Diabetes Education Standards Recognition Program

A Quality Assessment Tool for Diabetes Education Programs
1. Introduction to the Diabetes Education Standards Recognition Program

2. Application for the Diabetes Education Standards Recognition Program

3. Diabetes Education Standards Recognition Program
   Self-Assessment Documents

4. Diabetes Education Standards Recognition Program
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Introduction to the Diabetes Education Standards Recognition Program
The Self-Assessment and Recognition Program was first developed in 1996 by the National Review Panel, Diabetes Educator Section (DES) and the Canadian Diabetes Association (CDA). The program was revised in 2004 by a consulting team in conjunction with the DES Recognition Program Working Group, and was renamed the Diabetes Education Standards Recognition Program. The process of review continued in 2014 following the release of the 2013 CDA Clinical Practice Guidelines (CPGs), building on the foundation of the current CPGs, the DES Mission and Belief Statements, Accreditation Canada Q-Mentum Program – Standards for Populations with Chronic Conditions, and the CDA Board of Directors’ Vision 2020: 5-Year Strategic Plan.

The current *Standards for Diabetes Education in Canada* serves as the foundation for this self-assessment. The Standards included in this manual are also available on the CDA’s website (www.diabetes.ca). They are derived from the DES Belief Statements (described fully in the Standards document). The Standards are articulated utilizing the Donabedian framework, which was created as a means of evaluating the quality of healthcare, and includes three main components: Structure, Process and Outcomes.

All portfolios will be reviewed by the Standards Recognition Committee members, and to ensure the external review process is fair and unbiased, the triangulation method of evaluation will be used.
INTRODUCTION

Participation in the Standards Recognition Program is a voluntary self-assessment process. This self-assessment program focuses on individuals with diabetes, their families and/or communities and:

1. The organization and support services or structure that assists in providing care;
2. How education is provided, or the process leading to the desired outcome;
3. The impact or outcome at the end of the learning experience, both behavioural changes and patient knowledge.

Each of these three categories has multiple Standards, with examples of indicators for each Standard. Indicators are verifiable examples of how a Standard can be met. Your Diabetes Education Program may have other indicators that illustrate how you meet the Standard, and the self-assessment documents in this program allow you to incorporate these indicators for each Standard.

The documents needed to complete the self-assessment will be provided to you electronically, upon completion of the Notification of Intent to Apply for the Diabetes Education Standards Recognition Program. Sample data collection forms are also provided (patient questionnaire, chart audit form, diabetes care plan form). You may choose to use your own forms if the information needed for data collection is the same. Review the self-assessment forms before deciding if your own forms will provide the necessary data. (For definition of community, please reference the current Standards for Diabetes Education in Canada.)

Data collection may be retrospective, up to 12 months prior to submitting the Diabetes Education Standards Recognition Program documents.

You will not be asked to submit examples of information (patient questionnaires, forms, education materials, etc.) in hard copy as part of your application, but this information should be forwarded in electronic format. Upon review of your self-assessment documents, the Standards Recognition Program reviewers may request other supporting documents. Therefore, please retain all pertinent supporting documents until you receive the Standards Recognition Program reviewer’s decision.

BENEFITS TO YOUR DIABETES EDUCATION PROGRAM

Your Diabetes Education Program will:
• assess actions and effectiveness of care and services against the Standards for Diabetes Education in Canada;
• examine and plan to improve (where applicable) the quality of care and services provided, with the ultimate goal of improving the health of individuals with diabetes;
• earn peer and patient recognition as a program that provides Excellence of Care, which will be made visible by displaying in a public area the Recognition Certificate you will receive;
• earn public and professional recognition through the posting of your program on the CDA website for the duration of the recognition period; and
• have the ability to be benchmarked and compared against services by other diabetes education programs across Canada.
LENGTH OF RECOGNITION PERIOD

Recognition is granted for a period of five years, after which a Diabetes Education Program may apply for renewal (see Section 2).

QUESTIONS/COMMENTS

For information concerning any aspect of the Diabetes Education Standards Recognition Program, please contact:

Coordinator, Professional Membership & Projects – Diabetes Educator Section
Canadian Diabetes Association
1400–522 University Avenue
Toronto, Ontario, Canada
M5G 2R5
Telephone: 1-800-BANTING
Application for the Diabetes Education Standards Recognition Program
ARE YOU READY TO APPLY?

Has your Diabetes Education Program implemented the Diabetes Educator Section Standards for Diabetes Education in Canada?

- Yes
- Not Yet

Based on the services your centre provides, are the appropriate components of the 2013 CDA CPGs for the Prevention and Management of Diabetes in Canada implemented?

- Yes
- Not Yet

Have you recently done, or are you ready to do, a client survey?

- Yes
- Not Yet

Have you recently done, or are you ready to do, a client chart audit?

- Yes
- Not Yet

Do you want to be recognized as a Diabetes Education Program that provides excellence of care?

- Yes

YOU ARE READY TO BEGIN THE APPLICATION PROCESS!

Implement Diabetes Education Standards.

Implement 2013 CDA CPGs.

Use a tool/form to complete this.

Use a tool/form to complete this.

Engage support from your administrators (if applicable). See sample letter.

Application
SAMPLE SUPPORT LETTER TO BE SENT TO DIRECTORS (CEO, PROGRAM DIRECTOR, CHIEF OF ENDOCRINOLOGY, ETC.)

Date:

Ms./Mr./Dr. First/Last Name, Administrator’s Title, Hospital/Healthcare Institution, Street Address, City, Province, Postal Code

Dear ______________________:

As a Diabetes Education Program committed to continued excellence of care, we wish to apply for the Canadian Diabetes Association (CDA) Diabetes Educator Section (DES) Diabetes Education Standards Recognition Program.

The recognition program is a self-assessment that is completed by members of our program team. The assessment is based on the current Standards for Diabetes Education in Canada produced by the CDA/DES. It focuses on our clients with diabetes, their families/support persons and the communities we serve. The process evaluates three categories of Standards: the impact or outcome of our care and services, the process used and our structure.

Our diabetes education team believes it is important for us to evaluate our performance and effectiveness against national standards for diabetes care, and to examine and improve, if need be, the quality of care and services that we provide. Completion of this program is an important continuous quality improvement (CQI) activity for our program. Finally, and perhaps most importantly, involvement in this process will provide positive reinforcement for both clients and staff of our program.

Your support and approval of our application to undertake the Diabetes Education Standards Recognition Program is requested. Your signature in the space provided below will indicate your approval. Please return your reply within the next two weeks to:

Contact Name
Name of Diabetes Education Program
Street Address, City, Province, Postal Code

Sincerely,

Name
Title

I support the Diabetes Education Program named above in its application for recognition as a Centre of Excellence by the Diabetes Educator Section of the Canadian Diabetes Association.

__________________________________________
Signature of Administrator

__________________________________________
Date
COMPLETING THE SELF-ASSESSMENT DOCUMENTS

» STEP 1: IS YOUR DIABETES EDUCATION TEAM READY?

1. Confirm you have the support of all of your diabetes education team members.
2. Engage administrators, as appropriate (sample letter provided with program binder).
3. Appoint a team coordinator, who will accept responsibility for applying for recognition, arranging meetings, coordinating completion of all reports and be available for required followup.
4. Organize a timetable of regular meetings — with all team members participating — to begin the self-assessment process, plan client surveys, and client chart audits, etc.
5. Diabetes education programs (DEPs) intending to apply for recognition must first purchase the current edition of the Standards Recognition Binder ($250) and the Standards for Diabetes Education in Canada booklet ($10) or download them from the website.

» STEP 2: GETTING STARTED

Ensure that all members are prepared for the first meeting as follows:

1. Read the current Standards for Diabetes Education in Canada booklet, and review the three categories of Standards (Process, Outcome and Structure) and examples of indicators that demonstrate your achievement of these Standards. Information on the most recent Standards can be obtained from the CDA website.
2. Read the Glossary of Relevant Terms in the current Standards for Diabetes Education in Canada.
3. Review information needed to complete the “Diabetes Education Program Profile” (Manual: Section 3). Completion of the profile section includes the entry of administrative data and statistics regarding client visits over the past year.
4. Review the self-assessment documents (Manual: Section 3), which provide other indicators and opportunities for you to present program-specific data indicating how each Standard can be met.
5. Reflect upon how your program applies these indicators, or in what other ways your centre meets the Standard.

DEPs that intend to apply for recognition, must submit a $50 non-refundable administrative fee by Dec. 1 of the year prior to submission. Upon receipt, the documents required to complete the self-assessment will be provided to you electronically. A fee of $800 to the CDA National Office must accompany submission of the DEP’s portfolio for recognition by Feb. 1 of the following year. The notification form must be sent to:

Coordinator, Professional Membership & Projects – Diabetes Educator Section
Canadian Diabetes Association
1400–522 University Avenue
Toronto, Ontario, Canada
M5G 2R5
STEP 3: DIABETES EDUCATION PROGRAM PROFILE

Administrative data and statistics regarding the previous year of operation will be needed to complete your Diabetes Education Program’s profile. Some of these data will be helpful later in the process, when you are completing the self-assessment documents.

STEP 4: CLIENT SURVEYS, FOCUS GROUPS, CLIENT CHART AUDITS

Data from a client survey or focus group and a client chart audit will be needed to complete the self-assessment documents. Sample forms, which you may wish to use, are included in the appendices. You may use your own forms if the information is similar to the forms provided. Review the forms and plan the implementation of the survey and audit.

STEP 5: THE SELF-ASSESSMENT PROCESS

Documentation should be completed in the electronic format provided by the CDA as outlined in Step 3.

1. Complete the document for each Standard shown in Section 3 of the manual. (Please note: the indicators given are examples only.)
2. You may have other indicators for each Standard, and you are welcome to tell us about your own ways of meeting the Standard. Therefore, you need not answer YES to all indicators in the self-assessment tool in order to meet the Standard.
   • If there is no N/A box, then reply either YES or NO. You do not have to answer YES to all indicators to meet the Standard.
   • For each Standard where N/A is a reasonable option, it is included to help you best describe your centre and clients.
   • There are several data tables to complete in the self-assessment documents. These provide you with the opportunity to reflect on the data and the overall functioning of your Diabetes Education Program. Once the table is completed, you are asked to answer a reflective statement following it.
   • Each Standard gives your program the opportunity to identify areas of strength and plans for improvement, when applicable.

STEP 6: COMPLETING THE EVALUATION FORM FOR THE SELF-ASSESSMENT PROCESS

We value your feedback. Please complete the Evaluation of Self-Assessment Process (included in Section 3 of the manual).

STEP 7: SUBMITTING YOUR APPLICATION FOR RECOGNITION

The application submission deadline for recognition is Feb. 1 of each year.

1. Ensure that all documents and forms have been completed:
   • Diabetes Education Program Profile
   • Structure Standards
2. Attach to the summary report a list of all team members involved in the completion of the documents.

3. The cost of processing and evaluating your application is $800. Please enclose a cheque payable to the Canadian Diabetes Association.

4. Send an electronic version (printed documents are acceptable only if you are unable to scan everything into an appropriate electronic format) of all completed and supporting documents to:

   Coordinator, Professional Membership & Projects – Diabetes Educator Section
   Canadian Diabetes Association
   1400–522 University Avenue
   Toronto, Ontario, Canada
   M5G 2R5

5. You may expect a response by June 30.
GLOSSARY OF RELEVANT TERMS

--- A ---

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

--- B ---

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

--- C ---

**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 (extended family, friends, schools, workplace).

**Continuous quality improvement**
A system of continuous evaluation of process with a goal of improving efficiency and quality.

--- D ---

**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 services delivered in this setting are coordinated and include the interprofessional core team. At minimum, the team includes a nurse, dietitian and physician. The role of the physician can be fulfilled by an onsite specialist or the client's family physician and/or a referring physician. 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, such as support groups, CDA 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 the evaluation of healthcare, as well as the creation of standards of healthcare.

— E —

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

— G —

Guidelines
Directions or principles that provide guidance to appropriate behaviour and/or current or future policies. 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.

— H —

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.)

— I —

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.

— O —

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 called a client.

**Patient centred**
Describes 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 leads to desired client outcomes.

---

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

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

**Structure standards**
Supporting resources (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 (family, friends, neighbours, support groups).

---

**ADAPTED FROM:**

3. Qmentum Program. Populations with chronic conditions. Ottawa, ON: Accreditation Canada; 2013
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Focus</strong></td>
<td>Working with communities to anticipate and meet needs</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Providing timely and equitable services</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>Keeping people safe</td>
</tr>
<tr>
<td><strong>Worklife</strong></td>
<td>Supporting wellness and professionalism in the work environment</td>
</tr>
<tr>
<td><strong>Client-Centred Services</strong></td>
<td>Putting clients and families first</td>
</tr>
<tr>
<td><strong>Continuity of Services</strong></td>
<td>Experiencing coordinated and seamless services</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>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: result – planning)?</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>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: resources applied yield anticipated/desired results)?</td>
</tr>
</tbody>
</table>
PROCESS FOR RENEWAL OF RECOGNITION

Recognition must be applied for every five years. Once you are granted Full Recognition, ensure that the team takes an annual look at the changes, effects on the Diabetes Education Program’s activities, and progress you have made toward the action plan you identified in your last submission. **It is important to include this progress in your next recognition submission.**

The date on your program’s Recognition Certificate indicates when the recognition period ends. One year before your recognition period ends, the DES will send you a reminder letter. Submissions for evaluation are accepted Feb. 1 of each year.
Diabetes Education
Standards Recognition Program
Self-Assessment Documents
• You may not be asked to submit examples of information (patient questionnaires, forms, education materials, etc.) in hard copy as part of your application; however, this information should be forwarded in an electronic format. It is advisable to include any documentation you feel would help the reviewers develop a better picture of your program. Upon review of your self-assessment documents, the Standards Recognition Program reviewers may request other supporting documents. Therefore, please retain all pertinent supporting documents until you receive the Standards Recognition Program reviewer's decision.

• It is also important to provide detailed information to prove how each standard was met.

• By June 30, you will receive a letter regarding the reviewers’ assessment of your application.
DIABETES EDUCATION PROGRAM PROFILE

Name of Diabetes Education Program: __________________________________________________________

Address: ________________________________________________________________________________

Province: ___________________________ Postal Code: ____________________________________________

Contact Person: ______________________ Title: _________________________________________________

Telephone: __________________________ Fax: ____________________________________________________

Email: ______________________________ Website: _____________________________________________

1. The vision of our Diabetes Education Program is: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
YES NO

2. We have a mission statement, which includes our goals, values, objectives and the scope of our program.

☐ ☐

3. Our program has a strategic plan.

☐ ☐

(If YES, indicate when last revised): __________________

On the following pages, you are asked for data and statistics regarding your program. Some of you may collect data in a different format that provides the same information regarding client volume (new and followup, types of patient/treatment, type of counselling, whether individual or group, etc.). Kindly present your statistics in your available format; you are not required to complete tables if you are able to submit the same information in another format.
1. Estimated total population in our catchment area: .............................. ☐ Don’t know

2. Estimated population with diabetes in our catchment area: ................. ☐ Don’t know
   (Contact the National Diabetes Surveillance System or your provincial Ministry of Health to obtain your province/territory prevalence rate; use this figure to estimate the total number of people with diabetes in your catchment area).

   Estimated diabetes prevalence rate for our area: ......................(%) 

3. The number and percentage of this diabetes population actively serviced by our program:

   ......................(number)  ......................(%) 

   (This can be calculated by adding your active and inactive cases and dividing by the estimated population with diabetes. It is of value to know the active percentage vs. overall number of cases seen in your program.)

4. Describe the population served: .................................................................

---

**TYPE AND VOLUME OF PATIENTS SEEN PER YEAR**

1. For each applicable client population, please indicate the average number of active patients and number of new referrals seen per year. In the space on the next page, please provide your definition of active client (seen in the last year; seen in the past two years, etc.).

<table>
<thead>
<tr>
<th>Client population</th>
<th># of new referrals</th>
<th># of active patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (≥19 years of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth (&lt;19 years of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconception counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational diabetes mellitus (GDM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy with pre-existing diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-diabetes (IGT/IFG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Our definition of “active” client is: ____________________________________________
__________________________________________________________________________
__________________________________________________________________________

Our definition of “new referral” is: ____________________________________________
__________________________________________________________________________
__________________________________________________________________________

Our definition of “newly diagnosed” is: ________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. In addition to the above data, please describe in the space below other population characteristics that affect your diabetes service (per cent male/female, age, type of diabetes, ethnicity, literacy, language of service delivery, demographics, transitional care, etc.).
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3. Total number of “new” referrals to our program (diagnosed >12 months ago but first time to our program)

4. Total number of “newly diagnosed” (diagnosed within the last 12 months) client visits to our program

5. Total number of followup visits (telephone/fax/email) to our program

6. Total number of insulin starts (since attending our program)

7. Total number of patients started on insulin pump therapy (since attending our program)

8. Estimated number of individual patients seen

9. Estimated average number of visits per client

10. Do you collect any other types of statistics or data?

YES  NO

If YES, indicate in the space provided what you collect and the value of this data to your program: ____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Self-Assessment Documents
TYPE OF SERVICE PROVIDED

Does your Diabetes Education Program provide:

1. Inpatient services? □ □ □
2. Outpatient services? □ □ □
3. Satellite/outreach services? (a travelling team to service a specific community) □ □ □
4. Emergency services? □ □ □

If YES, describe in the space below whom you are providing emergency services to and how you provide them (on-call 24+ hours, 24 hour call-in, call-in during regular hours, etc.):

ACCESS TO SERVICE

1. Please indicate the time to access your program for each of the following types of patient. Some programs offer group intake or survival skills teaching prior to an individual appointment/assessment. In this case, we refer to this as group instruction. Note: wait time is elapsed time between appointment booking until seen by a member of your Diabetes Education Program staff.

<table>
<thead>
<tr>
<th>Type of client</th>
<th>Wait time, group instruction</th>
<th>Wait time, individual instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly diagnosed type 1 adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly diagnosed type 2 adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly diagnosed GDM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly diagnosed youth (&lt;19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly diagnosed pre-diabetes (IFG/IGT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New client to program (not newly diagnosed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to program (&gt;12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin start</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin pump</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Followup (after initial teaching period)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Does your program have triage criteria for:

- urgent and non-urgent referrals
- determining the frequency of followup visits

If YES, please describe them:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

CLIENT POPULATIONS AND HOW THEY ARE EDUCATED BY OUR DIABETES EDUCATION PROGRAM

1. We provide group education sessions:

<table>
<thead>
<tr>
<th>Type of group session</th>
<th>Average # sessions/month</th>
<th>Average # patients/session</th>
</tr>
</thead>
<tbody>
<tr>
<td>New referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Followup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Families/caregivers are encouraged to attend group and/or individual teaching sessions

3. Others are encouraged to attend group and/or individual teaching sessions (please specify):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Do you offer special programs for specific groups? (pregnancy, elderly, transition care, etc.)

If YES, please describe them:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**HOURS OF SERVICE**

1. Please indicate your days and times of operation. Place a (✓) in the appropriate column and indicate the actual hours of operation.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Full days (8:00 am – 4:00 pm)</td>
<td>✓</td>
<td></td>
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<tr>
<td>Half days (am or pm)</td>
<td>✓</td>
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</tr>
<tr>
<td>Evenings</td>
<td>✓</td>
<td></td>
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<tr>
<td>Other (please specify)</td>
<td>✓</td>
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</tr>
</tbody>
</table>

**SPECIAL PROJECTS AND RESEARCH ACTIVITIES**

1. Describe in the space provided below any special projects, quality improvement initiatives or research activities related to diabetes education that have taken place in your program in the past five years that you would like to share (describe content, process and frequency).

In summary, our self-assessment of the data we have provided in this profile suggests:

1. We were able to provide the required data easily.

   YES □   NO □

2. Our strengths *in point form* in data collection are:

   •
   •
   •

3. Our gaps *in point form* in data collection are:

   •
   •
   •

4. Our plans *in point form* for improving our data collection methods are:

   •
   •
   •
Diabetes Education Standards Recognition Program Self-Assessment Documents Structure Standards
**STRUCTURE STANDARD 1**

Human resources enable achievement of Outcome and Process Standards.

1. Staffing profile for individuals involved in or accessible to the Diabetes Education Program.

<table>
<thead>
<tr>
<th>Professional staff</th>
<th>Full-time FTE</th>
<th>Part-time FTE</th>
<th>Total FTE</th>
<th>Non-diabetes education program staff</th>
<th>Bachelor’s degree</th>
<th>Master’s degree</th>
<th>Doctorate</th>
<th>CDE</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitian</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Nurse</td>
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<td></td>
<td></td>
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<tr>
<td>Physician</td>
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<tr>
<td>Endocrinologist</td>
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<tr>
<td>Social worker</td>
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<td></td>
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<tr>
<td>Clinical nurse specialist</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Kinesiology</td>
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<td></td>
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<tr>
<td>Nurse practitioner</td>
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<td></td>
<td></td>
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<tr>
<td>Psychologist</td>
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<tr>
<td>Foot care</td>
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<td>Other</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support staff</th>
<th>Full-time</th>
<th>Part-time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative assistants/support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Program coordinator or clinical lead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Number of years of staff experience in diabetes education, hours of assessment and teaching per week and average wait times.

<table>
<thead>
<tr>
<th>Professional</th>
<th># of professionals/years of experience</th>
<th>Average # of hours of assessment and instruction per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;2 years 2–5 years 6–10 years &gt;10 years</td>
<td># of hours for direct patient care # of hours for indirect patient care Average wait time</td>
</tr>
<tr>
<td>Dietitian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrinologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td></td>
<td></td>
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<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinesiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. After reviewing the data in the table in Question #1, our interprofessional staffing is adequate to meet the program’s goals with regard to:

- staffing level
- team composition

4. There is access to a diabetes program within 1-2 business days for:

a) uncontrolled diabetes symptomatic with BG levels >20 mmol/L, or ketonuria >1.5 mmol/L
b) newly diagnosed type 1 diabetes
c) pregnancy with pre-existing diabetes
d) recent treatment for diabetic ketoacidosis/nonketotic hyperosmolar hyperglycemia or severe/recurrent hypoglycemia

e) a crisis that drastically affects the individual’s ability to manage their diabetes.

Explain how this process occurs in your program, and please provide a process map if available:

5. There is access to diabetes education within 1–2 weeks for women with GDM.

6. After evaluating the information completed in the Diabetes Education Program Profile and the answers to the previous five questions, staffing in our program allows for:

   a) timely access to our services

   b) adequate time for individual assessments

   c) adequate time for education of patients and families

   d) adequate time for ongoing followup

   e) If you answered NO to the above questions, what measures or processes have you put in place to address adequate and timely access to diabetes self-management education?

7. What is your average wait time for a newly diagnosed person with uncomplicated type 2 diabetes (minimal oral or lifestyle management)? Please describe them in detail and include any forms or process maps used for this process:
8. Services available or via telemedicine or distance for our patients:

<table>
<thead>
<tr>
<th>Service available</th>
<th>Available in your program</th>
<th>Available in community</th>
<th>Available via telemedicine or distance</th>
<th>Not Available</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; family services</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Child life specialist</td>
<td></td>
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<tr>
<td>Dentistry</td>
<td></td>
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<tr>
<td>Dermatologist</td>
<td></td>
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<tr>
<td>Clinical nutrition</td>
<td></td>
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<tr>
<td>Endocrinology/internist</td>
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<tr>
<td>Exercise specialist</td>
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<tr>
<td>Foot care specialist</td>
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<tr>
<td>Income security</td>
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<tr>
<td>Home care services</td>
<td></td>
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<tr>
<td>Mental health professional: social worker</td>
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<tr>
<td>Psychologist, psychiatrist, spiritual counsellor</td>
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<tr>
<td>Nephrologist</td>
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<tr>
<td>Neurologist</td>
<td></td>
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<tr>
<td>Nursing</td>
<td></td>
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<tr>
<td>Obstetrical care</td>
<td></td>
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<tr>
<td>Occupational therapist</td>
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<tr>
<td>Ophthalmologist</td>
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<tr>
<td>Optometrist</td>
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<tr>
<td>Pharmacist</td>
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<tr>
<td>Physical therapist</td>
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<tr>
<td>Volunteer</td>
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<tr>
<td>Other (please specify)</td>
<td></td>
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</tr>
</tbody>
</table>
9. An ongoing relationship is fostered between the Diabetes Education Program and the following (check all that apply).

<table>
<thead>
<tr>
<th>Association</th>
<th>Briefly describe relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes education groups</td>
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</tr>
<tr>
<td>Canadian Diabetes Association</td>
<td></td>
</tr>
<tr>
<td>Canadian Mental Health Association</td>
<td></td>
</tr>
<tr>
<td>Canadian National Institute for the Blind</td>
<td></td>
</tr>
<tr>
<td>Community healthcare services</td>
<td></td>
</tr>
<tr>
<td>Diabète Québec</td>
<td></td>
</tr>
<tr>
<td>Health councils/boards</td>
<td></td>
</tr>
<tr>
<td>Juvenile Diabetes Research Foundation</td>
<td></td>
</tr>
<tr>
<td>National Aboriginal Diabetes Association</td>
<td></td>
</tr>
<tr>
<td>Other relevant associations (Heart &amp; Stroke Foundation, Kidney Foundation)</td>
<td></td>
</tr>
<tr>
<td>Service clubs and organizations</td>
<td></td>
</tr>
<tr>
<td>Support groups</td>
<td></td>
</tr>
<tr>
<td>Other groups (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

10. Our review of the chart above indicates that our program fosters ongoing relationships/communication with external associations, services, support groups, etc. ☐ ☐ ☐

11. We have other ways of demonstrating that our staffing enables the achievement of the Outcome and Process Standards (please describe):

   ....................................................................................................................................................... 
   ....................................................................................................................................................... 
   ....................................................................................................................................................... 

In summary, our self-assessment of this Standard is:

1. We meet this Standard. ☐ ☐

2. Our justifications for meeting this Standard are:

   •
   •
   •

3. Our strengths (in point form) are:

   •
   •
   •
4. Our plans (in point form) for improving our service to better meet this Standard are:

- 
- 
- 

**STRUCTURE STANDARD 2**

Physical resources enable achievement of Outcome and Process Standards.

1. There are adequate physical resources in our program, which are conducive to learning.

2. Physical resources are assessed as adequate in terms of:
   a) individual counselling space (for privacy/confidentiality)
   b) washroom facilities (hand washing and urine testing instruction and so on)
   c) proximity of waiting room to teaching areas
   d) classroom space for group teaching
   e) amount of private office/teaching space for professionals
   f) space for storing teaching resources
   g) access for the physically disabled
   h) environmental and health and safety standards are met (air ventilation, lighting, room temperature)

3. a) There are adequate educational resources available for patients regarding the nature of diabetes, risk factors and prevention of complications.
b) There are appropriate culturally sensitive resources in a language understood by patients.

<table>
<thead>
<tr>
<th>Type of resource</th>
<th>CDA</th>
<th>Provincial association</th>
<th>In-house</th>
<th>Commercial</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posters</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pamphlets</td>
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<tr>
<td>CD-ROM</td>
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<tr>
<td>Audio-video</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

4. There are adequate technological and communications resources.

5. There are translation resources available and signalling for the hearing impaired.

6. Communication technology and office resources are assessed for adequacy:

   a) client medical record system, including lab reports
   b) telephone services
   c) office supplies
   d) office equipment
   e) computer hardware and software access
   f) fax equipment
   g) Internet access for staff
   h) Internet access for patients
   i) email access
   j) secure space to keep confidential documents
7. There is a clear indication of organizational support for diabetes education as reflected in the organization’s
   • mission statement
   • strategic plan
   • resource allocation, including provision for continuing education

8. We have other ways of demonstrating that our physical resources enable us to achieve the Outcome and Process Standards (please describe in the space provided):
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard.  

2. Our justifications for meeting this Standard are:
   •
   •
   •

3. Our strengths (in point form) are:
   •
   •
   •

4. Our plans (in point form) for improving our service to better meet this Standard are:
   •
   •
   •

----------------------------------------  ----------------------------------------
CDA Reviewer’s Initials                    Date
STRUCTURE STANDARD 3

Coordination and administration of diabetes education services enable achievement of Outcome and Process Standards.

1. We have an organizational chart and policies/procedures that define the Program’s structure and administrative responsibilities, such as:
   - human resources management & performance review
   - financial and data management
   - continuous quality improvement
   - program review стрategic planning
   - norms for physical resources

2. Appropriate support personnel exist, such as:
   - program coordinators/managers
   - quality coordinator
   - clerical support

3. Appropriate processes exist, such as:
   - yearly performance review for staff is completed
   - program review is completed periodically
   - continuous quality improvement indicators are measured

4. There is an administrative process in place to deal with any breach of the Code of Ethics by diabetes education staff.
5. We have other ways of demonstrating that co-ordination and administration of diabetes education services enable us to achieve the Outcome and Process Standards (please describe in the space provided): ☐ ☐ ☐

In summary, our self-assessment of this Standard is:

1. We meet this Standard. ☐ ☐

2. Our justifications for meeting this Standard are:

   •  •  •

3. Our strengths (in point form) are:

   •  •  •

4. Our plans (in point form) for improving our service to better meet this Standard are:

   •  •  •

---

CDA Reviewer’s Initials

Date

STRUCTURE STANDARD 4

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

1. We have team meetings. ☐ ☐
<table>
<thead>
<tr>
<th>Meeting/committee</th>
<th>Frequency</th>
<th>Who attends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weekly</td>
<td>Monthly</td>
</tr>
<tr>
<td>Program planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team business/daily functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic planning/annual objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team-building activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisory committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program board of directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (please describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Teamwork and communication in our program is promoted and is evident by the interactions indicated above.  

3. We have other ways of demonstrating that teamwork and communication are promoted within our program (please describe in the space provided):  

   .........................................................................................................................................................  
   .........................................................................................................................................................  
   .........................................................................................................................................................  

In summary, our self-assessment of this Standard is:

1. We meet this Standard.  

2. Our justifications for meeting this Standard are:

   •
   •
   •  
   •
3. Our strengths (in point form) are:

   •

   •

   •

4. Our plans (in point form) for improving our service to better meet this Standard are:

   •

   •

   •

---

STRUCTURE STANDARD 5

The competence of diabetes educators is regularly assessed and promoted.

1. We have an orientation program for new staff to our Diabetes Education Program, which includes the following:

   • mission and organizational structure
   □ □

   • strategic plan, goals and objectives
   □ □

   • performance expectations of educators
   □ □

   • physical layout
   □ □

   • Canadian Council on Health Services Accreditation standards
   □ □ □

   • policies, procedures, standards and guidelines
   □ □

   • relevant legislation
   □ □

   • infection control requirements
   □ □
• occupational health and safety training

• continuous quality improvement program

• community partners and resources

• other (please specify):

2. Diabetes Education Program staff receive a written performance appraisal three months after hiring.

3. Diabetes Education Program staff receive written annual performance appraisals according to organization policy.

4. We have a process in place for educators to receive regular, constructive feedback on their performance/professional practice.

5. We encourage diabetes education staff to join the Canadian Diabetes Association’s Diabetes Educator Section.

6. All diabetes educators are Certified Diabetes Educators.

Questions (7–10) apply only to non-certified diabetes education staff. If all of your professional staff are certified, proceed directly to Question #11.

7. Professional development activities related to diabetes education for staff who are not Certified Diabetes Educators:

<table>
<thead>
<tr>
<th>Type of activity</th>
<th># of hours in past 12 months</th>
<th># of staff who participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conference calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiovisual presentations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending workshops</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal club</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting or assisting with workshops</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducting or participating in research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation of manuscript(s) for publication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of activity</td>
<td># of hours in past 12 months</td>
<td># of staff who participated</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Formal (college/university) education classes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-directed learning (regular review of publications, interdisciplinary discussion on topical issues)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation for certification and recertification as diabetes educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Do you encourage staff to engage in professional development?  
   □  □  □

9. Continuing education is actively encouraged for all staff involved in diabetes education, as seen in the table above.  
   □  □  □

10. We have other ways of demonstrating that the competence of diabetes educators in our program is assessed and promoted (please describe in the space provided):  
    ..............................................................................................................
    ..............................................................................................................
    ..............................................................................................................
    ..............................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard.  
   □  □

2. Our justifications for meeting this Standard are:

   •
   •
   •

3. Our strengths (in point form) are:

   •
   •
   •
4. Our plans (in point form) for improving our service to better meet this Standard are:

•

•

•

•

STRUCTURE STANDARD 6

Mechanisms are in place to ensure that community values are reflected in diabetes education. (There are many ways of measuring; here are some examples.)

1. The structures we have in place for ensuring these community values are reflected by the data presented in this chart:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Community group represented on committee</th>
<th>Function/purpose of committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of directors of the service or governing organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisory committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic planning/annual objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other committees (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Reviewing our structures above, we facilitate active community partnerships in diabetes education programming.

3. Reviewing our structures above, community values are represented in our diabetes education programming.

4. The community is assessed for diabetes education services needed.
5. Community needs assessments are accomplished via:
   - focus groups
   - needs survey/evaluation
   - community meetings
   - committee participation, as in the previous chart
   - other (please specify):

   ☐ ☐ ☐

6. We have other ways of demonstrating how we ensure that community values are reflected in our diabetes education programs (please describe in the space provided):

   ☐ ☐ ☐

In summary, our self-assessment of this Standard is:

1. We meet this Standard.
   ☐ ☐

2. Our justifications for meeting this Standard are:

   • • • •

3. Our strengths (in point form) are:

   • • • •

4. Our plans (in point form) for improving our service to better meet this Standard are:

   • • • •

CDA Reviewer’s Initials

Date
Diabetes Education Standards Recognition Program Self-Assessment Documents

Process Standards
Self-Assessment Documents

PROCESS STANDARD 1

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

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.

YES NO N/A

1. A needs assessment is completed for each client upon initial admission into the program.

Our diabetes education program needs assessment is reflected by the data presented in this chart:

<table>
<thead>
<tr>
<th>The following are assessed:</th>
<th>Yes</th>
<th>No</th>
<th>Client</th>
<th>Family/support</th>
<th>Team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge needs</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Diabetes knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health literacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Readiness to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cognitive functioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural/community context</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socio-economic needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal caregiver support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation of data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (please specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Reviewing our assessment process from the chart above, our needs assessment is based on the participation of the person with diabetes and relevant others.
3. Adaptations are made to ensure that the assessment process and interpretation of data and choices/options facilitates the person with diabetes.

4. Our assessment process is based on the current CDA CPGs.

5. We have other ways of demonstrating that our diabetes education is based on a client–program needs assessment (please describe in the space provided): ..............................................................................................................................................
..............................................................................................................................................
..............................................................................................................................................
..............................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard. ☐ ☐

2. Our justifications for meeting this Standard are:

   •
   •
   •
   •

3. Our plans (in point form) for improving our service to better meet this Standard are:

   •
   •
   •

PROCESS STANDARD 2

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

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.
1. The diabetes education plan is client centred and ongoing.  

Our process for diabetes self-management education (DSME) is reflected by the data presented in this chart:

<table>
<thead>
<tr>
<th>Education plans</th>
<th>Aspects of the DSME care plan</th>
<th>Who contributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist (new column)</td>
<td>Collaborative goal setting</td>
<td>MD, RN, Endocrinologist, Social worker, YMCA</td>
</tr>
</tbody>
</table>
| Individual’s responsibility for self-management | Consideration-based needs planning, Stepped action planning, Barriers encountering, Problem solving/
followup, Plans for followup | MD, RN, RD, Endocrinologist, Social worker, YMCA |
| Family/support person of the individual | | |

2. Reviewing our diabetes self-management education plan process from the chart above indicates that the individual with diabetes and family/support persons are included in the development of the diabetes education plan.

3. Our approaches to the diabetes self-management education plan are adaptive to the learning needs/styles of persons with diabetes.

4. Our diabetes self-management education plan utilizes all the current CDA CPGs to plan diabetes care for our patients.

5. We have other ways of demonstrating that our plans for diabetes education are client centred (please describe in the space provided):

In summary, our self-assessment of this Standard is:

1. We meet this Standard.
2. Our justifications for meeting this Standard are:

•
•

3. Our plans (in point form) for improving our service to better meet this Standard are:

•
•

---------------------------------------------------------------------
CDA Reviewer's Initials

---------------------------------------------------------------------
Date

**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.

*There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.*

1. We have guidelines for assessing and teaching people with diabetes.

2. The following topics for self-management of diabetes are outlined in the current CDA CPGs. Please indicate which topics are included, as appropriate, in your education program.

Diabetes management

a) describe diabetes disease process and treatment options

b) monitor metabolic control:

• glycemia (targets)

• ketones
- interpret results and make appropriate changes
- c) physical activity
- d) healthy eating
- e) utilizing medications in treatment of diabetes
- f) hypoglycemia/ hyperglycemia prevention and management
- g) problem solving for daily living
- h) psycho/social aspects of diabetes
- i) Special situations (travel, sick days)

Diabetes complications
- j) preventing, detecting and treating acute complications
- k) preventing, detecting and treating chronic complications

Special populations (if applicable to program)
- l) diabetes in children and adolescents
- m) diabetes in pregnancy

3. Behavioural models/theories are incorporated into the program, to facilitate improving self-care behaviour (Stages of Change, empowerment, self-efficacy or communication models/theories).

4. Literacy and age-appropriate education principles are incorporated into the program to facilitate improving self-care behaviour. If YES, please provide details: .................................................................

5. The program has adapted to meet the needs of our patients’
- culture
- language

Self-Assessment Documents
Please explain how your program has adapted to meet the needs of the patients: ☐ ☐ ☐
...........................................................................................................................................................
...........................................................................................................................................................
...........................................................................................................................................................
...........................................................................................................................................................

6. We have other ways of demonstrating that the implementation of our diabetes self-management education is centered around the person with diabetes and facilitates learning that leads to behavioural change (please describe in the space provided): ☐ ☐ ☐
...........................................................................................................................................................
...........................................................................................................................................................
...........................................................................................................................................................
...........................................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard. ☐ ☐

2. Our justifications for meeting this Standard are:

   •
   •
   •

3. Our plans (in point form) for improving our service to better meet this Standard are:

   •
   •
   •

PROCESS STANDARD 4

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

There are many ways to demonstrate how this Standard is met. Here are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.
1. We interact with relevant partners regarding resources and services identified by individuals with diabetes, in collaboration with their healthcare provider(s), as needed, to support diabetes self-management.

Give us three examples of how you have engaged community partners. Please tell us who was involved, why and the result of this engagement. Community partners may include, but are not exclusive to, non-profit agencies, chronic disease management programs in the community or Meals On Wheels. EXAMPLE: A Hindu community resource centre was engaged by a local diabetes education program to assist with healthy cooking classes for referred patients of the Diabetes Education Program. Almost 60% of attendees of the cooking classes reported at least four positive changes in cooking meals, such as a 20% reduction in frying foods to steaming or baking, a 30% increase in the inclusion of fruits and vegetables daily over starchy foods, an 80% increase in the use of unpolished rice over refined rice and a 20% average reduction in total calories consumed per day.

1) ..................................................................................................................................................

2) ..................................................................................................................................................

3) ..................................................................................................................................................

4. Processes are in place for appropriate followup, evaluation and continuity of support, services and resources.

5. We have other ways we partner with community resources or services (please describe in the space provided): ..........................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard.

2. Our justifications for meeting this Standard are:

   •
   •
   •
3. Our plans (in point form) for improving our service to better meet this Standard are:

- 
- 
- 

PROCESS STANDARD 5

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

*There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.*

<table>
<thead>
<tr>
<th>Issues</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional ethics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical application of current knowledge about diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current professional standards of practice and impact on client care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mission, goals and objectives of our program and impact on client care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. As a team of healthcare professionals, are all of your health professionals regulated and practising at their respective colleges’ level/scope of practice.

□ □

2. We have discussed the following issues:

3. Do you have processes or mechanisms to address issues around scope of practice or ethical principles (breach of confidentiality)?

□ □ □

Please specify: ________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
In summary, our self-assessment of this Standard is:

1. We meet this Standard.

2. Our justifications for meeting this Standard are:
   - 
   - 
   - 
   - 

3. Our plans (in point form) for improving our service to better meet this Standard are:
   - 
   - 
   - 
   - 

---

**PROCESS STANDARD 6**

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

*There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.*

1. Processes are in place to obtain feedback from the patients, family and relevant others, as well as the general community, regarding the effectiveness of diabetes self-management education. Please provide us with examples of how you collect feedback and how readily you do so for each of the following:

   a) Patients: ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

   b) Family/informal caregivers: ........................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

   c) Community: ............................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

---

Self-Assessment Documents
2. We have effectiveness and evaluation monitoring processes in place that can inform our program on how we are doing.

   a) We have dedicated time (planning time) and resources (that is, team lead, team meetings) for those initiatives. These may include staff performance reviews or peer feedback. Please describe in detail three examples of quality or effectiveness processes in place. Processes include, but are not limited to, workload measurement, benchmarking and questionnaires. Please describe initiatives that include monitoring, who reviews them and any followup that is related to the evaluation process.

   1. ........................................................................................................................................
   2. ........................................................................................................................................
   3. ........................................................................................................................................

   3. What followup processes are in place to respond to and address variances? Please explain in detail. (Example: staff meeting to address documentation issues and goal setting with patients).

   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard.  

2. Our justifications for meeting this Standard are:

   •
   •
   •

3. Our plans (in point form) for improving our service to better meet this Standard are:

   •
   •
   •
Diabetes Education Standards Recognition Program
Self-Assessment Documents
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.

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.

1. Our assessment of the self-management knowledge, behaviours and areas for improvement of individuals with diabetes served by our program includes evaluation of:

   - the individualized blood glucose target for A1C
   - the recommended blood pressure target
   - the recommended LDL, HDL ratio and triglycerides targets
   - drugs used for diabetes management
   - healthy eating (nutrition) programs
   - strategies to cope with life stress, and for reducing behaviours such as smoking, alcohol intake and long-term problems of suboptimal diabetes control
   - quality of life related to diabetes control

2. We have other ways of demonstrating how well individuals with diabetes understand how they are affected (please describe in the space provided):

   In summary, our self-assessment of this Standard is:

   1. We meet this Standard.

   2. Our justifications for meeting this Standard are:

   •
   •
   •
3. Our plans (in point form) for improving our service to better meet this Standard are:

- • •

OUTCOME STANDARD 2

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

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.

1. Chart audits are done regularly to evaluate evidence of client-centred goals and action plans designed to facilitate self-management and are derived through the shared decision making of patients and diabetes educators.

   a. What prompts the process of the chart audits? ..........................................................................................................................

   b. What data are you collecting? ........................................................................................................................................

   c. How many charts do you review? ...................................................................................................................................

   d. How has this changed your practice? ...................................................................................................................................

2. Note: in the following a) and b), a YES answer indicates patients have good physiological control.

Our self-assessment of the client chart audit results indicates our patients

a) have good physiological control with regard to frequency of:

- • hypoglycemic episodes (if client is at risk)

   □ □ □
<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>diabetes-related absences from work/school</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>diabetes-related interruptions of regular daily activities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>diabetes-related visits to emergency services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>diabetes-related hospital admissions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

b) made progress toward their appropriately individualized target values for each of the following, where their individual target values are appropriate for the individual:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>preprandial blood glucose</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>postprandial blood glucose</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>waist-to-hip measurement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>blood pressure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>glycosylated hemoglobin (A1C)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>LDL-C</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>TC:HDL-C ratio</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>triglycerides</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>weight</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>waist circumference</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

c) made progress toward their lifestyle goals in that they:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a goal to stop smoking and have taken action toward stopping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have a goal to improve dietary intake and have taken action toward improvement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have a goal to change their exercise regimen and have taken action toward an appropriate exercise regimen</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
d) Individuals with diabetes advocate screening and monitoring for diabetes complications (short- and long term), including:

- annual dilated eye examination
- annual neuropathy exam (monofilament vibration to great toe)
- annual lower extremity exam (foot care)
- taking action toward individualized patterns for SMBG
- annual random ACR, serum creatinine, creatinine clearance
- annual influenza shot

3. We have other ways of demonstrating how our patients make informed decisions and take action toward healthy living (please describe in the space provided):

In summary, our self-assessment of this Standard is:

1. We meet this Standard.

2. Our justifications for meeting this Standard are:
3. Our plans (in point form) for improving our service to better meet this Standard are:

- 
- 
- 

OUTCOME STANDARD 3

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

*There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. We have partnerships with community services, organizations or sectors to promote prevention of diabetes in our catchment area. □ □ □

2. Information regarding the nature of diabetes, risk factors and prevention of complications is available to our community (posters, media spots, brochures, flyers, newspaper articles). □ □ □

3. We participate in providing updates on diabetes risk factors, prevention and complications for healthcare professionals working with our community. □ □ □

4. We have other ways of demonstrating how we work within our communities to promote health, and prevent and reduce diabetes and its complications (please describe in the space below): .................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

In summary, our self-assessment of this Standard is:

1. We meet this Standard. □ □
2. Our justifications for meeting this Standard are:

- 
- 
- 

3. Our plans (in point form) for improving our service to better meet this Standard are:

- 
- 

OUTCOME STANDARD 4

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

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.

1. We have partnerships with community services, organizations or sectors to increase awareness of diabetes in our catchment area.

2. Information regarding the nature of diabetes, risk factors and prevention of complications is available to our community (posters, media spots, brochures, flyers, newspaper articles).

3. We participate in providing updates on diabetes risk factors, prevention and complications for healthcare professionals working with our community.

4. The ways of demonstrating how we make our communities aware of risk factors and delaying complications of diabetes include (please describe in the space provided): ..................................................................................

..................................................................................

..................................................................................

..................................................................................

..................................................................................

..................................................................................

..................................................................................
In summary, our self-assessment of this Standard is:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. We meet this Standard.

2. Our justifications for meeting this Standard are:
   - •
   - •
   - •

3. Our plans (in point form) for improving our service to better meet this Standard are:
   - •
   - •
   - •

—----------------------------------
CDA Reviewer's Initials          Date
—----------------------------------

OUTCOME STANDARD 5

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

There are many ways to demonstrate how this Standard is met. Below are a few examples. You are encouraged to share your own indicators (examples of activities) that you believe show how the program meets this Standard.

1. We have guidelines that describe the type of patients most appropriate for referral to our program.

2. Are your volume of referrals year after year:
   - increasing
   - remaining stable
   - decreasing
3. We ask our patients to report:
   a) days missed from school/work
   b) visits to emergency room
   c) hospitalizations, due to their diabetes

4. Our data indicate that we:
   • triage referrals
   • manage wait times successfully
   • respond to referrals based on acuity and volume
   Please provide two examples of how your program demonstrates these points:

5. We have other ways of demonstrating that we meet the needs of and respond to those referred. Please provide examples:

In summary, our self-assessment of this Standard is:

1. We meet this Standard.

2. Our justifications for meeting this Standard are:

3. Our plans (in point form) for improving our service to better meet this Standard are:

----------------------------------------
CDA Reviewer's Initials            Date
----------------------------------------
Self-assessment period: ________________________________

List of team members involved in completion of this application:

<table>
<thead>
<tr>
<th>Name of team member</th>
<th>Profession/position/affiliation with program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>12.</td>
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<td>13.</td>
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<td>14.</td>
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</tbody>
</table>

DIABETES EDUCATION STANDARDS RECOGNITION PROGRAM
EVALUATION FORM FOR THE SELF-ASSESSMENT PROCESS

1. Is this the first time you have applied for DES Diabetes Education Standards Recognition?
   □ YES □ NO

2. Did you find the manual informative in helping you complete the self-assessment tool?
   □ YES □ NO

   If YES, what did you find most useful? .............................................................................................................
   ...........................................................................................................................................................................
   ...........................................................................................................................................................................
   ...........................................................................................................................................................................
   ...........................................................................................................................................................................

   If NO, what problems did you encounter with the manual? .......................................................................................
3. Did you find the manual easy to follow? (Did sections flow together? Is the manual well-organized? Is the manual easy to follow? Are instructions clear?)

If NO, what would you suggest be changed?

4. Did you find the terminology used in the manual easy to understand?

If NO, why not?

5. Are there any areas where you would like to see more information?

If YES, please indicate which areas:

6. Did you use the forms provided with this manual?

If YES, please indicate which ones and provide any suggestions for change:

- Form A: Questionnaire for individuals with diabetes
- Form B: Questionnaire for women with gestational diabetes mellitus
- Form C: Audit of client chart
- Form D: Sample diabetes patient care flow sheet

If NO, why not?

Suggestions for change:
7. Do you think you will apply for recognition renewal?

[ ] Yes [ ] No

If NO, why not? ..............................................................................................................................................................
..............................................................................................................................................................
..............................................................................................................................................................

8. Do you have any suggestions for how the process for this program could be simplified?

[ ] Yes [ ] No

If YES, how? ..............................................................................................................................................................
..............................................................................................................................................................
..............................................................................................................................................................

9. Other comments: ..............................................................................................................................................................
..............................................................................................................................................................
..............................................................................................................................................................
Diabetes Education Standards Recognition Program Decision Process
Decision Process

By June 30th following submission of your application, you will receive a letter stating the DES reviewer(s) assessment of your application. There are three possibilities:

- **Full Recognition.** The certificate is valid for 5 years, and we post the name of your Diabetes Education Centre on the CDA and DES websites.

- **Provisional Recognition.** In order to be considered for Full Recognition, further information or clarification is required.

Within the time frame given by the reviewer, you must submit to the Coordinator, Professional Membership & Projects (address below), the required documentation or clarification and/or rebuttal to the reviewer's comments. Within eight weeks of submission of this documentation, you will be informed of the status of your application.

- **Application Does Not Meet Requirement For Recognition.** You will be advised of the reasons your application does not meet the requirements. Requests for clarification of the reasons or rebuttal should be addressed to:

  Coordinator, Professional Membership & Projects – Diabetes Educator Section
  Canadian Diabetes Association
  1400–522 University Avenue
  Toronto, Ontario, Canada
  M5G 2R5
  Telephone: 1-800-BANTING
SURVEYS can be completed by using either the questionnaire or focus group option.

A: QUESTIONNAIRE OPTION

1. Client Selection

Selection of clients to complete the questionnaire is to be by random or stratified random selection.

- Random selection (for example, client’s medical record number is drawn from a hat, or every nth client who attends the program during a specific time is asked to complete a questionnaire).

- Stratified random selection (separate homogenous groups representative of different segments of the client population, for example, by type 1, type 2, age, length of time followed by the centre, etc.).

2. Survey Sample Size

Complete a minimum of 10 client questionnaires using Form A, Form B, or your own form, if it provides similar data. This information is needed in order to answer the Outcome Standards. Examples:

- If your program largely serves an adult, non-gestational population, complete 10 questionnaires (Form A). If you also have a GDM population, have 5–10 questionnaires (Form B) completed by that population as well.

- If your program largely serves a GDM population, complete 10 questionnaires (Form B). If you also have a non-gestational population, have 5–10 questionnaires (Form A) completed by that population as well.

- If your program largely serves a pediatric population, complete 10 questionnaires (Form A). The questionnaire can be completed either by the child/adolescent or the family or support person. If you also have a GDM population, have 5–10 questionnaires (Form B) completed by that population as well.

3. Analysis of Results

The results of the completed questionnaires should be summarized by a professional member of the Diabetes Education Program. This same person then reviews the results and prepares a summary report for the diabetes education team to review and use in answering the Standards documents. In assessing the questionnaires, it is essential to focus on themes that emerge from the collective data and reflect the centre, and not the knowledge of any single respondent.
4. Implementing Results

Members of the Diabetes Education Program team develop an action plan to deal with any issues that are identified. This may involve reviewing what and how the educators teach the content inherent in the identified themes that emerge, to see what might contribute to particularly strong responses, as well as weak themes. Aspects of the action plan should be included in the summary of self-assessment statements for the appropriate Standard.

B. FOCUS GROUP OPTION

Focus groups for obtaining client input may be used independently as another way to assess the quality of the centre or as an alternative to clients completing questionnaires.

1. Purpose

- To identify perceptions of clients (quality of life, perceptions of quality of service).
- May be used to identify clients’ behavioural changes, rather than knowledge, with respect to the topics discussed (for example, is aware of target blood glucose and blood lipid targets, can describe short-term problems, is aware of strategies to prevent long-term complications, etc.)

2. Goals

- Open dialogue with focus group members eliciting their responses to questions regarding the impact upon their care of education provided by the Diabetes Education Program.
- It is essential that the focus group facilitator encourages this dialogue without directing or influencing clients’ views in any way.

3. Definition of a Focus Group

- Small group of people (5–10 at most) who share a common goal or are stakeholders in a similar context, gathered together to explore specific topics/issues.
- Traditionally used in advertising and marketing to identify and explore issues, problems and creative solutions.
- Degree of structure depends on the purpose of the focus group; it ranges from unstructured group interaction to guided discussion that seeks responses to specific questions.

4. Selection of Focus Group Participants for Client Feedback

- Participants may include clients, clients’ families or support persons.
- Selection of participants may be random or stratified random.
random selection (for example, client’s medical record number is drawn from a hat, or every nth client who attends the centre during a specific time is asked to participate in a focus group at a scheduled time).

Stratified random selection (separate homogenous groups representative of different segments of the client population, for example, by type 1, type 2, age, length of time followed by the centre, etc.).

5. Selection of the Facilitator for the Focus Group

• The facilitator must be someone external to the Diabetes Education Program, preferably with experience.

• The facilitator should have knowledge of diabetes and principles of adult learning.

6. Role of the Facilitator

• Pose questions and stimulate open discussion and exploration of ideas without directing or influencing the group’s opinions in any way.

• Start by asking individuals to reflect and write down their responses to the questions asked before moving to group discussion.

• Ask structured questions (use questions on forms A and/or B or another questionnaire, if it has the same topics) and probe for elaboration/clarification as needed but without leading participants’ responses.

• With participants’ consent, discussions may be audio- or videotaped to facilitate reporting themes/trends that emerge.

7. Analysis of Results

The facilitator summarizes comments/suggestions of the focus group in a brief report. Verify with participants, if possible, the accuracy of the report of the focus group’s discussions before submission to the diabetes education team for review.

8. Implementing Results

Members of the Diabetes Education Program team develop an action plan to deal with any issues that are identified. This may involve reviewing what and how the educators teach the content inherent in the identified themes that emerge to see what might contribute to particularly strong responses, as well as weak themes. Aspects of the action plan should be included in the summary of self-assessment statements for the appropriate Standard.
To facilitate auditing the client charts, you may consider using Form D for a period of time before the audit.

1. Selecting Charts

Randomly select 10 charts. Using Form C, audit each chart. This task may be assigned to one person, or several members of the diabetes education team may share the task.

2. Analysis of Results

The results of the completed audit should be summarized by a member (professional or clerical) of the Diabetes Education Program. A professional member of the centre then reviews the results and prepares a summary report of the results and trends for the diabetes education team to review and use in answering the Standards self-assessment documents.

3. Use of Results

Members of the team should develop an action plan to deal with any issues that are identified. Aspects of the action plan should be included in the summary of self-assessment statements for the appropriate Standard.
FORM A: QUESTIONNAIRE FOR INDIVIDUALS WITH DIABETES

Your health and well being is important to us! We want to know what we do well and how we can improve our services.

Instructions:

• Please do not put your name on this form.

• Please mark with a ✓ all choices that apply in each question.

• A family member or friend can help you complete this form.

• Your diabetes educator should not help you with this form, but other staff in the centre may do so.

» PERSONAL DATA

1. A family member or friend helped me complete this form: Yes □ No □

2. I have had diabetes for _____ months, or _____ years.

3. I have been followed by this Diabetes Education Program for _____ months, or _____ years.

4. The type of diabetes I have is:

   Type 1 □ Type 2 □ I do not know □

5. My diabetes is treated with (please ✓ all that apply):

   insulin injections □ insulin pump □ healthy eating □

   diabetes pills □ exercise □

   I am: under 12 years old □ 13–15 years old □ 16–21 years old □

   22–35 years old □ 36–50 years old □ 51–75 years old □

6. I am: Male □ Female □
7. My level of schooling is:

- Grade 8 or less □
- Completed high school □
- Completed college/university □
- Some high school □
- Some college/university □

**HEALTH CHANGES**

1. Please tell us about your health and the changes you may have experienced since attending this Diabetes Education Program (please check the appropriate box):

<table>
<thead>
<tr>
<th>Basic diabetes management</th>
<th>More often</th>
<th>Less often</th>
<th>As always</th>
<th>Don’t know</th>
<th>Never or N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I can tell the symptoms of low blood glucose (BG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Number of times/week that I have low BG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) When I have low BG, I am able to treat it. My treatment is:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d) My BG is high</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e) I recognize the symptoms of high BG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) I test for ketones when my BG is high or I am sick</td>
<td>Yes □</td>
<td>No □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have ketones in my urine/blood</td>
<td>Yes □</td>
<td>No □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) My hemoglobin A1C is at my target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>h) I eat a variety of foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>i) I include exercise in my routine</td>
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</tbody>
</table>

**Short-term problems**

| j) Because of my diabetes I miss school/work                    |            |            |           |            |              |
| k) Diabetes interferes with activities of daily life            |            |            |           |            |              |
| l) I can control my BG when I am sick                          |            |            |           |            |              |
| m) Because of my diabetes I have used emergency services (ambulance, emergency clinic, ER visit) |            |            |           |            |              |
| n) Because of my diabetes I have been admitted to a hospital   |            |            |           |            |              |
2. My blood glucose control is measured by:
   • urine testing
   • testing my blood glucose at home
   • hemoglobin A1C (3-month average)
   • a method I don’t know about
   • other (please describe): __________________________________________________________

3. I would like my BG before a meal to be: __________  □  □  □
4. I would like my BG 1–2 hours after a meal to be: __________  □  □  □
5. I would like my BG before bed to be: __________  □  □  □
6. I would like my A1C to be: __________  □  □  □
7. I would like the ketones in my urine to be: __________  □  □  □
8. I would like my LDL (bad) cholesterol value to be: __________  □  □  □
9. I would like my ratio of TC (total cholesterol) to HDL (good) cholesterol to be: __________  □  □  □
10. I would like my triglycerides to be: __________  □  □  □
11. I would like my blood pressure to be: __________  □  □  □

12. With my diabetes educator(s):
    a) I am included in discussions of my treatment options  □  □  □  □  □
b) I am included in discussions of my education options

<table>
<thead>
<tr>
<th>NOT AS MUCH AS I LIKE</th>
<th>AS MUCH AS I LIKE</th>
<th>MORE THAN I LIKE</th>
<th>N/A</th>
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<tr>
<td>□</td>
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</table>

c) I am offered followup appointments with diabetes education staff

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<th>NOT AS MUCH AS I LIKE</th>
<th>AS MUCH AS I LIKE</th>
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</table>

d) My family/support person is involved in the education process

<table>
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<th>NOT AS MUCH AS I LIKE</th>
<th>AS MUCH AS I LIKE</th>
<th>MORE THAN I LIKE</th>
<th>N/A</th>
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<tr>
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</table>

13. If I disagreed with what I was taught concerning my treatment, I:

- □ ignored the instructions
- □ decided to only see the doctor for followup
- □ followed instructions anyway
- □ discussed it with my diabetes educator
- □ changed my treatment on my own
- □ this has not been a problem for me

14. Long-term complications of poor diabetes control are:

- □ kidney problems
- □ eye problems
- □ heart problems
- □ tingling and loss of feeling in the feet (nerve problems)
- □ craving sweet foods
- □ none of the above
- □ unknown to me
- □ other (please describe): ...........................................................................................................................................................................
15. To help prevent eye problems, I:

- wear protective goggles
- have my eyes checked every year by an ophthalmologist/eye specialist
- have a dilated eye exam every year (drops in the eye)
- have my glasses checked every year
- keep my blood glucose (sugar) well controlled
- do nothing
- don't know
- didn't know that diabetes can cause eye problems
- take other steps (please describe): ________________________________

16. To help prevent foot problems, I:

- do not walk barefoot
- keep my feet clean and dry
- wear tight elastic stockings
- wear properly fitting shoes
- check my feet daily for blisters, sores
- ask my physician or diabetes educator to check my feet
- do nothing
- don't know
- didn't know diabetes can cause foot problems
- take other steps (please describe): ________________________________
17. To help prevent kidney problems, I:

☐ eat a high-protein diet
☐ drink cranberry juice
☐ keep my blood glucose well controlled
☐ keep my blood pressure well controlled
☐ have my urine checked for protein every year
☐ do nothing
☐ don’t know
☐ didn’t know diabetes could cause kidney problems
☐ take other steps (please describe): 

18. To help prevent heart problems, I:

☐ do not smoke
☐ exercise regularly
☐ maintain a healthy body weight
☐ eat foods that are lower in fat and salt
☐ have my cholesterol checked regularly
☐ have my blood pressure checked at each visit
☐ keep my blood glucose as close to normal as possible
☐ do nothing
☐ don’t know
☐ didn’t know that diabetes can cause heart problems
☐ take other steps (please describe): 

Appendices
19. I was referred to other services (foot doctor, eye doctor, homecare services) when needed.

20. Since receiving diabetes education from this program, my eating habits have changed. I now consume:

- [ ] whole grain bread and cereals
- [ ] fewer sweets
- [ ] vegetables every day
- [ ] fresh fruits every day
- [ ] sugar-free liquids – water, diet soft drinks, etc.
- [ ] fewer high-fat foods
- [ ] milk and milk products
- [ ] balanced meals and snacks
- [ ] meals and snacks at regular times
- [ ] other foods (please describe): .................................................................

21. Since attending this Diabetes Education Program, I am:

a) better able to manage my diabetes  
   - [ ]      [ ]      [ ]      [ ]

b) better able to manage stress  
   - [ ]      [ ]      [ ]      [ ]

c) comfortable with my diabetes:

   with family  
   - [ ]      [ ]      [ ]      [ ]

   with friends  
   - [ ]      [ ]      [ ]      [ ]

   at school  
   - [ ]      [ ]      [ ]      [ ]
22. What other changes have you made, or do you plan to make, as a result of the diabetes education you have received from this Diabetes Education Program? (Please describe in the space provided below.)

THANK YOU FOR YOUR FEEDBACK!
Please ✓ the appropriate box. The responses submitted indicate how this client would assess diabetes education in the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Complete</th>
<th>Incomplete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic diabetes management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Short-term complications of poor blood glucose control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Target values for physiologic measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Long-term complications of poor blood glucose control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Healthy ways of living with diabetes</td>
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<td></td>
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</tbody>
</table>

Areas of concern are:
(Please describe in the space provided below.)

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CDA Reviewer's Initials          Date
FORM B: QUESTIONNAIRE FOR WOMEN WITH GESTATIONAL DIABETES MELLITUS

Your health and well-being is important to us! We want to know what we do well and how we can improve our services.

Instructions:
• Please do not put your name on this form.
• Please mark with a ✓ all choices that apply in each question.
• A family member or friend can help you complete this form.
• Your diabetes educator should not help you with this form, but other staff in the centre may do so.

» PERSONAL DATA

1. A family member or friend helped me complete this form: Yes ☐ No ☐

2. I have had gestational diabetes for ........ months.

3. I had gestational diabetes with previous pregnancies: Yes ☐ No ☐

4. I have been followed by this Diabetes Education Program for .... months, or ...... years.

5. My gestational diabetes is treated with (please ✓ all that apply):
   - insulin injections ☐
   - insulin pump ☐
   - healthy eating ☐
   - other ☐ (please specify): .................................................................

6. I am: under 22 years old ☐ 22–35 years old ☐ over 36 years old ☐

7. My level of schooling is:
   - Grade 8 or less ☐ completed high school ☐ completed college/university ☐
   - some high school ☐ some college/university ☐
HEALTH CHANGES

1. Please tell us about your health, and the changes you may have experienced since attending this Diabetes Education Program (please check appropriate box).

<table>
<thead>
<tr>
<th>Basic diabetes management</th>
<th>More often</th>
<th>Less often</th>
<th>As always</th>
<th>Don’t know</th>
<th>Never or N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) My blood glucose is high</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b) I have ketones or urine in my blood</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) My weekly rate of weight gain has been appropriate</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d) I eat a variety of foods</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e) I include exercise in my routine</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Please ✓ all choices that apply in each question.

2. I developed diabetes during this pregnancy because I:

- □ am overweight
- □ eat too much sugar and too many sweets
- □ have a family history of diabetes
- □ had diabetes during a previous pregnancy
- □ don’t know how to avoid diabetes
- □ have another condition (please describe): .................................................................

3. My blood glucose control is checked by:

- □ urine testing
- □ testing my blood glucose at home
- □ glycosylated hemoglobin/A1C (three-month average)
4. To better control my blood glucose level, I eat:
   - three main meals, no snacks
   - fewer sugars/sweets
   - small meals with snacks in between
   - high-fibre foods
   - whatever I want
   - other foods (please describe):

5. I would like my BG before a meal to be: $\quad \quad$ 
   - $\blacksquare$ Target
   - $\blacksquare$ Don’t know
   - $\blacksquare$ N/A

6. I would like my BG one hour after a meal to be: $\quad \quad$ 
   - $\blacksquare$ Target
   - $\blacksquare$ Don’t know
   - $\blacksquare$ N/A

7. I would like my BG two hours after a meal to be: $\quad \quad$ 
   - $\blacksquare$ Target
   - $\blacksquare$ Don’t know
   - $\blacksquare$ N/A

8. I would like the ketones in my blood or urine to be: $\quad \quad$ 
   - $\blacksquare$ Target
   - $\blacksquare$ Don’t know
   - $\blacksquare$ N/A

Please $\checkmark$ all choices that apply in each question.

9. If I do not control my diabetes during pregnancy, my baby:
   - can be big (>4 kg / >8.8 pounds)
   - will get diabetes later in life
   - can have heart or lung problems
   - can have low blood glucose after birth
   - will not be affected
   - will have other problems (please describe): 

10. After this pregnancy is over, I will have to:

☐ lose weight if I am overweight

☐ have my blood glucose rechecked in six months

☐ change my lifestyle to prevent developing type 2 diabetes

☐ do nothing

☐ do something, but I don’t know what

☐ take other steps (please describe): ..........................................................................................................................................................................

<table>
<thead>
<tr>
<th></th>
<th>NOT AS MUCH AS I LIKE</th>
<th>AS MUCH AS I LIKE</th>
<th>MORE THAN I LIKE</th>
<th>N/A</th>
</tr>
</thead>
</table>

11. With my diabetes educator(s):

a) I am included in discussions of my treatment options

b) I am included in discussions of my education options

c) I am offered followup appointments with diabetes education staff

d) My family/support person is involved in the education process

<table>
<thead>
<tr>
<th></th>
<th>NOT AT ALL</th>
<th>SOMEWHAT</th>
<th>VERY MUCH</th>
<th>N/A</th>
</tr>
</thead>
</table>

12. Since attending this Diabetes Education Program, I am:

a) better able to manage my diabetes

b) better able to manage stress

c) comfortable with my diabetes:

with family

<table>
<thead>
<tr>
<th></th>
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<th>SOMEWHAT</th>
<th>VERY MUCH</th>
<th>N/A</th>
</tr>
</thead>
</table>
13. What other changes have you made or do you plan to make as a result of the diabetes education you have received from this Diabetes Education Program? (Please describe in the space provided below.)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Please ✓ the appropriate box.

The responses submitted indicate how this client would assess diabetes education in the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>COMPLETE</th>
<th>INCOMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic diabetes management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Short-term complications of poor blood glucose control</td>
<td></td>
<td></td>
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<tr>
<td>3. Relationship of diabetes to pregnancy outcome</td>
<td></td>
<td></td>
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<tr>
<td>4. Target values for physiologic measures</td>
<td></td>
<td></td>
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<tr>
<td>5. Healthy ways of living with diabetes</td>
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</tbody>
</table>

Areas of concern are:
(Please describe in the space provided below.)

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CDA Reviewer's Initials                  Date
### FORM C: AUDIT OF CLIENT CHART

Chart # (circle): 1 2 3 4 5 6 7 8 9 10  
Client #: ..............................................................................

Date of first referral: ......................................................  
Date of first assessment: ..................................................

Check appropriate column. If you answer no to any question, explain why in the Comments column.

<table>
<thead>
<tr>
<th>What information is available in the client chart?</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A standard Diabetes Patient Care Flow Sheet (Form D) or equivalent has been used</td>
<td></td>
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<tr>
<td>The initial client assessment is documented (risk factors, lifestyle, medications, tests, referrals needed, etc.)</td>
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<tr>
<td>□ initiated</td>
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<tr>
<td>□ in progress</td>
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<tr>
<td>□ completed</td>
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<tr>
<td>If assessment is not complete, is there evidence that follow-up is planned or taking place in order to complete it?</td>
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<tr>
<td>Date of first assessment is recorded</td>
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<tr>
<td>Educational plan is documented</td>
<td></td>
<td></td>
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<tr>
<td>Education completed is documented</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Target for blood glucose is identified: Client’s/Educator’s</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Target for A1C is identified: Client’s/Educator’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target for lipids is identified: Client’s/Educator’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target for body weight is identified: Client’s/Educator’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target for BMI is identified: Client’s/Educator’s</td>
<td></td>
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<tr>
<td>Target for blood pressure is identified: Client’s/Educator’s</td>
<td></td>
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<tr>
<td>Client’s goals for living with diabetes are identified</td>
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<tr>
<td>Client’s influenza vaccine was given</td>
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<tr>
<td>Client met with diabetes team</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Referrals (with dates sent) are identified in the chart. Referrals are made to/for:</td>
<td></td>
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<tr>
<td>• Canadian Diabetes Association</td>
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<td></td>
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<tr>
<td>• Cardiologist</td>
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<td></td>
<td></td>
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<tr>
<td>• Clinical nutrition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Endocrinologist</td>
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<td></td>
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<tr>
<td>• Family doctor</td>
<td></td>
<td></td>
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<tr>
<td>• Foot care specialist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Nephrologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What information is available in the client chart?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----</td>
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<td>----------</td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Occupational therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometrist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabète Québec</td>
<td></td>
<td></td>
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<tr>
<td>Psychologist/mental health</td>
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<td></td>
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<tr>
<td>Social work</td>
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<td></td>
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</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
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<tr>
<td>Has the client seen an ophthalmologist within the last 12 months?</td>
<td></td>
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<tr>
<td>Has the client had random urine for ACR tested within the last 12 months?</td>
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<tr>
<td>Has an A1C been done within the past three months?</td>
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<tr>
<td>Has the client had lipid values (LDL-C and TC: HDL-C) done within the last 12 months?</td>
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</tr>
<tr>
<td>Followup with the client is recorded. (Monitoring results, nutrition goals, etc.)</td>
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<tr>
<td>Indication of involvement of:</td>
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<td></td>
<td></td>
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<tr>
<td>• client</td>
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<td></td>
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<tr>
<td>• family/support persons</td>
<td></td>
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<tr>
<td>• peers—others with diabetes</td>
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<tr>
<td>• community—people at school/work</td>
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<tr>
<td>• support groups/agencies</td>
<td></td>
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<tr>
<td>Dates of client visits to emergency services for diabetes are recorded</td>
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<tr>
<td>Dates of diabetes-related hospital admissions are recorded</td>
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</tbody>
</table>

---------------------------------------------
Auditor’s Name                  Date Audit Completed
---------------------------------------------
## FORM D: SAMPLE DIABETES PATIENT CARE FLOW SHEET

<table>
<thead>
<tr>
<th>Name:</th>
<th>Type of diabetes:</th>
<th>Date of birth:</th>
<th>Age at diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Type 1</td>
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<tr>
<td></td>
<td>□ Type 2</td>
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</tbody>
</table>

### Care objectives (risk factors, comorbidities) date

- □ Hypertension (target 130/80)
- □ Dyslipidemia
- □ CAD  □ Smoking (date stopped)
- □ PAD  □ Alcohol (access/discussed)
- □ CKD  □ Mental health Dx
- □ PCOS □ Foot disease
- □ ED   □ Retinopathy

### Self-management (discuss with patient)

- □ Refer to diabetes teaching team (date)
- □ Weight management:
  - Wt: ........
  - Ht: ........
  - BMI: ........ (Normal: 18.5–24.9 kg/m²)
  - Target weight: ........
  - WC: ........ (M <102 cm; F ≤88 cm)
- □ Physical activity (150 min/wk): ........
- □ Glucose meter/lab comparison
- □ Patient care plan (including pregnancy planning)

### Visits (three to six months)

<table>
<thead>
<tr>
<th>Date</th>
<th>BP</th>
<th>Wt</th>
<th>A1C target &lt;7%</th>
<th>Notes (goals, clinical status)</th>
<th>Diabetes medication baseline: allergies, side effects, contraindications. Consider: ASA, ACEI, ARB, as indicated.</th>
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Review blood glucose records. Target: pre-meal 4–7 mmol/L; two-hour postprandial 5–8 mmol/L

### Laboratory

- □ Nephropathy
  - Date: ........
  - ACR target: M <2; F <2.8
  - eGFR target: >60 (or creatinine)
- □ Neuropathy
  - Check feet for lesions and sensation (10 g monofilament)
  - Check for pain, ED, GI symptoms
  - Date: ........ Findings: ........
  - Date: ........ Findings: ........
  - Date: ........ Findings: ........
- □ Retinopathy
  - Annual eye exam:
  - Date: ........
  - Date: ........
  - Ophthalmologist/Optometrist: ........

### CAD Assessment

- □ Not high risk
- □ High risk: definition M ≥45 y; F ≥50 y or has one of the following:
  - Macrovascular disease
  - Microvascular disease
  - Multiple risk factors (family history)
  - 1 extreme risk factor
  - Duration of DM >15 yrs + age >30 yrs
  - ECG: ................
  - Stress ECG: ................
  - Other: ................

### Lipids

- □ Targets: high CVS risk
  - Primary target: LDL ≤2 mmol/L
  - Secondary target: TC/HDL <4

<table>
<thead>
<tr>
<th>Date</th>
<th>TC</th>
<th>LDL</th>
<th>TC/HDL</th>
<th>TG</th>
<th>Medications</th>
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<tbody>
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### Vaccinations

- □ Annual influenza
  - Date: ........
  - Date: ........
- □ Pneumococcus
  - Date: ........

### Foot disease

- □ Check feet for lesions and sensation (10 g monofilament)
- □ Check for pain, ED, GI symptoms
- □ Date: ........ Findings: ........
- □ Date: ........ Findings: ........
- □ Date: ........ Findings: ........

### Edema

- □ Refer to diuretics
- □ Review blood glucose records, pre-meal 4–7 mmol/L, two-hour postprandial 5–8 mmol/L

### Retinopathy

- □ Annual eye exam:
  - Date: ........
  - Date: ........
  - Ophthalmologist/Optometrist: ........