators:

1.1 Individuals describe to the best of their ability how diabetes affects them. This may include

- Factors involved in the development of diabetes
- Basic components of diabetes management appropriate to the type of diabetes
- How diabetes affects them in health and illness
- The relationship between diabetes and other chronic diseases (e.g. cardiovascular disease, kidney disease)
- How to recognize, prevent and treat short-term and long-term complications

1.2 Individuals indicate an understanding of the relationship between nutrition, exercise, medications, stress and healthy living with diabetes.

OUTCOME STANDARD 2

Individuals make informed decisions and take action towards healthy living with diabetes. Actions occur in the context of spiritual and cultural values, socioeconomic needs, current state of health and desired quality of life.

Indicators:

2.1 Individuals demonstrate an understanding of diabetes management and self-care options, their related implications and the need for ongoing education.

2.2 Individuals describe actions that can be used to decrease the risk of short-term and long-term complications.

2.3 Individuals demonstrate adaptive problem solving in their decisions for living with diabetes.

2.4 There is improved physiological control of diabetes, which is demonstrated when the following indicators are maintained or progress toward the individual's goal range:

- Albumin-to-creatinine ratio
- Blood glucose
- Waist-hip ratio

- Glycated hemoglobin (A1C)
- Pediatric growth chart
- Serum lipids
- Target blood pressure

2.5 Individuals report or demonstrate increased ability to accomplish their goals for healthy living with diabetes, i.e.:

- Increased personal control regarding diabetes
- Integrating diabetes self-care into their employment, leisure, family and personal routines

2.6 Diabetes-related absences from school or work are minimized.

2.7 Emergency visits and/or hospital admissions for reasons directly related to diabetes are minimized.

OUTCOME STANDARD 3

The diabetes education program works with partners in our community to promote health, and prevent and reduce diabetes and its complications.

Indicators:

3.1 Information regarding risk factors contributing to diabetes, preventive actions and potential complications is made accessible.

3.2 Partnerships exist with community groups, organizations or sectors to promote the prevention of type 2 diabetes.

OUTCOME STANDARD 4

Our communities are aware of the support available for individuals living with diabetes.

Indicators:

4.1 Diabetes education services partner with communities to identify ways or take action to alter social and environmental factors to promote healthy living with diabetes.

4.2 There is indication of community support for diabetes education and/or the development of such services as

- Programs, support networks and educational materials
- Publicity regarding how and when to access available resources
- Obtaining/advocating for community resources or financial support for programs and services to support healthy living with diabetes

OUTCOME STANDARD 5

Our diabetes education program responds and meets the needs of the community referred.

Indicators:

5.1 Referral and follow-up records indicate that the individuals use resources required for risk-factor identification, early intervention and prevention of complications.

5.2 Emergency visits and hospital admissions related to preventable complications of diabetes are minimized.

5.3 Length of a hospital stay related to complications of diabetes is minimized.

Legend of Relevant Dimensions

Dimensions

Population focus: Working with communities to anticipate and meet needs

Accessibility: Providing timely and equitable services

Safety: Keeping people safe

Worklife: Supporting wellness and professionalism in the work environment

Client-centred services: Putting clients and families first

Continuity of services: Experiencing coordinated and seamless services

Effectiveness: Doing the right thing to achieve the best possible results: Are the objectives of the interventions being achieved? How big is the effectiveness or impact of the project, compared to the objectives planned? (Comparison: does the result match the planning?)

Efficiency: Doing the right thing economically to achieve the best possible results: Are the objectives being achieved economically by the intervention? How big is the efficiency or utilization ratio of the resources used? (Comparison: do the resources applied yield the anticipated/desired results?)

Glossary of Relevant Terms

Accessibility
A measure of the ease with which a specific population can obtain appropriate healthcare services and be served by facilities within the healthcare system.

Benchmarking
A point of reference, serving as a standard by which one's performance may be measured. The process of identifying, understanding and adapting outstanding practices from other organizations to help your program improve its performance.

Community
A group of people who are connected with each other on the basis of diabetes. Those with diabetes, or at risk for diabetes, or those indirectly affected by diabetes (e.g. extended family, friends, schools and workplaces).

Continuous quality improvement
A system of continuous evaluation of processes, with a goal of improving efficiency and quality.

Diabetes Education Program
Uses an interprofessional team approach to provide diabetes education and care for people (and their community) with, or at risk for developing, diabetes. The programs and services delivered in this setting are coordinated and include the interprofessional core team. At minimum, the team includes a nurse, a dietitian and a primary care provider. The role of the primary care provider can be fulfilled by an onsite specialist or the client's primary care provider and/or a referring primary care provider. Training healthcare professionals may also be a role of this type of service.

Diabetes resource
A tool or support that people with diabetes may access, e.g. support groups, Canadian Diabetes Association regional leadership centres, information centres or signature programs, literature, videos or websites.

Donabedian framework
The Donabedian framework was created as a means of evaluating the quality of healthcare, and includes three main components: Structure, Process and Outcomes. This framework was created to enable both the evaluation of healthcare, as well as the creation of standards for healthcare.

Emergency services
This is where unscheduled care is given, and includes telephone calls for assistance, emergency clinic visits, hospital emergency room visits or ambulance services.

Guidelines
Directions or principles that provide guidance to appropriate behaviour and/or that present current or future policy rules. Guidelines may be developed by government agencies, institutions, professional organizations/societies or governing boards. The text provides a comprehensive guide to problems and approaches in any field of activity.

Health
A resource for everyday life – not the objective of living; health is a positive concept emphasizing social and personal resources as well as physical capacity. (Source: World Health Organization, 1986)

Indicators
Verifiable examples of how a standard must be met.

Interprofessional
Involving two or more distinct healthcare professions, comprising knowledge from several domains, and combining the principles and concepts of all.

Outcome standards
Observable, verifiable effects, which indicate that specified intentions or action strategies have been achieved or implemented.

Patient
Anyone who receives education services (an individual, family or community). Also referred to as a client.

Patient-centred
Activities/processes that focus on the client and the client's perceptions; these are directed by the client's needs and goals, which may be independently determined, but are most often defined in collaboration with members of the multi- and interprofessional healthcare teams.

Persons affected by diabetes
Includes those with diabetes, as well as family members, support persons and the community.

Process standards
Performance expectations of those who provide education, which lead to desired client outcomes.

Standard
Any type, model or example for comparison; a criterion of excellence; any established measure of extent, quantity or quality that equals goals or value.

Strategic planning
Determining goals for the future (next year, in two years, in three years, etc.). Strategic planning should specifically address how these goals will be achieved and what measures will be used to determine success.

Structure standards
Supporting resources (e.g. facilities, equipment, time, personnel) essential to the achievement of "Process" and "Outcome" standards.

Support persons
Those who generally provide ongoing support to the individual living with diabetes (e.g. family, friends, neighbours, support groups).

Adapted from:

1. Diabetes Educator Section. Glossary of relevant terms. In: *Standards for Diabetes Education in Canada 2009.* Toronto, ON: Canadian Diabetes Association, 2009.
2. Diabetes Educator Section. *Directory of Diabetes Services in Canada.* Toronto, ON: Canadian Diabetes Association, 2004.
3. Qmentum Program. *Populations with Chronic Conditions.* Ottawa, ON: Accreditation Canada, 2013.
4. Donabedian, A. *An introduction to quality assurance in health care.* New York: Oxford University Press, 2003.

Additional copies of
Standards for Diabetes Education in Canada 2014
are available from:

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