LEARNING CENTRE

A Clinician Guide

Training School Personnel on International Best Practice
Type 1 Diabetes care in Australian schools

ISPAD
International Society for Pediatric and Adolescent Diabetes

Australian Paediatric Society

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This Clinician Guide to training school personnel on best practice Type 1 Diabetes (T1D) individualised care is based upon the International Society for Pediatric and Adolescent Diabetes (ISPAD) Clinical Practice Consensus Guidelines 2018 on Support and Management of Children and Adolescents with Type 1 Diabetes in Schools[(1)] and the ISPAD Position Statement 2018 on Type 1 Diabetes in Schools[(2).] The clinician guide has been created, funded and endorsed by the Australian Paediatric Society and is consistent with the ISPAD principles of best practice clinical governance, advocacy, education and science.

The aim of this clinician guide is to empower treating medical teams with a tool that provides clinicians with a framework to work constructively with schools and to assist the school to fulfil its duty of care to students with T1D. The clinician guide will assist the treating medical team to train school personnel to execute prescribed complex clinical care and/or insulin administration/supervision during school hours following informed parental consent.

As proactive management of students with T1D at school is now the benchmark, treating medical teams are obliged to prescribe treatment consistent with international best practice. This clinician guide supports school personnel, parents and treating medical teams to work together in the best interests of the student with T1D.

The student with T1D should not be disadvantaged in the quality of T1D care whilst at school. It is essential that the quality of diabetes management during school hours is comparable to the student's usual diabetes management at home (ISPAD Position Statement 4.2).

The contribution made by school personnel to appropriately assist the student with T1D at school should be acknowledged and appreciated by all (ISPAD PS 6.11).

1. Background

1.1 Type 1 Diabetes

Type 1 Diabetes (T1D) is a complex medical condition that requires skilled medical and psychosocial management. Intensive insulin therapy (IIT) is the recommended therapy for young people with T1D because it leads to improved health outcomes and reduced risk of short- and long-term complications. IIT comprises frequent blood glucose and/or sensor glucose monitoring, carbohydrate quantification, insulin dose calculation, insulin administration with meals, and insulin and nutrition adjustments for physical activity (ISPAD PS 1.1).

1.2 Individualised care

Person-centred, individualised patient care now underpins contemporary health guidance. T1D management has become increasingly complex with the increased availability of and access to advanced technologies, pre-emptive interventions, individual variability (co-morbid conditions, family support, maturity, personality, skills), and variability of school resources and school experience. Optimal management of T1D at school demands individualised management for all students.

Each family will have access to different resources, coping skills and economic circumstances. School personnel will have a varying interest and level of expertise. Hence, care of the student must be individualised (ISPAD PS 3.3).

The Australian Paediatric Society (APS) has strongly advocated for federal government funding to enable all treating medical teams to train school personnel to deliver best practice, person-centred care to all Australian children with T1D at school. The APS also advocates for education providers and state governments to provide reasonable adjustments and satisfactory resourcing to enable ongoing individualised support at school.

The APS strongly supports the development of an effective supportive relationship between treating medical teams and school personnel. With the child at the centre of care, the 3-way relationship between parent, school and medical team is the cornerstone to successful outcomes for management of T1D in schools.

Caring for a student with T1D is best achieved through a cooperative, supportive and respectful relationship between the three key stakeholders – parent (and student when they are capable of greater independence in self-care), school personnel and medical team (ISPAD PS 4.1).

1.3 ISPAD Guidelines

The APS has a strong affiliation with ISPAD and endorses the ISPAD Clinical Practice Consensus Guidelines 2018 for Support and Management of Children and Adolescents with Type 1 Diabetes in Schools[1] and the ISPAD Position Statement 2018 on Type 1 Diabetes in Schools[2].

Well-resourced countries (such as Australia) must aim at interventions that uncompromisingly ensure optimal medical management that make it possible for the student to maintain blood glucose levels in or near the normal range during school hours (ISPAD PS 1.4).

2. Responsibilities

2.1 Roles and responsibilities

The roles and responsibilities have been clearly described by ISPAD.

The responsibilities of the 3 main stakeholders are:

- ***Parents** are ultimately responsible for the medical decisions made on behalf of their child. Therefore, the parent's informed consent and decisions regarding the health and well-being of their child are paramount. It is imperative that parents remain engaged as part of the team even when the student with T1D reaches adolescence (ISPAD PS 8.1).*

- *The student's **treating doctor** or nurse practitioner is responsible for prescribing medications. The medical team is responsible for outlining in detail the recommended medical requirements for that student. The medical team usually comprises a doctor and diabetes educator and may also include, if available, dieticians, psychologists, social workers and exercise specialists who work directly with the child and family (ISPAD PS 8.2).*

- *The **school** and the authorities responsible for managing schools are responsible for executing the parental and medical orders outlined in the student's Diabetes Management Plan and for facilitating the training of school staff, to ensure that they are competent to execute the care plan recommended by parent and medical team (ISPAD PS 8.3).*

Schools are responsible for ensuring that their personnel are adequately educated about T1D and trained in the application of prescribed treatment for the individual student (ISPAD PS 7.1).

2.2 Education and training

ISPAD has defined 3 levels of education and training which are applicable to Australia to ensure an internationally consistent approach.

***Level 1:** All school personnel should be educated about basic medical understanding of T1D (including recognition and urgency of treatment for low blood glucose) and the effect of T1D on the student and the entire family including the social, economic and emotional impact of living with T1D. (ISPAD PS 7.3).*

There are many examples of generic education materials that are specific to T1D that may be applicable to Level 1. Several adequate education resources are available in Australia.

***Level 2**: Those school personnel most responsible for the day-to-day management of the student with T1D should also be trained to*

- *recognise low blood glucose symptoms and signs*
- *initiate treatment for high or low blood glucose levels*
- *know and understand when and whom to call for assistance, including emergency responders, parents and medical team. (ISPAD PS 7.3).*

The Diabetes Management Plan (DMP) is the treating medical team's medical order, and the treating team is accountable for all advice and treatment in the DMP. Treating medical teams must ensure that their orders are accurate, relevant and in the patient's best interests.

All education providers for the individual student with T1D require specific training about how to manage that individual to fulfil their duty of care obligations to that student. The training must be person centred and individualised and based upon the student's specific needs relating to their maturity, skills, resources and personality. The content of training must reflect the individual prescribed management for that student as outlined in the DMP.

Level 2 training is best delivered by the treating medical team and/or parent in combination with the T1D e-learning modules (www.t1d.org.au). The T1D e-learning modules, launched in late 2017, are an innovative, free education and training resource based on a proven learning platform and winner of the 2019 ISPAD International Prize for innovation in Paediatric Diabetes care.

The content of the training is the responsibility of the medical team and parent and may be assisted by on-line training courses. Training should be executed by people with the appropriate understanding of the student's individual needs and skill set. Training must have informed parental consent to administer the prescribed medical treatment and manage complex medical care for their child (ISPAD PS 7.3).

Those staff who have volunteered for training in insulin administration/supervision will have extended training needs and obligations (Level 3). School nurses should also complete the T1D Level 3 course.

***Level 3:** Those school personnel with authorisation or seeking authorisation through training and informed parental consent to administer insulin require a higher level of training on*

- *insulin administration*
- *dose calculation and adjustments*
- *the legal aspects of insulin administration*
- *insulin delivery devices including insulin pumps*
- *glucagon administration.*

2.3 Training by parent

For many students, especially in secondary school, training by the parent alone is adequate and fulfils the requirements of consent and individualised care. The school's duty of care obligations owed to employees and Occupational Health and Safety (OH&S) requirements to be adequately trained in T1D management for that student may be assisted by the satisfactory completion of the appropriate levels of the ISPAD endorsed T1D e-learning modules combined with individualised training by the parent.

If the treating medical team feels that parent training alone may be inadequate, the team can request (with parental consent) to instruct school personnel.

Training by the parent must reflect the individual prescribed management for that student as outlined in the student's DMP. The parent has the ultimate right to make medical decisions for their child. This includes the content, where reasonable, of the DMP.

2.4 Assessment of competency of school personnel

It is the education provider's responsibility, as the employer of school personnel, to ensure that its employees are appropriately qualified, trained and competent to perform the duties for which they are employed. Parents have the right and obligation to assess whether the school employee is capable to act on their behalf and administer/supervise a dangerous (Schedule 4) drug, insulin, to their child.

Education providers are required under OH&S legislation to provide safe systems of work, which includes providing the necessary information, instruction, **training** and/or supervision to enable them to do their work in a way that is safe and without risks to their health (or the health of others – students). The obligation to keep all employees informed and up to date with the specific student needs is ongoing and cannot be assumed.

It is not within the scope of practice of the Health Care Professional (HCP) to assess and declare competency of school personnel to safely administer insulin and/or to deliver prescribed complex medical care to the student. The HCP role is to advise and instruct on the individual student requirements so that schools can implement measures to fulfil their obligations.

3. Preparation

Treating medical teams should adhere to the human rights agreements committed to by the Australian Government which **recognise everyone's right to have the highest possible standard of physical and mental health.**

The APS recommends that treating medical teams prescribe treatment consistent with ISPAD best practice guidance and maintain optimal care, regardless of location. Many examples exist where Australian schools have successfully implemented ISPAD best practice T1D clinical management.

Each treating medical team should choose education resources appropriate and suitable to its practice and its team philosophy. The APS recommends those resources based on ISPAD guidelines available at no cost through the T1D Learning Centre (www.t1d.org.au).

The resources should include

1. **A Diabetes Management Plan**. *A detailed DMP signed by parent (and student where applicable) and medical team outlines the medical instructions for the individual student at school. This plan should specify what diabetes responsibilities can or cannot be undertaken by the student, based on the child's age, diabetes self-care knowledge and cognitive maturity, i.e. blood glucose checking, insulin administration, meal planning and adjustment, adjustment for exercise (ISPAD PS 6.1).*

2. **A concise Diabetes Action Plan**. *As part of the DMP, an easily accessible concise Diabetes Action Plan (DAP) outlining recognition and individualised treatment protocols for high and low blood glucose levels and glucagon administration, if prescribed and available (ISPAD PS 6.2).*

3. A copy of **ISPAD Position Statement on Type 1 Diabetes in Schools**[2]. This is a comprehensive reference document that guides international best practice and is applicable to Australian schools. A copy of the best practice guidance should be available in every school attended by a student living with T1D.

4. An **e-learning platform** that covers ALL levels of education and training as per ISPAD Guidelines[1,2]. The e-learning platform should provide a comprehensive guide, especially related to the critical issues of insulin administration or supervision and complex diabetes care consistent with international best practice. The international award winning T1D e-learning modules (www.t1d.org.au) are comprehensive e-learning tools.

5. **The APS Position Statement on CGM in schools**[3]. This document is based upon ISPAD and American Diabetes Association (ADA) best practice and evidence-based guidelines and may assist clarity of management of Continuous Glucose Monitoring (CGM) in the school.

6. **A Parent Guide for international best practice T1D care in Australian schools**[4] is available at the T1D Learning Centre (www.t1d.org.au) and is based upon ISPAD guidelines. The Parent Guide is designed to empower parents to understand their rights and outlines the steps required for successful integration of their child with T1D into school.

4. Facilitation

4.1 Parent consent

Informed parental consent to discuss any aspects of a patient with a third party (such as school personnel) is an imperative aspect of good and ethical medical practice.

The parent is the only party who can provide informed consent to the prescribed medical treatment (ISPAD PS 5.8).

Informed consent requires a specific discussion about the purpose of disclosing aspects of a patient's medical history to a third party and should not be part of a blanket or vague consent process. Medical teams should not disclose health information data to any third party without informed parental consent.

4.2 Arrange meeting

The meeting time for training all school personnel responsible for management of that student should occur as close as possible to the student returning to school to enable retention of information and access to responsible school personnel. The meeting time allocation may require travel time.

Scheduling the meeting relies on the treating medical team allocating time blocks that may suit the school and then for the school to confirm its availability and that of the parent(s). Video conference allows a greater degree of flexibility for all parties. Scheduling is usually a very simple communication process of telephone or exchanging email between the three main parties. Email should not contain the child's clinical information or medical advice, and the parent should be copied in on all correspondence.

4.3 Pre-meeting learning

It is valuable for school personnel who are responsible for the student's management to have completed the international award winning T1D e-learning modules prior to the training meeting between school, parent and/or medical team. It is also advisable that the treating medical team familiarise themselves with the T1D e-learning modules and resources (including video simulations and case scenarios) on the T1D Learning Centre website.

It is not necessary, and is possibly counterproductive, for those staff to complete any other e-learning or attend "training" seminars that deliver non-individualised generic information. Information given to school personnel in such seminars may not be relevant to that student, may not be transparent or may not be consistent with ISPAD best practice guidelines.

Third parties who may provide generic T1D education or have some knowledge of T1D but bear no responsibility for clinical outcomes must not provide medical advice on any aspects of the medical management of the child with T1D (ISPAD PS 7.6).

4.4 Meeting school personnel

The optimal method of meeting with school staff is to conduct a face-to-face meeting at the student's school. However, when this is not possible (due to location or other logistics), a meeting via videoconference is a good alternative, especially in regional Australia.

Costs of professional development and training by the treating team to school personnel should be discussed with the school prior to meeting. This may assist the school to prioritise professional development costs to the recommended individualised training, with the generic diabetes education available free of cost through the T1D e-learning modules.

4.5 Time allocation

Allocation of time depends upon the complexity of the child, degree of self-management and experience of the school. If staff have completed the pre-learning education, it would be expected that to provide quality education and training (allowing time for staff to ask questions), the meeting duration would be between 45 and 90 minutes.

Further education and training sessions may be required during the year if the student's care has significantly changed (such as commencement of new diabetes devices/technology), if school personnel have changed or if the student has changed schools.

4.6 Face-to-Face meeting

Time must be allocated for travel to and from the school with some contingency time. Some diabetes units invite the responsible school personnel to their institutions for training. This may improve time efficiency for the treating medical team but impacts more upon the school and may reduce the number of school personnel and parents able to attend. Large group sessions comprising different schools meeting concurrently with the treating medical team do not facilitate individualised care and risk contravening medical privacy and confidentiality obligations and hence are not recommended.

4.7 Videoconference logistics

Videoconference can be easily arranged once the meeting time has been confirmed. It allows maximum access to school personnel and members of the treating medical team including the doctor as part of a case meeting. Videoconference does potentially reduce the personalised nature of the interaction but can still be very effective. Video conference can be arranged through Skype, Zoom, GoToMeeting, Microsoft Teams or even FaceTime.

4.8 Trainers who are not part of treating medical team

If training is to be performed by a third-party paediatric-trained credentialled diabetes educator (CDE) at the request of the parent, it is imperative that the parents be in attendance to grant consent and clarify the individual needs of their child. It is recommended that a formal consent document be signed prior to the training session. The CDE is not permitted to give any advice contrary to the advice and prescribed treatment given by the student's treating medical team and consented to by the parent. The CDE must consult with the student's treating medical team prior to the visit to ensure the delivery of a consistent message and should refer to the student's DMP and the parent for guidance.

5. Application

5.1 Introduction

Everyone attending the multidisciplinary meeting should **introduce themselves, their roles and their responsibilities** to the student with T1D and / or parent.

Caring for a student with T1D is best achieved through a cooperative, supportive and respectful relationship between the three key stakeholders – parent (and student when they are capable of greater independence in self-care), school personnel and medical team (ISPAD PS 4.1).

School personnel should consider the student's medical team as an accessible resource to contact with parental permission. A single member of the medical team should be identified as the source of contact for each student with T1D (ISPAD PS 4.4).

5.2 Explain WHY targeting normal blood glucose levels, prevention of high or low blood glucose levels and reduced blood glucose variability is beneficial for the student in terms of

1. optimal learning potential
2. reduced risk of mood swings
3. reduced risk of low blood glucose requiring immediate attention
4. reduced risk of longer-term health complication
5. recovery time from hypoglycaemia episodes to normal cognitive function.

ISPAD supports maintaining blood glucose levels as close to normal as possible during school hours to facilitate learning, concentration and participation in all aspects of school life. (ISPAD PS 6.1).

Once school personnel have a clear understanding of the importance of maintaining target glucose levels to avoid short- and long-term complications of T1D and facilitate an optimal learning environment, most schools are very enthusiastic to assist with complex diabetes management.

5.3 Explain team strategy and medical requirements for the individual

You may wish to briefly explain your team philosophy and why your team elects to follow **international ISPAD guidelines**. Importantly, school personnel should understand that each individual student with T1D has different requirements both medically and emotionally, including the level of ability to self-manage.

The individual medical requirements and blood glucose targets are best determined by parents and the student's medical team (ISPAD PS 3.4).

Parents are the final arbiters of whether their child can self-manage certain aspects of T1D, including glucose monitoring and self-administration of insulin. The medical team should guide and support parents to ensure the student is not subject to inappropriately unrealistic expectations (ISPAD PS 6.4).

5.4 Contemporary T1D management

Contemporary T1D management requires proactive and preventative action utilising intensive insulin administration, technology and carbohydrate counting. It is helpful for the school personnel to understand how simple interventions may make a significant difference. It is unacceptable to not actively manage a high or rising blood glucose when evidence demonstrates effects on learning, verbal comprehension and working memory and when intervention tools are readily available. When explained using analogies such as with cancer (e.g. we would not underdose chemotherapy because of school time), school personnel will frequently understand why their role in assisting students to actively manage T1D at school is so important.

Simple interventions include

- corrective insulin injection or bolus via insulin pump
- temporary changes in basal rates via insulin pump
- pre-bolus for food.

It is unacceptable to allow hypoglycaemia to occur when there are management tools that identify potential hypoglycaemia. These include

- use of CGM arrows to predict a low blood glucose level and proactive intervention before the child has developed hypoglycaemia
- proactive physical activity interventions as outlined in the DMP, which may be insulin bolus adjustments, basal adjustments or food interventions.

If schools are not taking appropriate actions in these scenarios, they are not preventing harm to the student that is reasonably foreseeable.

5.5 Acknowledge impact of T1D on the family

It is helpful for school personnel to understand the relentless burden T1D imposes on families and the investment parents have in their child living with T1D.

School personnel must understand the emotional burden experienced by families when given a diagnosis of an incurable disease such as T1D that will relentlessly impact upon the student, siblings, family relationships and parental working lives. ISPAD PS 3.1).

5.6 Acknowledge the child as a person

Because school transcends a broad developmental spectrum, each student's needs may have varying personal and emotional requirements over time. The school should be encouraged to discuss emerging or changing social and emotional issues for that student.

The privacy of the student and confidentiality issues relating to the student with T1D must be respected, acknowledged and discussed with the student and parent (ISPAD PS 3.5).

All aspects of T1D management should occur with minimal disruption to normal class routines and activities, requiring appropriate support for school personnel (ISPAD PS 6.11).

5.7 Dispel myths of children "learning responsibility" of self-management

It is helpful to address some common concerns raised by parents regarding a school's lack of experience with the relentless demands of T1D management.

*Schools should not expect that young people with diabetes will "learn responsibility" for self-managing T1D by **leaving them unsupported** during school hours. Nor will the **duration** the student has lived with T1D determine their ability to be self-sufficient. Young students may be capable but should not be solely responsible for their management at school (ISPAD PS 6.3).*

6. Individual issues and reasonable adjustments

"Reasonable adjustments" for a student with T1D includes insulin or glucagon administration where prescribed. In well-resourced countries it also includes (if prescribed and authorised by the parent in the DMP) continuous glucose monitoring interpretation and intervention (which may include use of predictive arrows and alerts) and use of insulin pump settings (ISPAD PS 5.4).

6.1 Questions about T1D e-learning modules

Explore the need for clarification or any issues that may have arisen from school personnel completing T1D e-learning modules.

6.2 Questions about T1D Parent Guide

Explore whether there is any need for clarification of parental rights, informed consent, confidentiality and the roles and responsibilities of schools and parents.

6.3 Definitions of roles – identify the agent(s) managing insulin administration on behalf of parents

Insulin is classified as a Schedule 4 drug in Australia and is only authorised to be administered by certain categories of healthcare worker (e.g. Div. 1 Registered Nurse). Such personnel are not universal in Australian schools, so the reliance is often upon non-medical personnel to undertake the complex care of a student, where these personnel are permitted and when they have been consented and authorised by the parent. The parent's authorisation and consent must consider the personnel's training and ability to undertake their child's individual needs as ordered and instructed.

6.4 Previous exposure of school to T1D

The school may have had experience with other students with T1D, all with different management regimens and different personal attributes. School personnel may have received advice that varies from ISPAD best practice. Adults within the school may have their own personal experience of diabetes. This opens the opportunity to explain the need for individualised care and the guidance source of your team's strategies. Because a school may have received individualised training for a certain student does not negate the rights and requirement for all students with T1D to have individualised training, nor the obligation to ensure all school personnel have appropriate training and instruction to fulfil an individual child's needs.

6.5 Hypoglycaemia

There is often significant fear that a student may suddenly lose consciousness or start fitting due to hypoglycaemia. **The school should be reassured** that this is a very rare event where hypoglycaemia is prolonged (at least over 30 minutes) and severe (under 2mmol/l). ISPAD defines hypoglycaemia as less than 3.5mmol/l but recommends treatment below 4mmol/l because of potential to fall further. Teams with a hypoglycaemia definition of less than 3.5mmol/l do NOT have a greater incidence of severe hypoglycaemia as evidenced by data reported in the Australian Diabetes Data Network.

Continuous Glucose Monitoring (CGM) can be a very reassuring tool for school personnel who seek to avoid or be quickly alerted to hypoglycaemia.

Glucagon administration should be discussed in the context of individual needs at school or camp and the availability of glucagon training videos at the T1D Learning Centre.

6.6 Continuous glucose monitoring

The APS has developed Guidelines for the use of CGM in Australian Schools[3] based on the ISPAD and ADA position statements of best practice in schools.

CGM provides valuable information about glucose levels for the student, caregivers, school nurse, and diabetes care team. Continuous Glucose Monitors update glucose data every 5 minutes, providing 288 readings per day. In addition, CGM have trend arrows that, in combination with the current glucose level, allow the student and the school personnel responsible for the student's complex medical care, to know what the current glucose level is, where it is going, and how fast it is changing[3].

Training may include explaining

- CGM lag times of sensor glucose to blood glucose and requirements to check blood glucose if sensor glucose is low or not consistent with clinical state
- CGM trend arrows
- the ability for CGM to have followers (e.g. parent and/or school personnel) via smart phone
- how to manage CGM alerts – discussing individualised strategies for activity, illness and exams based on the student's DMP – and facilitate contemporary proactive T1D management.

6.7 Other medical issues and technology

Offer to discuss and put into context other medical or technical issues that may need clarification.

6.8 Individual strengths and challenges of the student separate from diabetes

Individuals with T1D may have idiosyncrasies or emotional issues that should be alerted to the school. Hypoglycaemia and hyperglycaemia may affect mood and may be expressed in different ways. Emotional health disorders, especially anxiety, may manifest in illogical behaviour. Children may appear responsible but can easily forget necessary diabetes tasks. Many children may be capable but should not be responsible for complex diabetes care in primary school and early secondary school levels.

6.9 Logistics

Drug administration requires safeguards and diligence, so it is helpful to ensure that school personnel understand the importance of administering the right drug to that individual at the correct dose (including carbohydrate accuracy) at the time specified.

The parent has certain responsibilities including ensuring in-date diabetes supplies and delivering their child's DMP including concise DAP. Parents must work with the school to establish how the school will facilitate the prescribed treatment (as outlined in the DMP) in the school's Student Health Support Plan.

Schools should be supported by the student's medical team to establish processes to address issues and provide appropriate information regarding the use and handling of diabetes equipment including lancets, syringes/needles and used test strips. Schools should be provided with the necessary resources such as sharps containers (or other means of disposal, dependent on local circumstances), and information to deal with such issues constructively and cooperatively, whilst minimising risks to both students and school staff. Ideally, this should be organised prior to the student commencing or returning to school following a diagnosis of T1D (ISPAD PS 4.6)

6.10 Recording

Insulin dose and accompanying data should be recorded by the school personnel. This is part of the student's sensitive health information and medical record. This is the property of the parent and should not be disclosed to any other parties.

6.11 Communication

An effective communication process between parent/student (when capable) and school personnel should be respectful, transparent and easily accessible (ISPAD PS 4.3).

Clarification of the communication process should be made during the training, including the order in which concerns are escalated. The parent should be the first point of contact.

6.12 Privacy and consent

HCPs delivering training to school personnel must comply with state and federal privacy legislation and the confidentiality and informed parental consent obligations as defined by their profession and the medical and nursing boards. Health information is regarded as one of the most sensitive types of personal information, so the Privacy Act 1988 provides extra protections. Training must include

disclosure on how both the patient or parent and school or school personnel information is collected and used. The treating medical team's professional relationship and obligations are to the child with T1D and their parent.

Privacy legislation requires specification of the purpose of collecting the information. That consented information, once collected, must be used specifically for that purpose. If medical or demographic data information relating to education and training (e.g. names and details of school personnel who were trained, type of training, outcome of training etc.) is requested by third parties including government, support organisations or diabetes charities, the HCPs must not disclose that information without the specific consent of the parent and those individuals whose information is being collected.

The treating medical team may undertake an advocacy (and even mediation) role for the child and the parent in the school environment; however, the treating medical team must always obtain informed parental consent for any specific discussion with any third party (including school personnel) regarding its patient.

Parental consent for the treating medical team to be contacted as an escalation point in the event of an emergency should be outlined and signed in the DMP. It does not permit the treating team or school to further discuss healthcare plans, treatment or needs without specific consent.

6.13 Schools and duty of care with T1D

School personnel have a duty of care to the student to keep them free from harm that is reasonably foreseeable which includes the effects of blood glucose levels out of target range.

Schools have a duty of care for their students and school personnel to take reasonable care to protect them from harm which is reasonably foreseeable, including out of target range blood glucose levels and from discrimination, bullying, stigmatisation, which can have a significant impact on self-esteem, motivation and emotional health (ISPAD PS 5.6).

Hypoglycaemia is an emergency care situation. Schools and school personnel (including teachers, specialist teaching staff, nurses, aides and those with a direct supervisory role) are obliged to protect the student from this foreseeable harm and give immediate and appropriate assistance to the student experiencing hypoglycaemia.

Schools' duty of care to the student also includes protecting them from foreseeable harm and taking reasonable care to implement the student's prescribed medical treatment. This includes the complex medical care requirements such as drug administration, actioning hyperglycaemia and other health management procedures and wellbeing needs.

School personnel must be authorised to undertake complex medical care procedures:

a) School personnel with recognised health care professional qualifications and registration are within their professional scope of practice (i.e. – Div. 1 Registered Nurse). Individualised training on that specific student's needs is still required.

b) School personnel whose scope of practice does not include complex medical care, where permitted, can volunteer to accept the responsibility to undertake that student's complex medical care, including insulin and/or glucagon administration. Individualised training on that specific student's needs is required. If school personnel elect not to volunteer, the school is obliged to find an alternative solution and/or resource to implement the prescribed treatment.

School personnel cannot undertake the complex care needs of T1D without the requisite authority, education, training and consent.[4]

Schools also have a duty of care to its staff to ensure each staff member's safety. School personnel must be provided the necessary information, instruction and training to manage the student's individual medical needs. Schools must ensure that school personnel are able to competently execute and manage the medical needs of the student.

School personnel can be assisted to meet their compliance obligations by

- *education about T1D*
- *appropriate training by the parent/medical team according to the individual needs of the student*
- *authorisation and consent by the parent and*
- *acting within their scope of practice according to the training and consent they have received (ISPAD PS 5.7).*

6.14 Concerns about blood products

Checking blood glucose levels with fingerstick may create concern for some schools because blood is involved. Individualised training should advise schools on the student's capability of self-use of the device. Most very young children are incapable and require assistance.

Students experiencing out of range blood glucose levels may have impaired cognitive function. Low blood glucose or a rapidly changing blood glucose may cause the student to be temporarily incapable of performing a blood glucose check via finger stick, interpreting the result and executing the required action. These events are emergency situations. The school personnel have a duty of care to that student to prevent harm that is reasonably foreseeable so must perform and/or assist with blood glucose checking urgently.

The T1D Learning Centre contains a video demonstrating the correct blood glucose check technique. The parent can train school personnel on the specific device used by the student.

6.15 School camps

The team should enquire whether a school camp is scheduled for the year so appropriate forward planning can be initiated between the school, the parent and the medical team. Quality early discussion may find solutions that avoid the student from being unfairly disadvantaged and may also allay school and parental anxiety about medical and emotional challenges that may be encountered for that student, to enable a positive experience for all.

7. References

1. ISPAD Clinical Practice Consensus Guidelines 2018 on Support and Management of Children and Adolescents with Type 1 Diabetes in Schools https://cdn.ymaws.com/www.ispad.org/resource/resmgr/consensus_guidelines_2018_/20.management_and_support_of.pdf
2. ISPAD Position Statement 2018 on Type 1 Diabetes in Schools. https://www.t1d.org.au/images/docs/Goss_et_al-2018-Pediatric_Diabetes.pdf
3. APS Guidelines for the Use of Continuous Glucose Monitoring (CGM) in Australian Schools CGM https://www.t1d.org.au/images/docs/APS_CGM_in_schools_PS_final.pdf
4. A Parent Guide for international best practice T1D care in Australian schools https://www.t1d.org.au/diabetes-at-school/a-parent-guide

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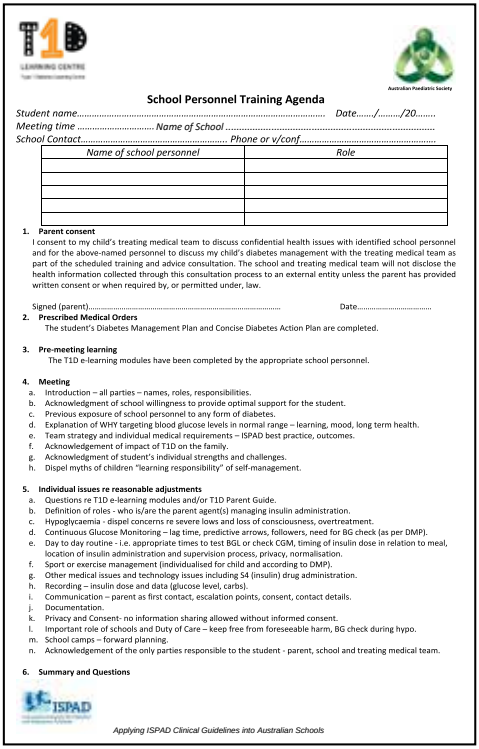
Peter Goss (chair), Jenny Goss, Megan Paterson, Shelly Jedrisko, Andrea Curtis, Lucy Casson, Fran Brown, Linda Hammond, Anna Peters, Rachel Milosevic, Lorraine Pitman, Tamara Boyer, Simone Beever, Tanya Carroll, Tim Warnock, Mark De Souza, Allan Kerrigan.

T1D Learning Centre Training Agenda can be downloaded at t1d.org.au



School Personnel Training Agenda

Student name..... *Date*...../...../20.....

Meeting time ..... *Name of School* .....

School Contact..... *Phone or v/conf*.....

Name of school personnel	*Role*

1. **Parent consent**
   I consent to my child's treating medical team to discuss confidential health issues with identified school personnel and for the above-named personnel to discuss my child's diabetes management with the treating medical team as part of the scheduled training and advice consultation. The school and treating medical team will not disclose the health information collected through this consultation process to an external entity unless the parent has provided written consent or when required by, or permitted under, law.

   Signed (parent)..... Date.....
2. **Prescribed Medical Orders**
   The student's Diabetes Management Plan and Concise Diabetes Action Plan are completed.
3. **Pre-meeting learning**
   The T1D e-learning modules have been completed by the appropriate school personnel.
4. **Meeting**
   a. Introduction – all parties – names, roles, responsibilities.
   b. Acknowledgment of school willingness to provide optimal support for the student.
   c. Previous exposure of school personnel to any form of diabetes.
   d. Explanation of WHY targeting blood glucose levels in normal range – learning, mood, long term health.
   e. Team strategy and individual medical requirements – ISPAD best practice, outcomes.
   f. Acknowledgement of impact of T1D on the family.
   g. Acknowledgment of student's individual strengths and challenges.
   h. Dispel myths of children "learning responsibility" of self-management.
5. **Individual issues re reasonable adjustments**
   a. Questions re T1D e-learning modules and/or T1D Parent Guide.
   b. Definition of roles - who is/are the parent agent(s) managing insulin administration.
   c. Hypoglycaemia - dispel concerns re severe lows and loss of consciousness, overtreatment.
   d. Continuous Glucose Monitoring – lag time, predictive arrows, followers, need for BG check (as per DMP).
   e. Day to day routine - i.e. appropriate times to test BGL or check CGM, timing of insulin dose in relation to meal, location of insulin administration and supervision process, privacy, normalisation.
   f. Sport or exercise management (individualised for child and according to DMP).
   g. Other medical issues and technology issues including S4 (insulin) drug administration.
   h. Recording – insulin dose and data (glucose level, carbs).
   i. Communication – parent as first contact, escalation points, consent, contact details.
   j. Documentation.
   k. Privacy and Consent- no information sharing allowed without informed consent.
   l. Important role of schools and Duty of Care – keep free from foreseeable harm, BG check during hypo.
   m. School camps – forward planning.
   n. Acknowledgement of the only parties responsible to the student - parent, school and treating medical team.
6. **Summary and Questions**

Applying ISPAD Clinical Guidelines into Australian Schools

t1d.org.au

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Prize for Diabetes Innovation

Australian children and families living with Type 1 Diabetes are indebted to ISPAD for their advocacy and determination to achieve the best outcomes for children and adolescents with diabetes at school. The T1D Learning Centre is an initiative of the Australian Paediatric Society and is endorsed by ISPAD.

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