NURSING SUPPORT SERVICES - INDIVIDUAL CARE PLAN
DIABETES MANAGEMENT INSULIN PUMP

CHILD'S NAME:		**DATE OF BIRTH (YYYY/MM/DD):**			
SETTING:		**GENDER:**		☐ MALE	☐ FEMALE
ADDRESS:		**PHONE:**		**PHN #:**	

PARENT(S)/GUARDIAN(S) NAME:		**HOME PHONE:**		**CELL PHONE:**	
ADDRESS:				**WORK PHONE:**	
PARENT(S)/GUARDIAN(S) NAME:		**HOME PHONE:**		**CELL PHONE:**	
ADDRESS:				**WORK PHONE:**	

NSS COORDINATOR:		**HEALTH UNIT LOCATION:**	
NSS PHONE:		**DATE OF PLAN (YYYY/MM/DD):**	

BRIEF HEALTH HISTORY/PERTINENT DATA/MEDICATIONS:	**ALLERGIES:**	
(name) has type 1 diabetes. This was diagnosed in (month and year of diagnosis). (name) requires insulin at school, using an insulin pump. (Insulin will be administered by school staff OR school staff will supervise (name) administering (his/her) insulin). The specifics re: low and high blood glucose (BG), daily routine etc. are listed within the care plan. (name) should be encouraged to be as independent as possible in managing their diabetes.		

CONTACTS	NAME	PHONE	EMERGENCY PLAN
EMERGENCY CONTACT			If (name) is **unconscious**, exhibits **seizure activity**, has **LOW BG and is unable to swallow fast-acting sugar**, or has any other illness or injury requiring **immediate medical attention**, activate this plan: 1. Remain with (name), (send someone to find staff trained in Glucagon administration), call 911 and call parent/guardian 2. Check blood glucose level while waiting for ambulance if not already done. 3. If BG is low – administer Glucagon if trained (& suspend insulin pump if trained) 4. Protect (name) from injury. 5. If unconscious/seizing, place (name) in side lying position. 6. DO NOT Restrain Movements. 7. DO NOT put anything into (name's) mouth. 8. Accompany (name) to the hospital if the parent/guardian not available.
PRIMARY CAREGIVER(S)			
ALTERNATE CAREGIVER(S)			
TEACHER			
(RESOURCE TEACHER)			
OTHER **REVIEWED DATE:**			

CHILD'S NAME: **DOB: (YYYY/MM/DD)** **SETTING:**

Daily Flow Sheet – as needed care

When Student has Signs or Symptoms of Low or High BG (refer to pages 5 & 6)

TIME	ACTION	RESPONSE
As required	Test Blood Glucose (refer to page 4) ****If student has signs/symptoms that could be due to low BG and you are unable to test BG, ALWAYS treat for low BG (refer to page 5)****	If 3.9 mmol/L or below: • **Treat for low BG** (refer to page 5)
		If 4.0 - ___ • Give a snack labelled "activity" (to prevent low BG)
		• If ___ – ___ mmol/L, no action required
		If ___ mmol/L or above: • Caregiver will administer insulin (refer to page 8) • Refer to page 6 for management of hyperglycemia • If ___ mmol/L or above, **or if this is the second BG in a row above 15 mmol/L**, call parent to inform

Before Physical Activity (PE, DPA, active play before lunch (reverse lunch), _____)
Student is at increased risk of hypoglycemia when participating in physical activity, and requires (BGM/snack) prior to physical activity.

TIME	ACTION	RESPONSE
As required (list specific times, if known and consistent e.g. reverse lunch)	Test Blood Glucose (refer to page 4)	If 3.9 mmo/L or below: • **Treat for low BG** (refer to page 5) • Student will not participate in physical activity until BG is 4.0 mmol/L above AND a snack labelled "activity" is eaten
		If 4.0 – ___ mmol/L: • Student will eat a snack labelled "activity" AND ____ (fast acting sugar)
		If ___ – ___ mmol/L: • Student will eat a snack labelled "activity"
		If ___ - ___ mmol/L or above: • Student does not require a snack
		If ___ mmol/L or above: • Caregiver will administer insulin (refer to page 8) • Refer to page 6 for management of hyperglycemia • If student has symptoms of hyperglycemia, **student should not participate in physical activity until symptoms resolve** • If ___ mmol/L or above, **or if this is the second BG in a row above 15 mmol/L**, call parent to inform

Daily Flow Sheet – scheduled care

Start of school:

TIME	ACTION	RESPONSE
am	Test Blood Glucose (refer to page 4)	If 3.9 mmol/L or below: • **Treat for low BG** (refer to page 5)
		If 4.0 -____ mmol/L, no action required
		If ___ mmol/L or above: • caregiver will administer insulin (refer to page 8) • refer to page 6 for management of hyperglycemia • If ____ mmol/L or above, call parent to inform

Before recess:

TIME	ACTION	RESPONSE
am	Test Blood Glucose (refer to page 4)	If 3.9 mmol/L or below: • **Treat for low BG** (refer to page 5) • Student will not participate in recess, eat a snack or receive insulin until BG is 4.0 mmol/L or above. • Once BG is 4.0 or above, proceed with snack/insulin (refer to page 8)
		If 4.0 - ____ mmol/L • Student will eat a snack labelled "recess" • No insulin is required
		If ___ mmol/L or above: • Caregiver will administer insulin (refer to page 8) • Student will eat the snack labelled ("activity or recess") • If ____ mmol/L or above, refer to page 6 for management of hyperglycemia • If ____ mmol/L or above, **or if this is the second BG in a row above 15 mmol/L**, call parent to inform

Before pre-lunch play (reverse lunch):

TIME	ACTION
	• If student will participate in outside play or indoor physical activity, follow directions for **Before Physical Activity**

Immediately before student eats lunch:

TIME	ACTION	RESPONSE
	Test Blood Glucose (refer to page 4)	If 3.9 mmol/L or below: • **Treat for low BG** (refer to page 5) • Student will not eat lunch or receive insulin until BG is 4.0 or above. • Once BG is 4.0 or above, proceed with lunch/insulin (refer to page 8)
		If 4.0 mmol/L or above: • Caregiver will administer insulin (refer to page 8) • Student will eat lunch • If ___ mmol/L or above, refer to page 6 for management of hyperglycemia • If ___ mmol/L or above, **or if this is the second BG in a row above 15 mmol/L**, call parent to inform

Two hours after lunch:

TIME	ACTION	RESPONSE
pm	Test Blood Glucose (refer to page 4)	If 3.9 mmol/L or below: • **Treat for low BG** (refer to page 5)
		If 4.0 – ____ mmol/L, no action required
		If ____ mmol/L or above: • the caregiver will administer insulin (refer to page 8) • If ___ mmol/L or above, **or if this is the second BG in a row above 15 mmol/L**, call parent to inform • Refer to page 6 for management of hyperglycemia

NURSING SUPPORT SERVICES - INDIVIDUAL CARE PLAN: DIABETES MANAGEMENT INSULIN PUMP

CHILD'S NAME: DOB: (YYYY/MM/DD) SETTING:

HEALTH CARE ISSUE/PROCEDURE	INTERVENTIONS/ACTIONS

1. Blood Glucose Monitoring (BGM)
 	
(name) requires routine BGM at the times listed on the Daily Flow Sheet on pages 2 and 3:
 	
BGM should also be done any time (name) has signs or symptoms of low/ high blood glucose.
 	
Equipment and supplies required:
• BGM kit (meter, unexpired test strips, lancing device, lancets)
• gloves
• fast acting sugar (e.g)
  • juice
  • glucose tablets
  • table sugar dissolved in water
• Extra starch and protein snacks i.e. granola bar
• (also list any further child-specific supplies)
 	
These supplies are located (state location)
	The caregiver and/or student will:
	
	1. Encourage as much independence as developmentally appropriate
	
	2. Use *Contact with Blood and Body Fluids: Protecting Against Infection* (HealthLinkBC File #97) when working with blood. http://www.healthlinkbc.ca/healthfiles/hfile97.stm
	
	3. Ensure (name) washes and dries hands.
	
	4. Wash own hands and wear gloves if doing/assisting with this procedure.
	
	5. Instructions will vary with different meters but these are the basic steps:
	  • Insert test strip into the meter.
	  • Prick finger with lancing device to get a small drop of blood.
	  • Apply blood drop to test strip and await result.
	  • Record blood glucose on NSS Diabetes/Insulin Management Record. Readings may also need to be noted in a personal log book.
	  • Remove strip and discard in the garbage.
	
	6. When/if disposing of lancet have (name) remove lancet and put in sharps container.
	
	7. Clean any surface contaminated with blood using a 10% bleach solution or other WHMIS-approved disinfectant, as per facility policy.
	
	8. Return equipment and supplies to designated area.
	
	Report to your supervisor and follow employer policy and *Contact with Blood and Body Fluids: Protecting Against Infection* (HealthLinkBC File #97) if you receive a contaminated finger poke.

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CHILD'S NAME: **DOB: (YYYY/MM/DD)** **SETTING:**

HEALTH CARE ISSUE/PROCEDURE	INTERVENTIONS/ACTIONS

2. Management of Low Blood Glucose (BG) (Hypoglycemia)
 	
Hypoglycemia means low blood glucose **(below 4.0 mmol/L)**.
 	
(name's) usual signs and symptoms of low blood glucose are **:**
• (list **child-specific** signs/symptoms)
 	
Equipment and supplies required:
• BGM kit (meter, unexpired test strips, lancing device, lancets)gloves
• fast acting sugar (e.g)
  • juice
  • glucose tablets
  • table sugar dissolved in water
• (also list any further child-specific supplies)
 	
These supplies are located (state location)
	The caregiver and/or student will:
	1. Ensure all meals and snacks are eaten at scheduled times to prevent low blood glucose.
	2. Check blood glucose (BG) level at routinely scheduled times and in response to signs/symptoms of potential low blood glucose.
	
	3. **When BG is 3.9 mmol/L or below:**
	  • Stay with (name). Send another adult to get fast-acting sugar if necessary.
	  • Give (10 OR 15) grams of fast-acting sugar i.e.:
	  • (list child-specific forms of fast-acting sugar)
	****If BG is less than 2.5 mmol/L, give (specify what will deliver up to 20 g fast-acting sugar**
	  • Wait 15 minutes – **do not give anything else to eat or drink**
	  • Re-check BG
	If BG level is still 3.9 mmol/L or below, repeat steps above
	  • Call parent/guardian to inform if BG remains 3.9 mmol/L or below after two treatments
	  • Repeat steps above until BG is 4.0 mmol/L or above.
	
	(name) must not eat or drink anything except fast acting sugar when BG is 3.9 mmol/L or below.
	
	4. Children using insulin pumps do **NOT** require a follow-up snack once BG is 4.0 mmol/L or above, **unless the low BG occurs before, during or immediately after physical activity**. In that case, the student should eat a snack labelled "for activity".
	
	5. An adult should observe (name) for recurrent signs or symptoms of low BG for 30 minutes.
	
	6. Document blood glucose levels and your actions in the Diabetes/Insulin Management Record.
	
	If (name) experiences signs or symptoms of low blood glucose, and you are unable to test BG, ALWAYS treat for low blood glucose, as above.
	
	If at any time (name) is unconscious, has a seizure, or is unable to swallow fast-acting sugar, activate the Emergency Plan on page one.

CHILD'S NAME: **DOB: (YYYY/MM/DD)** **SETTING:**

HEALTH CARE ISSUE/PROCEDURE	INTERVENTIONS/ACTIONS
3. Management of High Blood Glucose (Hyperglycemia) **Hyperglycemia means high blood glucose.** (name's) usual signs and symptoms of high blood glucose are: • (list child-specific signs/symptoms) **Equipment and supplies required:** BGM kit (meter, unexpired test strips, lancing device, lancets) • (also list any further child-specific supplies) **These supplies are located (state location)** Checking urine for ketones, if required, is a parent/student responsibility.	**The caregiver and/or student will:** 1. Ensure all meals and snacks are eaten at scheduled times, and that only food sent by parent/guardian is eaten unless prior arrangements have been made. 2. Check BG at scheduled times, and in response to signs/symptoms of high blood glucose. 3. If BG is elevated above value determined by parent: • Encourage and allow (name) to drink water or sugar-free beverages • Allow for frequent trips to the bathroom • Name may require insulin - follow directions in Daily Flow Sheet (pages 2 and 3) regarding when to administer insulin. 4. If BG level is greater than ____ (value of 20 mmol/L or less, as determined by parent) or if 2 BG readings in a row are greater than 15 mmol/L assist (name) to check insertion site and infusion set for dislodged catheter, leaking at insertion site, or blocked/broken tubing. Call parent to inform. 5. Document BG readings and any actions in the Diabetes/Insulin Management Record. **Check BG if (name) experiences nausea, abdominal pain and/or vomiting. These symptoms, along with BG above 15 mmol/L could indicate the insulin pump is not delivering insulin, and (name) may be at risk for ketoacidosis. If left untreated, this is a serious condition. The parent will need to come to the school to give an insulin injection and change the tubing/insertion site.**

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CHILD'S NAME: **DOB: (YYYY/MM/DD)** **SETTING:**

HEALTH CARE ISSUE/PROCEDURE	INTERVENTIONS/ACTIONS
4. Food at School – Carbohydrate Counting • (name's) insulin doses at recess, lunch, and two hours after lunch(if needed) will be determined by (name's) BG and the number of grams of carbohydrate eaten. • (name's) parent/guardian will send all food for the day. Each food item will be labelled with the carbohydrate count. • If it is important a food item is eaten at a certain time of the day, it will be labelled accordingly. • (name) should not eat any other food unless prearranged with the parent/guardian. • Some foods do not affect BG, including most vegetables, meat and cheese. These will be labelled as zero carbs. • (name) may require a snack prior to activity. Snacks to be eaten prior to activity will be labelled "for activity". Carbs for these snacks should not be counted or used to determine an insulin dose. • Food to be eaten after school will be packaged separately and labelled.	. **The caregiver and/or student will:** 1. (name) will select items to be eaten for a snack/lunch. 2. Assist (name) to add numbers of carbohydrates in all chosen items, to get a total number for the snack/lunch. 3. Document the number of carbohydrates on the NSS Diabetes Insulin Administration Record. 4. Encourage (name) to eat all of each item chosen as part of a snack/lunch. Call the parent if (name) eats only part of a food item. 5. If (name's) insulin is administered after eating, (name) must not discard uneaten food items or carbohydrate labels until checked by school staff. 6. Call parents/guardians with concerns regarding: • missed or unfinished meals • eating food that is not sent by parent • food replacements and/ or special events

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CHILD'S NAME: DOB: (YYYY/MM/DD) SETTING:

HEALTH CARE ISSUE/PROCEDURE	INTERVENTIONS/ACTIONS
5. Insulin Administration (Name) uses the (PUMP BRAND/NAME) to administer (brand) insulin via insulin pump. Please see the insert on the next page for step-by-step instructions to calculate and deliver an insulin bolus dose. Insulin will be administered at the times listed on the Daily Flow Sheet (pages 2 and 3) (Name's) insulin is given before eating. OR (Name's) insulin is given immediately after eating. Actual carbohydrates to be eaten should be added and insulin administered within 15 minutes of starting to eat. (Name's) pump is locked while at school, to prevent tampering. Follow the pump-specific instructions to unlock and lock the pump.	**As directed in the Daily Flow Sheet (pages 2 and 3) the caregiver and/or student will:** 1. Wash hands. 2. Check BG before (name) begins to eat. *3.* Add the carbohydrates in the meal/snack (if (name) is eating). 4. Document BG and carbohydrates in the NSS Diabetes Insulin Administration Record. **5. If the BG before insulin administration was low:** • **Treat for hypoglycemia** • **Re-check BG 15 minutes after treatment. Do not give insulin until BG is 4.0 mmol/L or above** • **Enter 4.0 – 6.0 (number determined by parent) mmol/L into the pump as the BG, NOT the re-check BG following treatment OR don't enter any BG into the pump and bolus for carbs only as per attached, pump-specific instructions OR enter post-treatment re-check BG** 6. If required, unlock the pump, following pump-specific instructions provided. 7. Follow attached, pump-specific instructions to enter BG & carbs into the insulin pump. 8. If no food is eaten, or the food has no carbohydrates, enter zero carbs 9. Follow pump-specific instructions to administer the insulin dose calculated by the pump. If the pump calculates a dose of 0.0 units of insulin, no insulin needs to be administered, however make sure you push act or go so that this recommendation will show up in the history. 10. Remain with name) to confirm the dose has been delivered. 11. If required, lock the pump, following pump-specific instructions. 12. Document that the appropriate insulin dose was administered on the NSS Diabetes Insulin Administration Record.

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CHILD'S NAME: **DOB: (YYYY/MM/DD)** **SETTING:**

INITIAL REVIEW:

Parent(s)/Guardian(s) Approval/Signature	NSS Coordinator Signature	Date

ANNUAL REVIEW:

Parent(s)/Guardian(s) Approval/Signature	NSS Coordinator Signature	Date
Parent(s)/Guardian(s) Approval/Signature	NSS Coordinator Signature	Date