## 24 Aug/11

Wednesday, August 24, 2011 3:00 PM

Children's Hospital is developing basic training via web. For lay people, school care givers, parents and NSS coordinators Wouldn't be enough for our purposes

Health care professionals monitor themselves as to their competences to teach insulin administration.

From: Sent:	Wallace, Laure Friday, Novemb	n HLTH:EX ber 25, 2011 8:26 AM	
To:	Gibbons, Lenor	re EDUC:EX; Meaning, Shirley MCF:EX	; Fuller, Anne MCF:EX; Stevanovic,
Subject:	Aleksandra MC RE: Thoughts F	F:EX; Dobell, Leah MCF:EX Re; solutions for diabetes care	
Hi all			
ni ali,			
Lenore, thanks for	sharing your ideas. Here	e are some pieces to add and build upon	i this:
		S. 13	
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### Lenore Gibbons

Coordinator-Special Education Learning Division Ministry of Education phone 250-886-2083 fax 250-356-6161



BC'S EDUCATION PLAN ON THE WEB: WWW.BCEDPLAN.CA ON TWITTER: @BCEDPLAN

From: Wallace, Lauren HLTH:EX Sent: Tuesday, November 22, 2011 4:36 PM To: Gibbons, Lenore EDUC:EX; Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Stevanovic, Aleksandra MCF:EX Subject: PHO

HI everyone,

Here's a summary of the input received from our Deputy Provincial Health Officer. Eric Young. on the insulin administration in schools work includes S. 13

S. 13

Off to face the rain and wind! It's so gross out there.

Lauren Wallace Manager, Child & Youth Health | Healthy Women, Children & Youth Secretariat | Population and Public Health Division | Ministry of Health 250.952.2550 | Lauren.Wallace@gov.bc.ca

S. 13

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## Unsafe Article

Thursday, September 13, 2012 10:25 AM

pom unsup & Golool Special feature: Unsafe at School: Advocating for children with type 1 diabetes Issue: BCMJ, Vol. 54, No. 5, June 2012, page(s) 232-237 News&Notes Lila Yewchuk, MD, FRCPC, John Paul Morrison, Scott Yewchuk, BPE, BEd, MEd Admin Recent research has confirmed the deleterious effects that glucose extremes have on a child's learning, yet BC still has no province-wide standard of care for diabetic students. Type 1 diabetes (T1D) is a chronic, life-threatening autoimmune disorder that affects children of all ages. Before the discovery of insulin, T1D was fatal. Today children with T1D face a lifetime of insulin injections and require daily monitoring and treatment to keep blood glucose levels as close to normal as possible. Although there is an abundance of promising research, the cause of T1D is unknown and there is currently no cure. Worldwide, T1D affects millions of adults and at least 440 000 children under the age of 14, with 70 000 children newly diagnosed each year.[1] More than 300 000 Canadians live with type 1 diabetes.[1] Its incidence is increasing by 3% to 5% annually, with the greatest rise occurring in children aged 5 to 9.[1] In Ontario alone, the incidence of T1D increased by 48% between 1992 and 2002.[2] In British Columbia in 2004, the prevalence of T1D was estimated to be 0.15%, or 1477 children aged 0 to 18.[3] According to researchers, incidence is expected to double in children younger than 5 by 2020.[4] The goal in diabetes management is to optimize blood glucose control using hemoglobin A1c targets-a more precise measurement of blood glucose that tracks changes over 3 to 4 months. The aim is to avoid hyperglycemia (high blood glucose) and its well-documented, long-term microvascular consequences (including heart attack, stroke, kidney failure, blindness, amputation) while minimizing hypoglycemia (low blood glucose). Encouragingly, recent studies reveal that a 1% reduction in A1c lowers the risk of microvascular complications by 40%.[4] Glucose extremes in children with T1D In adults with T1D, the detrimental effect of acute glucose extremes on motor function and cognition is well documented.[5] Until recently, however, few studies were undertaken to examine the effects of acute blood glucose fluctuations in children, likely because of a reluctance to induce extreme glucose levels, and possible neurological insults, in younger patients with developing brains.

However, glucose fluctuations more extreme than those induced in studies occur routinely outside of the laboratory; these naturally occurring episodes of acute hypo- and hyperglycemia during daily routine have been shown to cause cognitive-motor disruptions in school-aged children.[6]

Recent research is uncovering the deleterious effects that glucose extremes have on a child's learning. Repeated hypoglycemia has been found to reduce spatial intelligence and delayed recall in children with T1D.[6,7]

In these same children, increased exposure to hyperglycemia reduces verbal intelligence and slows mental efficiency.[7] Hyperglycemia, not hypoglycemia, is "associated with adverse effects on the brain polyol pathway activity, neuronal structural changes, and impaired long-term spatial memory. This finding suggests that the hyperglycemic component of diabetes mellitus has a greater adverse effect on brain functioning than does intermittent hypoglycemia."[8-10]

This is echoed by the Canadian Diabetes Association (CDA) statement: "studies have found chronic hyperglycemia in young children [is] associated with poorer cognitive performance."[11] Correcting high blood glucose is therefore essential for a child's long-term health and learning needs.

#### Managing T1D in school-aged children

The Canadian Diabetes Association's 2008 clinical practice guidelines describe insulin therapy as the mainstay of medical management of type 1 diabetes and emphasize tight glycemic control for patients with T1D.[11] The guidelines make special mention of the pediatric population living with T1D: "regardless of the insulin regimen used, all children should be treated to meet glycemic targets."[11]

A statement from the American Diabetes Association (ADA)[12] also stresses the need to manage diabetes in children aged 6 to 12, which is described as a "particularly challenging" age group:

Many require insulin administration while at school, which demands flexibility and close communications between the parents, the health care team, and school personnel.[13] The lack of abstract thinking in most children of this age limits management choices and dictates that parents or other adults make most of the treatment decisions. While children in this age group may be more able to recognize and self-treat hypoglycemia, close adult supervision is still required... The ability of most children of this age to recognize, report, and seek treatment for hypoglycemia, combined with an absence of insulin resistance and psychological issues associated with puberty, makes this age group perhaps the most amenable to intensive glucose control. An A1c goal of = 8%... is recommended.[12]

While the Canadian Diabetes Association also recommends an A1c goal of < 8% in 6- to 12-year-old children, the International Society for Pediatric and Adolescent Diabetes recommends < 7.5% for all age groups.[11,14] In all cases, children should have their A1c targets determined individually.

For young Canadian children with T1D, receiving assistance with insulin administration while at school is rare, meaning that hyperglycemia can go untreated. This increases the risk for long-term chronic complications of the disease as well as for neurocognitive learning impairments that may appear immediately.[6]

#### Canada's contribution to T1D management

In 1922, Canadian surgeon Frederick Banting and his colleagues discovered insulin, which led to one of the most important health care advances of the 20th century. Since that time, Canada has been a leading country in the area of diabetes research.[15] The first continuous glucose monitor (CGM), a sensor and transmitting device used to communicate with the insulin pump, was developed in Toronto in the mid 1970s.

In conjunction with the US, Canada conducted the ground-breaking Diabetes Control and Complications Trial (DCCT), a comprehensive 10year study ending in 1993 that clearly demonstrated the importance of glycemic control in preventing microvascular complications of T1D.

This control was attained through intensive insulin therapy (more frequent insulin dosing), not conventional treatment (twice-daily insulin dosing).[16] This trial has been referred to as "the study that forever changed the nature of treatment of T1D"[17] by revealing the need for better management.

It is through intensive insulin therapies, such as the insulin pump and multiple daily insulin injections, that many children with T1D now experience the best glycemic control. When insulin is administered at a low level all day long by either of these methods, it is possible to do as the DCCT recommends: Improve glycemic control with the "reproduction of physiological insulin secretion."[16]

The 2010 landmark STAR 3 trial, a 1-year multicentre randomized controlled trial that compared the efficacy of sensor-augmented pump therapy with that of multiple daily insulin injections in 485 adults and children with type 1 diabetes, concluded that "in both adults and children with inadequately controlled type 1 diabetes, sensor-augmented pump

therapy resulted in significant improvement in [(A1c)] levels, as compared with injection therapy."[18]

STAR 3 is the first study that confirms sensor-augmented insulin pump therapy provides superior glucose control for children and adolescents, an age group that is particularly challenging to treat because of the social and physiological changes caused by growth and maturation.

In STAR 3, nearly 44% of pediatric patients using sensor-augmented insulin pump therapy achieved the American Diabetes Association's agespecific glucose control targets, compared with only 20% of patients in the multiple daily injection group.[18]

It is the longest and largest diabetes device trial of its kind, redefining what should be the standard of care for diabetes management. "For the first time, with the sensor-augmented insulin pump, adults, children and teens had a sustained improvement in A1c levels, which can greatly reduce the risk of complications from diabetes."[19]

While both the CDA and ADA promote optimal glycemic control in diabetes, only American children receive the support they need at school.[20] The American Diabetes Association initiated the Safe at School campaign, which resulted in a statement of principles to ensure children with T1D are guaranteed freedom from discrimination and access to medically necessary support while at school.

Recognizing that "diabetes must be managed 24 hours a day, 7 days a week," this support includes the administration of insulin and glucagon (a life-saving medicine used to treat emergency hypoglycemic reactions) and school assistance for young children not able to care for themselves.[21] Meanwhile, Canada has the fourth highest incidence of T1D, ranking ahead of Norway, the United Kingdom, and the US,[22] and yet to date, no Canadian diabetes organization has actively endorsed the Safe at School principles.

Although Canada is on the cutting edge of diabetes research and has made astounding contributions toward improving diabetes care, and although the CDA continues to lobby at the provincial and territorial levels for legislative change regarding safety at school,[20] children with T1D still do not receive the medical treatment they require while at school.

It is common to find Canadian children on traditional insulin therapies and not on newer intensive regimens just so that they can attend public school. Traditional regimens have fewer insulin injections and do not require a lunch-time insulin bolus; the result of this is convenience for school personnel. But this means children must fit into the school, instead of the school meeting their care needs.

The insulin strategies currently promoted by Canadian schools (twice-daily dosing) "rarely achieve optimal glycemic control because... they do not provide physiological or flexible insulin replacement... and may increase the risk of hypoglycemia."[16]

Given Canada's high incidence of T1D and the country's legacy as a world innovator in diabetes treatment, it is both ironic and tragic that Canadian policy has not kept pace with medical recommendations to ensure children receive care essential to them while at school.

#### The cost of inadequate care at school

If children with T1D do not receive proper medical support during school hours, the impact of this substandard care can reach beyond the child to the family, the classroom, and society. Families can suffer hardship as one parent is required to leave the workforce to attend to the child at school. Classrooms can be disrupted by the regular visits that diabetes care requires, and teachers can be distracted by the need to monitor the safety of the diabetic child.

In addition, the cost to the health care system is substantial. Diabetes and its complications cost the Canadian economy more than \$17.4 billion a year, with type 1 diabetes being the leading cause of adult blindness, stroke, heart disease, nerve damage, and amputation.[1] In addition, diabetic nephropathy occurs in 20% to 40% of patients.[23] For those diabetics with kidney disease, the average cost of dialysis treatment is \$50000 a year.

The one-time cost of a kidney transplant in BC is approximately \$20000, with an additional yearly cost of about \$6000 for antirejection medications.[24] Proper glycemic control, something not independently achievable in young children, is proven to reduce or eliminate these complications.

#### The right to reasonable accommodation

Apart from the medical implications, there are legal implications should a diabetic student be harmed or die because of insufficient care at school. Although children with T1D are considered disabled by the federal government, and classified by the BC Ministry of Education as "physically disabled, chronic health impaired" (Level 2 D),[25] these children do not always receive the accommodation they need. Until policy change occurs

and a better standard of care is set, children with T1D will continue to face discrimination.

Schools must provide appropriate medical treatment for each diabetic child to achieve glycemic target goals regardless of what insulin regimen is used. The health, safety, educational potential, and emotional well-being of these children depends on it.

Under the Canadian Charter of Rights and Freedoms, every citizen, including those with disabilities, has the right to equal protection and benefit without discrimination.[26] In the case of female firefighter Tawney Meiorin, the Supreme Court of Canada outlined steps to eliminate discriminatory conditions and satisfy the "duty to accommodate."[27]

In another case involving a 9-year-old boy with autism, Hewko v. BC, Madame Justice Koenigsberg stated that "reasonable accommodation is an integral part of the [school's] duty to consult" [28] and found that the Abbotsford School District did not "meaningfully consult" with the boy's family. Reasonable accommodation, as demonstrated in this case, involves providing a standard of care at school that reflects the care provided at home to ensure a "consistent educational program" for the child. [28]

For children with T1D, a "consistent educational program" would have staff trained in diabetes care to complement the care that the children receive at home. However, this is presently not the case. Current provincial Nursing Support Services (NSS) policy asserts that the care children with T1D need to safely attend school, namely the provision of insulin and glucagon administration, cannot be provided safely by an education aide.

While this policy may be the result of licensure concerns, the larger question raised is: Does such a policy directly or indirectly negatively affect children with T1D in a way prohibited in the Canadian Human Rights Act?[29]

Another case involving disabilities and the duty to accommodate, the Grismer case, suggests it is reasonable to ask if the argument that aides cannot "safely" care for a child with T1D has a bona fide justification, especially in light of the fact that some BC school districts currently permit staff to be trained in the administration of insulin and glucagon. Has the policy put forth by the NSS taken into account how these services could be provided safely, or is this belief based on "impressionistic assumptions"?[30]

For students with T1D, the present NSS care plan policy does not consider don proverida the negative impact on learning or health that results when aides cannot give insulin promptly to treat hyperglycemia. The current policy is unreasonable in that it forces families with young diabetic children to attend their children at school regularly, and if this is not possible, to choose an insulin regimen for their children that they might not choose otherwise.

iP The potential loss of glycemic control and, consequently, "instructional control,"[28] raises the question asked in Grismer: Must all students "meet a single policy standard, or could varying standards be adopted"[30] to meet the diverse needs of students? If varying standards can be adopted, then all children with type 1 diabetes could be accommodated at school and see cognitive and health benefits that would ultimately allow them to be more receptive to learning.

In March 2010, Canada's Parliament ratified the United Nations Convention on the Rights of Persons with Disabilities. All provinces and territories are now bound by the convention, which among other rights ensures that "effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion."[31]

#### Barriers to care

Being a student with type 1 diabetes in a BC school brings with it many risks. For those too young to self-manage, the risks are even greater. Currently, there is no province-wide standard of care for diabetic students and therefore no province-wide safety plan to ensure their well-being. Although the School Act includes general principles regarding care for children with health designations, and NSS has guidelines for training school personnel to deliver care in elementary schools, care is delivered inconsistently and limited provisions are made for those unable to selfmanage.

As a result, the care that children with T1D currently receive depends on five things:

- Which school district they are in.
- Which school within the district they attend.
- The nursing support available for that school.
- The principal in charge of that school.
- Whether the parents can advocate effectively for their child.

Overall, children receive vastly different care, with many receiving none. Most serious is the province-wide denial of the two critical components of Malina

molesestemale diabetes care: insulin and glucagon administration. Consequently, parents Wpurglycumles often fear for the safety of their children while at school.

Current NSS guidelines do not reflect the seriousness of the impact alaa haut it alan tour of the to diabetes can have on children's health and learning. Compounding this problem, the policy for health designations in schools falls under three ministries: Health, Education, and Children and Family Development.

Stor Complexity BUNN HAR, In addition to these challenges, BC's endocrinologists do not agree on school care, with some concerned that supporting insulin therapy and glucagon administration at the school level will directly tax their clinical resources. Consequently, parents who want intensive therapies, such as an insulin pump, must prove they have the means to personally support a child at school. Otherwise, they must wait several years until a child can

Another barrier to care involves concerns for the liability of those adaides provide medical support for students with physical disabilities and Just administer other injectable medications such as epinephrine, a life-saving injection for severe allergic reactions, the perception is that diabetes management is "too difficult."

\* peelp nort In fact, insulin administration is a skill that can be easily taught to school montforms personnel; the cost is negligible as extra funding is provided for the care of the diabetic children. Glucagon administration a skill parente tunically loarn in the diabetic children in the second s po llow up diabetic children. Glucagon administration, a skill parents typically learn in one teaching session lasting 10 to 15 minutes, can also be taught.

#### A possible solution

In an effort to improve support at school, a small number of BC families have already effected change for their children and proven that a new standard of care is possible. In five school districts, six students aged 6 to 8 now have working care plans that were negotiated independently.

In these plans, insulin therapy is administered by an aide trained by a nurse who is a certified diabetes educator. The aide is covered under current liability insurance provided to CUPE members. Management is clearly delineated with phone support from the parent. The result is that students have greater independence, classes have fewer disruptions, parents can remain in the workforce, and students have the best possible conditions for health and learning.

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710-15 min

This solution could be a province-wide one, since funding is already attached to students with diabetes, and the number of students requiring aides to administer insulin is relatively small—likely only 300 of the 600 children aged 5 to 12 on insulin pumps (written communication from Dr Daniel Metzger, endocrinologist at BC Children's Hospital, and Dr Sue Stock, endocrinologist at Lions Gate Hospital, 22 February 2012).

A policy that (1) allows school personnel to be trained to administer insulin and glucagon, and (2) requires the NSS to hire or train nurses who are certified diabetes educators, would give school districts the capacity to properly support diabetic students. If this is not possible, using outside agencies for medical care, an existing practice in BC schools, could meet this need.

In the past, children diagnosed with T1D lived highly regimented lives. They used "assigned fixed doses of insulin and had to follow a fixed meal schedule to fit the insulin regime."[16] However, as shown by the DCCT, glycemic control was rarely optimal using these traditional therapies. With the advent of methods that reproduce physiological insulin secretion, those living with type 1 diabetes today can have better quality of life and improved glucose control, through insulin therapies that fit their individual needs.

If schools will accommodate individual needs, then young children—who have the greatest number of years to live with diabetes and incur its complications—can live longer, healthier lives. Ultimately, improving the care that school-aged children with T1D receive in Canada will result in a healthier and more prosperous nation.

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## Summary to Date

Friday, August 10, 2012 12:35 PM

Latest actions included; Meeting with Rod with instructions to develop two documents. One for the DM to explain the current situation and short bullets for Rod.

Current situation is that:

Framework is being developed to provide guidelines for local solutions to admin of insulin. The document is geared toward use in schools. I have tried to massage languaging so that is doesn't assume school staff will be doing the administration.

The problem still remains that ministerial orders state that training must be provided by an appropriately qualified medical personnel.

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Copies of the recent memos to Educ executive are on the N drive under Diabetes.

#### Notes: Sept 14-2012

James approved a letter to provincial health officer and that was written subsequently. To be approved by Rod. Looking for formal advice to help build policy and get a feeling for provincial capacity. He might say that it is reasonable to be able to have parents provide training. He might approve of the idea of providing paediatric training in the province to support current capacity in Diabetes Education Centres in which case we could talk about a cost share.

Hourien ODInal-Childhealth BC-has been mentioned-re assistance/advice. Sanja Risticin Comprehensive School health:

Health has two people now working on school health through Health Families BC. (Scott Bedall and Meghan Day.)

They will be involved in life threatening illnesses. Diabetes, anaphalaxis, CPR.

Want to talk about regional capacity/ where the issues are. Will join a meeting soon. Should then talk about SchoolsPlus model in Sask/NB/Nova Scotia

Sept 14/12

	S. 14	
Main points:		
Rod has engaged Dr. Kendall to ask him for	S. 14	S. 13
	S. 13	
At this time, Rod is in the process of consulting the working group. There is a possibility that th	and will follow up wit is goes to a minister's (	h me and I will then consult with council for agreement.

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### Insulin Guideline/Protocol Jurisdictional Scan March 2013

Province/Territory	Blood Glucose Monitoring	Insulin Administration	Glucagon Administration	Training/ monitoring/ supervision of delegated tasks	Comments
Alberta		Locally ba	sed decision		In Alberta protocol for the management of diabetic care is a locally based decision and is the responsibility of school jurisdictions (district or division). A cross-sectoral joint funding model (Ministries of Education, Health and Wellness, and Child & Youth Services) is available to <b>enhance</b> the provision of a range of integrated health and related support services for identified children with special health needs registered in school programs and to improve access to these services.
Saskatchewan					
Manitoba United Referral and Intake System Diabetes Questions	Not stated	Not delegated to school staff. Must be administered by parent or a RN	Not stated	Registered Nurse	URIS appears to be similar to BC's inter-ministerial protocols and/or NSS Not clear if the RN is with URIS or from somewhere else
Ontario (Halton)	Supervise student	Parents or students	Not given by school	Not stated	Ultimate responsibility for

Province/Territory	Blood Glucose	Insulin	Glucagon	Training/	Comments
	Monitoring	Administration	Administration	monitoring/	
				supervision of	
				delegated tasks	
Diabetes Management:	in BGM	administer insulin	staff		diabetes management rests
A Protocol for Schools					with the family and the child.
Ministry of Education					School staff will call 911 in
2008					an emergency (will not
0	Destanted	Destanted	Destanted		administer fast acting sugar)
Quebec	Designated,	Designated,	Designated,	School nurse	Parents are primarily
Protocole d Intervention	voluntary school	voluntary school	voluntary school	ensures training is	responsible for the
	start supervise of	start supervise of	Stan auminister	completed. Not	modication for their child
sociaux lupo 2011		administration	Glucagoli	training or ovtont	Student's health condition
		auministration		or monitoring	must stable
				or monitoring	Nurses in/assigned to
					schools have specific duties
Nova Scotia Guidelines	Designated	Parents make	Not clear – stated	Health care	Training, supervision and
for Supporting Students	school personnel	arrangements for	as a parent	professionals train.	monitoring support is based
with TID in Schools	conduct BGM	insulin	responsibility but	supervise and	on an inter-agency
Nova Scotia Education		administration	schools are	monitor	agreement between the SD
November 2010			expected to		and HA.
			support parents in		
			order that insulin		
			be given when the		
			parent is not		
			available		
New Brunswick	Designated	Designated school	Designated, school	It is recommended	The provision of health
	school personnel	personnel can	staff administer	that a trained	support services is the
	can supervise or	supervise the	Glucagon if it is	health	ongoing responsibility of the
	conduct BGM	student in	prescribed in the	professional, such	parent.
		calculating and	student's plan	as a Diabetic	
		administering		Educator or	
		Insulin		Physician provide	

Province/Territory	Blood Glucose Monitoring	Insulin Administration	Glucagon Administration	Training/ monitoring/ supervision of	Comments
				delegated tasks	
				Level 11 training to designated school personnel	
NFLD/Labrador					
Yukon Policy: Administration of Medication to Students Yukon Education November 205 North West Territories	Not stated	Not stated	Not stated	Not stated	Policy covers medication administration in general
Nunavut					
Canadian Diabetic Association Kids with diabetes in your care	School personnel are not required to do BGM but can assist or supervise	Family and students	School personnel should be trained to administer, especially if EMS not guaranteed to arrive within 20 minutes	Not stated	

### Horn, Elizabeth M CITZ:EX

From: Sent: To: Subject: Allen, Roderick EDUC:EX Friday, September 14, 2012 4:10 PM Gibbons, Lenore EDUC:EX Re: Risk Management response

Very helpful. Thanks

-- Rod Allen Superintendent of Learning and Achievement Learning Division BC Ministry of Education 250-213-3000



BC'S EDUCATION PLAN ON THE WEB: <u>WWW.BCEDPLAN.CA</u> ON TWITTER: @BCEDPLAN

From: <Gibbons>, "Lenore EDUC:EX" <<u>Lenore.Gibbons@gov.bc.ca</u>>
Date: Friday, 14 September, 2012 1:23 PM
To: Rod Allen <<u>roderick.allen@gov.bc.ca</u>>
Subject: Risk Management response

Rod, Andrew Green in risk Managements

S. 13

S. 13

## Lenore Gíbbons

Coordinator-Special Education Learning Division Ministry of Education phone 250-886-2083 fax 250-387-6315

## BC's EDUCATION PLAN

ON THE WEB:WWW.BCEDPLAN.CA ON TWITTER: @BCEDPLAN

## ReAgenda for today's meeting

Friday, May 18, 2012 9:58 AM

Subject	Agenda for today's meeting
From	Fuller, Anne MCF:EX
То	Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Henson, Carolyn D HLTH:EX; Stevanovic, Aleksandra MCF:EX
Sent	Friday, May 18, 2012 9:09 AM

Hi everyone. Here are some suggested agenda items for today's call:

Update on changes to wording in NSS policy Framework Draft Purpose and intended audience Sections outlined – any missing, any changes needed to basic organization Content drafted to date – discussion Leads for next steps

Anne Fuller Provincial Consultant - FASD and Nursing Support Services Children and Youth with Special Needs Policy Ministry of Children and Family Development Victoria BC Phone: (250) 387-5947 Cell: (250) 588-4458

S. 16, S. 13

## RE: Next working group meeting on insulin administration

Thursday, January 5, 2012 4:02 PM

Subject	RE: Next working group meeting on insulin administration
From	Fuller, Anne MCF:EX
То	Fuller, Anne MCF:EX; Wallace, La uren HLTH:EX; Ste vanovic, Aleksandra MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Eligh, Connie MCF:EX
Sent	Wednesday, December 28, 2011 3:44 PM
Attachment s	NSS info re insulin ad PHO

Sorry, I didn't add the e-mail notes. Here they are:

From: Fuller, Anne MCF:EX Sent: Wednesday, December 28, 2011 3:38 PM To: Wallace, Lauren HLTH:EX; Stevanovic, Aleksandra MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Eligh, Connie MCF:EX Subject: Next working group meeting on insulin administration

Hello everyone	S. 22
S. 22	S. 13

S. 13

I will be sending out a meeting invitation soon...looks like the second week of January might work. Hope to talk with you soon.

Anne Fuller Provincial Consultant - FASD and Nursing Support Services Children and Youth with Special Needs Policy Ministry of Children and Family Development Victoria BC Phone: (250) 387-5947 Cell: (250) 588-4458

From:	Gibbons, Lenore EDUC:EX
Sent:	Monday, December 10, 2012 1:33 PM
То:	Stevanovic, Aleksandra MCF:EX; Henson, Carolyn D HLTH:EX; Lieberman, Audrey JAG:EX; Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Martin, Cheryl HLTH:EX; Standeven, Bill J EDUC:EX; Thompson, Donna M MCF:EX; Wallace, Lauren HLTH:EX
Subject:	RE: Next meeting for the Insulin Working Group

I don't anticipate a problem getting my ADM to approve fairly quickly.

## Lenore Gibbons

Coordinator-Special Education Learning Division Ministry of Education phone 250-886-2083 fax 250-387-6315

## BC's EDUCATION PLAN

ON THE WEB: WWW.BCEDPLAN.CA ON TWITTER: @BCEDPLAN

From: Stevanovic, Aleksandra MCF:EX
Sent: Monday, December 10, 2012 1:28 PM
To: Henson, Carolyn D HLTH:EX; Lieberman, Audrey JAG:EX; Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Martin, Cheryl HLTH:EX; Standeven, Bill J EDUC:EX; Thompson, Donna M MCF:EX; Wallace, Lauren HLTH:EX
Subject: RE: Next meeting for the Insulin Working Group

S. 14, S. 13

Pages 23 through 24 redacted for the following reasons: S. 14

From:	Egilson, Michael HLTH:EX
Sent:	Thursday, October 18, 2012 2:47 PM
То:	Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX;
	Stevanovic, Aleksandra MCF:EX; Wallace, Lauren HLTH:EX
Subject:	RE: Insulin Working Group - next steps

S. 13

### Regards

### Michael Egilson

Manager Child & Youth Health Healthy Women, Children and Youth Secretariat | Population and Public Health Division | Ministry of Health Ph: 250.952.2111 | 4-2, 1515 Blanshard St. Victoria, BC V8W 3C8 Pages 26 through 28 redacted for the following reasons: s. 14

## Pump info

Monday, August 15, 2011 9:11 AM

> From: Sent:

To: Subject:

#### Gibbons, Lenore EDUC:EX

Giyini, Keva WCF:EX	
Friday, August 12, 2011 2:17 PM	
Gibbons, Lenore EDUC:EX; Kennedy, Susan E	EDUC:EX
FW: Followup from Aug 5. mtg re. Insulin Admi	inistration

Keeping you in the loop also.

Keva Glynn | Executive Director, Early Years and Special Needs Policy Ministry of Children and Family Development Office 250.387.9714 | <u>keva.glynn@gov.bc.ca</u>

From: Henry, Effie HLTH:EX Sent: Friday, August 12, 2011 1:45 PM To: Mjolsness, Randi L MCF:EX; Glynn, Keva MCF:EX Cc: Geber, Joan HLTH:EX; McLaughlin, Sara HLTH:EX Subject: Followup from Aug 5. mtg re. Insulin Administration

Below is some of the info I committed in get in follow-up of last week's call:

#### Agreements for Parents re: use of pumps:

- Children who receive insulin pumps through Pharmacare are required to sign a "Patient/Family Agreement for an Insulin Pump" form (attached). One of the items parents must agree to is:
  - "If the Patient is a younger child, you acknowledge that school and daycare personnel will not
    operate the pump. You will have a plan for pump operation when the Patient is out of your care
    and you will be available at all times in case there is a problem."
- Prevalence/Incidence of insulin pumps for children:
  - According to Dr. Dan Metzger at BC Children's Hospital (BCCH), there are approximately 2,000 children in BC with diabetes, and BCCH sees about 1,000 of them. Of those 1,000, 1/3 are on insulin pumps; Dr. Metzger estimates up to half of the 1,000 children who receive care elsewhere are on insulin pumps. Overall in BC, he estimates 30 to 40% are on insulin pumps. He said he would need more time to figure out how many are aged 5 to 8. He also mentioned that children aged 9 to 11 can also have difficulty with their pumps – it really depends on the child.
  - PharmaCare only has data for kids who get pumps covered by Pharmacare:

#### BC PharmaCare Insulin Pumps for Children

Date	Pumps	PharmaCare Paid Amount
Dec 2008 - Mar 2009	80	\$445,750
Apr 2009 - Mar 2010	343	\$1,789,834
Apr 2010 - Mar 2011	261	\$1,248,422

#### • Training:

- Parents and children: When children receive insulin pumps, they must read three information handouts and go through a checklist (attached). Everyone in the province uses these handouts created by BCCH. The parents and children attend a three-hour training session at BCCH, and a one-hour follow-up to start the pumping process.
  - These handouts state in two places that "for children who are too young to operate the pump themselves, parents need to understand that the school will not operate the pump, nor do any

carbohydrate calculations. Parents will have to come up with a plan for managing the pump while their child is at school or daycare..."

- The handouts reference a webpage called "Tips for Managing Insulin Pumps at School" (attached), which explains that: "support for insulin pumps varies widely across the provinces and parents should not expect their child's school to administer the pump."
- Pump-trainers: Pediatric nurses with specific diabetes training facilitate the three-hour training sessions, and one-hour follow-up with parents and children. They are paid by the pump companies.
- Online training: BCCH is currently developing an online training program for the Nursing Support Services nurses. Dr. Metzger estimates there is one nurse for approximately every 20 schools.
- Ease of use: Dr. Metzger says the pumps are very scientific, but easy for some (especially kids) and more difficult for others.



Patient-Family Pump Info #1.pdf Pump Info #2.pdf Pump Info #3.pdf Tips on Insulin Agreement for a... Pumps at Schoo...

We will send you any additional information we receive on prevalence later.

#### Effie Henry

Executive Director, Hospital and Provincial Services | Ministry of Health | 6-2, 1515 Blanshard St. | Victoria, BC V8W 3C8 | 250-952-1514



2

## PHO

Tuesday, January 3, 2012 8:43 AM

Subject	РНО
From	Wallace, Lauren HLTH:EX
То	Gibbons, Lenore EDUC:EX; Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Stevanovic, Aleksandra MCF:EX
Sent	Tuesday, November 22, 2011 4:35 PM

#### HI everyone,

Here's a summary of the input received from our Deputy Provincial Health Officer, Eric Young, on the insulin administration in schools work includes:

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Off to face the rain and wind! It's so gross out there.

Lauren Wallace Manager, Child & Youth Health | Healthy Women, Children & Youth Secretariat | Population and Public Health Division | Ministry of Health 250.952.2550 | Lauren.Wallace@gov.bc.ca

## Pediatric Diabetes Health Care Services in BC – Are we meeting national standards?

The number of cases of type 1 diabetes (T1D) will increase by 70% by the year 2020. Type 2 diabetes (T2D), a disease previously seen <u>only in adults</u>, is occurring in children and youth, many of whom are obese. Diabetes management must be optimized during childhood and adolescence to prevent diabetes-related complications and ensure the best possible long-term health outcomes.

The objective of this work was to describe the quality of pediatric diabetes health services in BC by assessing adherence to national clinical practice guidelines (CPG).

**METHODS**: Four categories of adherence to CPGs were defined:

**Optimal** – 3 MSP visits and 3 A1c tests/yr; appropriate screening tests, 1 glucagon Rx

**Good** – 2 MSP visits and 2 A1c tests/yr; appropriate screening tests

Minimal - 2 MSP visits and 2 A1c tests/yr

Poor - <2 MSP visits and <2 A1c tests/yr

# Those receiving optimal/good care were considered "at goal" for adherence to CPG.

A population-level sample of individuals diagnosed with diabetes (either T1D or T2D) <u>at</u> <u><20 years of age</u> was obtained from linked administrative health databases through the application of a validated diabetes case-finding definition and diabetes-differentiating algorithm.

### **RESULTS:**

### **TYPE 1 DIABETES:**

The majority (54%) of person-years with T1D had poor adherence to CPG:



Only 16% of young adults (20-24 years) were at goal for adherence to CPG:



The proportion of person-years at goal varied across Health Service Delivery Areas and Health Authorities (Figure 1):

#### Figure 1. Pediatric Type 1 Diabetes in British Columbia

Proportion at Goal & Age-Standardized Incidence Rates Five-Year Aggregate (2002/03 - 2006/07) By Residence of the Patient (Health Service Delivery Areas)



Coastal Health Authorities were 40% and 52% less likely to be at goal for adherence to CPG, respectively.

Adherence to CPG for pediatric T1D decreased as years from diagnosis increased:

### Pediatric Diabetes Health Care Services in BC – Are we meeting national standards?



 Individuals 4-years post diagnosis of T1D were <u>78% less likely</u> to be at goal compared to the year they were diagnosed

50% of patients with T1D seen by a specialist only or specialist and GP (shared model) were at goal for adherence to CPG.



### **TYPE 2 DIABETES:**

The majority (68%) of person-years with T2D had poor adherence to CPG.



### **CONCLUSIONS AND NEXT STEPS**

- Children and youth with diabetes living in BC <u>do not</u> receive health services that meet national and international standards
- Waning physician/patient vigilance may contribute to decreasing adherence to CPG over time
- Adolescents and young adults are a particularly vulnerable population
- A shared care model achieves similar adherence to CPG as seeing specialists only for diabetes care
- More research is needed to better understand the facilitators and barriers to adhering to CPG for health care professionals and patients and their families
- Innovative clinical initiatives (i.e. transition clinics) that engage across diverse health providers (i.e. pharmacists, laboratories) should be explored to optimize health services for children and youth with diabetes

The proportion of person-years with T2D at goal for adherence to CPG was lowest in individuals >15 years of age.



Proportion of person-years at goal for adherence to CPG

Adherence to CPG for pediatric T2D decreased as years from diagnosis increased.



Similar to T1D, 50% of patients with T2D seen by a specialist or specialist and GP (shared model) were at goal for adherence to CPG.

#### **Proportion at goal**



Pages 34 through 51 redacted for the following reasons: s. 13

## Oct 10, phone meeting

Wednesday, October 10, 2012 9:09 AM

Health; Micheal, Lauren MCFD; Anne, Leah, Aleks Ed; Lenore

No updates about the tribunal.

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## PAB INFORMATION REQUEST – August 26, 2010

RE: Students requiring support with insulin pumps or pens

- Over the past few years, there has been an increase in the number of families with young school-aged children requesting insulin to be administered in the school setting via insulin pump or insulin pen.
- Parents of students who are unable to administer insulin, by either pen or pump, are responsible for arranging for this task to be done during school hours, where necessary. To negate the need for administration of an insulin bolus during the day, many parents of children on insulin pumps choose to provide a low carbohydrate snack for their child.
- The Ministry for Children and Family Development and Nursing Support Services (NSS), the Ministry of Education, VIHA, the BC Children's Hospital, and College of Registered Nurses of BC, are working together to review and consider what may be involved in having non-regulated care providers (i.e. aides in schools) adjusting insulin pumps for children while they are at school.
- Currently, only parents and children themselves (once they are old enough or are able to do so on their own) operate/manage the pump at school.

Nursing Support Services (NSS) Coordinators provide training to school staff in the **supervision** of self-administration of an insulin dose via insulin pump or pen where the child/youth is independent in the psychomotor skills involved. There are, however, a limited number of NSS Coordinators who are knowledgeable, certified diabetes educators/trainers.

NSS is a provincial program funded by the Ministry of Children and Family Development. MCFD contracts with Health Authorities for the services of NSS Coordinators, who are experienced paediatric nurses. NSS Coordinators delegate certain tasks, which would typically be performed by nurses, to school caregivers in accordance with College of Registered Nurses of BC Practice Standards.

Currently, NSS policy does not allow for delegation of the **operation** of an insulin pump to school staff.

Administering insulin does carry a significant risk, and there is significant
potential for harm if a wrong dose is given. There are a number of issues that
need to be considered, including liability, staffing, workload, training, etc. MCFD
and the Ministry of Education continue to work to address these issues. VIHA has
been working with the Ministries in an advisory capacity.

- Some school districts (and on a case by case basis) have established local practices for supporting students but there is currently no single policy for all school districts within BC to address this issue.
- Since January 2010, a full cross-ministry policy review (MCFD and MEd) has been underway to determine if a change in practice is feasible.

This review has involved consultation with and discussion among stakeholders – the College of Registered Nurses of BC (CRNBC), Nurse Clinicians from BCCH and VIHA diabetes clinics, representatives of NSS Coordinators and Supervisors, the BC Principals and Vice Principals Association (BCPVPA), and the BC Council of Administrators for Special Education (BC CASE) – to identify resources, guidelines, training, and monitoring needed to make practice consistent throughout the province, and identify factors that must be considered in safe delegation of insulin administration.

• A jurisdictional review of related policies/practices in Canada was undertaken by MCFD. The review revealed:

there have been no Canadian policies found to date that explicitly allow for the administration of insulin in the school or child care setting the delegation of glucagon in BC is individually considered in situations where hypoglycaemic episodes are common for a child or where timely access to emergency response is not available one NSS Coordinator (a Certified Diabetes Educator) has successfully delegated insulin administration to school staff in BC's Comox Valley one jurisdiction in the UK is routinely delegating insulin administration to school staff. In this case, it is Diabetes Educators who are delegating, and they are available by cell phone to offer support

 A meeting is to be held on September 29<sup>th</sup> with senior staff from the MEd and MCFD to decide on next steps. A more fulsome discussion paper is in the early stages of development. If a decision is made to further explore a policy change, a risk assessment has been suggested by the Ministry of Education and a cost analysis will be beneficial.

NOTE: Two BC families have been in regular contact with MCFD and MEd about this issue. They are concerned that their children, who have Type 1 Diabetes, will not be able to have his/her insulin pump adjusted at school by anyone other than them. One of the families is pressing for a revision to school district policy that will allow someone at the school to adjust insulin pumps for kids with T1D.

## NSS info re: insulin administration is schools

Tuesday, January 3, 2012 8:43 AM

Subject	NSS info re: insulin administration is schools
From	Dobell, Leah MCF:EX
То	Fuller, Anne MCF:EX; Eligh, Connie MCF:EX; Gibbons, Lenore EDUC:EX; Wallace, Lauren HLTH:EX
Cc	Stevanovic, Aleksandra MCF:EX; Lalani, Arif MCF:EX
Sent	Monday, November 28, 2011 11:09 AM

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Diabetes in schools 11 Page 1

Thanks!

L.

Leah Dobell, RN, BSN | Manager of Operations Nursing Support Services Children and Youth with Special Needs Ministry of Children and Family Development 2nd Floor - 940 Blanshard St. |Victoria, BC | V8W 9S5 Email | leah.dobell@gov.bc.ca Telephone | 250-216-0408 Fax | 250-356-2159

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Pages 57 through 58 redacted for the following reasons: S. 13, S. 17

# Gibbons, Lenore EDUC:EX

 From:
 Dobell, Leah MCF:EX

 Sent:
 Monday, November 28, 2011 11:10 AM

 To:
 Fuller, Anne MCF:EX; Eligh, Connie MCF:EX; Gibbons, Lenore EDUC:EX; Wallace, Lauren HLTH:EX

 Cc:
 Stevanovic, Aleksandra MCF:EX; Lalani, Arif MCF:EX

 Subject:
 NSS info re: insulin administration is schools

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 Finally, I'm bringing Connie Eligh back into the loop regarding these discussions.
 S. 22

 S. 22
 ihe has been involved in NSS for many years, both as a NSS Coordinator and at Provincial Office. Connie will be

 S. 22
 S. 22

 continue to include her in our e-mail communication and any teleconferences.

Thanks!

L.

Leah Dobell, RN, BSN |Manager of Operations Nursing Support Services Children and Youth with Special Needs Ministry of Children and Family Development 2nd Floor – 940 Blanshard St. |Victoria, BC |V8W 955

#### Email | leah.dobell@gov.bc.ca

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# Nov 8 Wallace

Thursday, November 10, 2011 12:03 PM

Gibbons, Lenore EDUC:EX

From: Sent: To: Subject:	Wallace, Lauren HLTH:EX Tuesday, November 8, 2011 10:27 AM Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX FW: Early Settlement Meeting- Insulin in Schools
Hi Everyone,	
	S. 14

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Lauren Wallace Manager, Child & Youth Health | Healthy Women, Children & Youth Secretariat | Population and Public Health Division | Ministry of Health 250.952.2550 | Lauren.Wallace@gov.bc.ca

From: Fuller, Anne MCF:EX Sent: November 7, 2011 2:01 PM To: Wallace, Lauren HLTH:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX Subject: RE: Early Settlement Meeting- Insulin in Schools

 Hi. I have tracked some comments and changes.
 S. 22

 S. 22
 but shall I book another meeting with all of us for next week or after the tribunal meeting?

From: Dobell, Leah MCF:EX Sent: Tuesday, November 1, 2011 12:15 PM To: Fuller, Anne MCF:EX; Gibbons, Lenore EDUC:EX; Wallace, Lauren HLTH:EX Subject: FW: insulin admin...again!!

#### Hi All,

FY1...doesn't look like we're going to get any easy answers regarding the necessity of intensive insulin regimes. I've also attached a response from Heather Nichol, the Clinical Nurse Specialist for Diabetes at BCCH, which includes responses from Cristina Pepe, Diabetes Clinic Nurse.

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S. 13



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Hope that a little bit clarifies things?

Dan

From: Dobell, Leah MCF:EX [Leah.Dobell@gov.bc.ca] Sent: October 31, 2011 4:10 PM To: Metzger Daniel; Pepe, Cristina; Herrmann, Sharleen Subject: RE: insulin admin...again!!

Thanks Dan,

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#### Thanks!

Leah

Leah Dobell, RN, BSN | Manager of Operations Nursing Support Services Children and Youth with Special Needs Ministry of Children and Family Development 2nd Floor - 940 Blanshard St. Victoria, BC V8W 955 Email | leah.dobell@gov.bc.ca

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From: Metzger Daniel [mailto:dmetzger@cw.bc.ca] Sent: Mon, October 31, 2011 3:28 PM To: Pepe, Cristina; Dobell, Leah MCF:EX; Herrmann, Sharleen Subject: RE: insulin admin...again!!

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-----Original Message-----From: Pepe, Cristina Sent: Monday, October 31, 2011 10:14 AM To: 'Dobell, Leah MCF:EX'; Herrmann, Sharleen Cc: Metzger Daniel Subject: RE: insulin admin...again!!

Hi Leah

I would suggest the place to start is to do a literature review and see what you find. I think the group will have to formulate their definition of 'necessary', since once you start providing a service, everyone will be 'necessary'. In terms of an individual, I will ask Dan if he has any ideas re how to proceed. Ciao, Cristina

Cristina Pepe RN BSN CDE Diabetes Nurse Clinician BC Children's Hospital (604) 875-2345 ext 7925 cpepe@cw.bc.ca

From: Dobell, Leah MCF:EX [mailto:Leah.Dobell@gov.bc.ca] Sent: Monday, October 31, 2011 9:39 AM To: Herrmann, Sharleen; Pepe, Cristina Subject: insulin admin...again!!

Hi Sharleen and Cristina,

The interministerial group looking at the issue of insulin administration in schools is really feeling we need a better understanding of how necessary S. 13

S. 13

S. 13 Do you have any suggestions for trying to get some sort of a consensus opinion from BC Pediatric Endocrinologists, or is there an individual who might be considered a lead? If the two of you have any time to talk over the next couple of days, that would be great. <sup>(2)</sup>

Happy Halloween! Leah

Leah Dobell, RN, BSN | Manager of Operations

Nursing Support Services Children and Youth with Special Needs Ministry of Children and Family Development

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# NB Ministry of Ed

Monday, May 28, 2012 1:35 PM





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**Medication services** includes administration of non-prescription medication such as cough syrup, eye drops or pain reliever, and medication prescribed by a physician such as an antibiotic, or an inhalant. Services in this category are temporary and require no training to deliver. In cases where the administration of medication is needed on a longer-term basis and requires training or is related to a condition that requires a management plan, this will be considered to be an **essential routine service**.

School personnel, as defined in the <u>Education Act</u>, includes: superintendents, directors of education and other administrative and supervisory personnel; school bus drivers; building maintenance personnel including custodians; secretaries and clerks; teachers; persons other than teachers engaged to assist in the delivery of programs and services to students; and other persons engaged in support areas such as social services, health services, psychology and guidance.

#### 4.0 LEGAL AUTHORITY

Education Act, sections

6 The Minister ...

- (a) shall establish educational goals and standards and service goals and standards ...
- (b) may prescribe or approve
  - (i) instructional organization, programs, services and courses, including special education programs and services, and evaluation procedures for such instructional organization, programs, services and courses, including special education programs and services,
  - (ii) pilot, experimental and summer programs, services and courses, including special education programs and services ...
- (b.2) may establish provincial policies and guidelines related to public education within the scope of this Act ...

12(4) Where an exceptional pupil is not able to receive a special education program or service in a school due to

- (a) fragile health, hospitalization or convalescence, or
- (b) a condition or need which requires a level of care that cannot be provided effectively in a school setting,

the superintendent concerned may deliver the program or service in the pupil's home or other alternative setting.

13(1) In support of the learning success of his or her child and the learning environment at the school, a parent is expected to ...

(d) ensure the basic needs of his or her child are met.

### Brunswick DEPARTMENT OF EDUCATION

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27(1) The duties of a teacher employed in a school include ... (e) attending to the health and well-being of each pupil.

28(2) The duties of a principal include ...(c) ensuring that reasonable steps are taken to create and maintain a safe, positive and effective learning environment.

#### 5.0 GOALS / PRINCIPLES

- 5.1 The <u>Education Act</u> ensures that all school-aged children have access to free school privileges. School-aged children should be provided with such essential health support services as are required during school hours and can be delivered in the school environment.
- 5.2 The provision of health support services is the ongoing responsibility of the parent. Consequently, in requesting the assistance of school personnel in the provision of these services, parents are temporarily delegating limited authority to the personnel of the public education system, for a particular purpose, rather than relinquishing any part of their parental responsibility.
- **5.3** School personnel and others entrusted with the supervision of students have a common law duty of care to assist students during medical emergencies, to the extent that is reasonable for persons without medical training.

#### 6.0 REQUIREMENTS / STANDARDS

#### 6.1 General

Responsibilities of Parent	Responsibilities of Superintendent/ Principal
Parents whose children require health	
support services shall:	Student Data Collection Form
	The superintendent shall ensure the medical
Minimize school involvement	information section of the Student Data
(a) take all reasonable measures to meet the	Collection Form template (Appendix A), is
health/medical needs of their child outside	included in student registration forms
of school hours. When this is not	developed by schools and sent to parents at
possible, parents shall make every effort	the beginning of each school year.
to cooperate with and minimize the	
involvement of school personnel in the	Medications
delivery of health support services;	No medications, over-the-counter or
	otherwise, shall be administered by school
Inform in writing	personnel without a written request signed by
(b) inform the school in writing of any health	a parent.
condition that has the potential to require	No. 4
action by school personnel and to ensure	No teacher shall be required to administer
the school is provided with any new,	routine injections as part of his/her regular
relevant information in writing. This	duties.



### Page 4 of 14

Responsibilities of Parent	Responsibilities of Superintendent/ Principal
<ul> <li>includes changes in symptoms, medication or management of the condition;</li> <li>Complete forms <ul> <li>(c) return to the school any form required under this policy, accurately completed and signed;</li> </ul> </li> <li>Contact <ul> <li>(d) ensure the parent, or another person authorized to act on the parent's behalf, can be reached to provide direction and/or can pick up the student should, in the opinion of school personnel, the student's condition require this;</li> </ul></li></ul>	Notwithstanding this, school personnel shall provide assistance in the case of medical emergencies, to the extent of their capability and the means available to them. <b>Plans and forms</b> Parents whose children require essential routine services or planning for emergency services shall be provided with a copy of this policy and the applicable forms.
Provide materials (e) provide any materials required to meet the health needs of their child; and	
Costs (f) cover any costs incurred by the school associated with medical treatment including the cost of transportation by ambulance should this be required.	



Responsibilities of Parent	Responsibilities of Superintendent/ Principal
<ul> <li>Parents requesting school personnel to administer medication or supervise the child's self-administering of medication shall:</li> <li>Inform in writing <ul> <li>(a) make their request in writing, including:</li> </ul> </li> <li>1. an explanation of the student's condition;</li> <li>2. the care requested (i.e. administering, assisting, supervising or reminding only); and</li> <li>3. instructions that indicate clearly: <ul> <li>i. the name of the medication,</li> <li>ii. dosage,</li> <li>iii. timing/frequency (when or how often, e.g., please give 1 teaspoon cough syrup at 11:30, or remind child to use inhalant pump around 2:00). If no time is indicated, specify how the school will know when to administer the medication,</li> <li>iv. method of administration (e.g. to be taken with food or on an empty stomach), and</li> <li>v. for prescription medications, the doctor's name and phone number, and any significant side-effects of which school personnel should be aware:</li> </ul> </li> </ul>	<ul> <li>The principal shall ensure:</li> <li>Complete Medication Log <ul> <li>(a) the Medication Log (Appendix B) is completed and the parent's written request is attached;</li> </ul> </li> <li>Maintenance of Medication Log <ul> <li>(b) once the requested service is completed, the Medication Log (Appendix B) is placed in the student's file; and</li> </ul> </li> <li>Appropriate precautions <ul> <li>(c) adequate precautions are taken for the safe storing of medications, respecting the particular storage requirements of the medication.</li> </ul> </li> </ul>
<ul> <li>Provide medication</li> <li>(b) provide a sufficient supply of medication in its original container, identified with the student's name. Parents must provide "bubble packs/blister packs" and other packaging that will assist schools to provide the correct dosage and prevent sharing of medication;</li> <li>Verify expiration</li> <li>(c) verify the expiration date of medication;</li> </ul>	

# Brunswick DEPARTMENT OF EDUCATION

### POLICY 704

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Responsibilities of Parent	Responsibilities of Superintendent/ Principal
<ul> <li>Safe transport and disposal</li> <li>(d) take appropriate measures to ensure safe transportation of the medication and assume responsibility for disposal of items requiring special precautions such as syringes, sharps and expired EpiPens<sup>®</sup>;</li> </ul>	
<ul> <li>Essential Routine Services and Emergency Plan Form</li> <li>(e) when students require long-term medication to manage a medical condition, parents shall complete the Essential Routine Services and Emergency Plan Form (Appendix C) to ensure school personnel have all the necessary information; and</li> </ul>	
<ul> <li>Inform school</li> <li>(f) parents shall inform the school whenever their child is bringing medication to school.</li> </ul>	



ibilities of Superintendent/
pal shall ensure:
lan
rent is provided an opportunity to with designated staff, prior to the ning of each school year as soon as ble to develop/update a written ment on the service to be provided the parent's, school's and student's appropriate) respective roles. The <i>tial Routine Services and</i> gency Plan Form (Appendix C) is to mpleted and signed by the parent, incipal, the student if 16 years old or and an appropriate health care ssional;
hough the Essential Routine and Emergency Plan Form (C) must be reviewed with parents the health care professional's is only required initially, and if the ents of the service requested have
raining ent training is provided at the ning of the school year to all ns who require it (e.g., bus drivers), propriate to the particular health ion and services to be provided. Ing shall also be provided during the I year, as needed, to any person ill have responsibility for the care of udent. Efforts shall be made to e the parents in the training. en a student requires ongoing n, this is considered an essential prvice. The Medication Log form
e rei



Responsibilities of Parent	Responsibilities of Superintendent/ Principal
In cases where a student has a condition that may result in a life-threatening situation, the parent shall: Make a plan (a) meet with staff designated by the principal, prior to the beginning of each school year, or as soon as possible, to develop/update a written agreement on the procedure to be followed in the event of a medical emergency, describing the parent's and school's respective roles (and the student's when appropriate). This information is to be recorded on Part III of the <i>Essential Routine Services and Emergency Plan Form</i> (Appendix C); Provide medication (b) ensure any required medications are appropriately labelled, are not expired, are provided in sufficient quantity and are on hand at the school and school-related functions at all times; Note: Parents should be aware that, in some areas of the province EpiPens <sup>®</sup> (epinephrine) are not available on ambulances. Depending on where the school is located, a child may require 3 or more EpiPens <sup>®</sup> to get to the nearest hospital; Medication management (c) if the medication needs to be on the student's person, ensure it is appropriately contained and managed; Provide medical ID (d) ensure the student wears a Medic Alert <sup>®</sup> bracelet or other suitable identification at all times; Attend training (e) attend the training provided for designated school personnel, so that the parent will be fully aware of the particular	<ul> <li>The principal shall ensure:</li> <li>Emergency plan for school <ul> <li>(a) there is a written plan for responding to medical emergencies which is regularly communicated to school personnel and any other persons who may be involved;</li> </ul> </li> <li>Emergency plan for outside school <ul> <li>(b) planning covers medical emergencies that may occur on school buses, special events at the school, field trips and coand extra-curricular events as well as in the normal school environment;</li> </ul> </li> <li>Train and communicate <ul> <li>(c) staff have the appropriate training for their respective roles in the emergency plan. This includes the provision of appropriate information to casual employees, including substitute teachers; and</li> </ul> </li> <li>Individual plans <ul> <li>(d) measures agreed to, described in Part III of the <i>Essential Routine Services and Emergency Plan Form</i> (Appendix C) of individual students, are put in place.</li> </ul></li></ul>



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Responsibilities of Parent	Responsibilities of Superintendent/ Principal
procedures being put into place; and	
Complete forms (f) in the case of life-threatening allergies, complete the <i>Extreme Allergy</i> <i>Management and Emergency Plan Form</i> (Appendix D) rather than the <i>Essential</i> <i>Routine Services and Emergency Plan</i>	

#### 6.5 Liability Protection

The Province of New Brunswick will indemnify and defend employees, members of the Parent School Support Committees and the District Education Councils, volunteers, and student teachers, in accordance with the principles and processes identified in Policy AD-3108 – <u>Personal Liability Protection</u> – New Brunswick Administration Manual.

#### 6.6 Specific Health Conditions

Note: This section contains additional requirements specific to certain health conditions. These are to be followed in the context of the previous sections of this policy.

#### 6.6.1 Life-Threatening Allergies – Risk of Anaphylactic Reaction

Responsibilities of Parent	Responsibilities of Superintendent/ Principal
Parents shall familiarize themselves with all sections of this policy and shall meet their	The principal shall ensure:
responsibilities as set out in this policy, as	Provide policy and forms
applicable.	<ul> <li>(a) parents are provided with a copy of this policy and the applicable forms;</li> </ul>
	Make a plan
	<ul> <li>(b) the parent, and student when appropriate, are provided with an opportunity to meet with designated staff, prior to the beginning of each school year or as soon as possible to develop/update the <i>Extreme Allergy Management and Emergency Plan</i> (Appendix D). This shall include a written agreement on the procedure to be followed in the event of a medical emergency, describing the parent's, school's and student's (when</li> </ul>



Responsibilities of Parent	Responsibilities of Superintendent/ Principal
	appropriate) respective roles. The Extreme Allergy Management and Emergency Plan (Appendix D) is to be signed by the parent, the principal, the student if 16 years old or older, and the student's physician;
	Note: Although the Extreme Allergy Management and Emergency Plan Form (Appendix D) must be reviewed with parents annually, the physician's signature is only required initially, and if the requirements of the service requested have changed.
	<ul> <li>Provide training</li> <li>(c) a training session on anaphylactic shock is held at the beginning of each school year. Efforts shall be made to include the parents in the training. The Allergy/ Asthma Information Association (AAIA) Anaphylaxis Reference Kit must be used for the training and the session must cover EpiPen<sup>®</sup> administration and the emergency plan to be put in place. Training must be delivered to all staff, including the principal, teachers, school day care personnel, bus drivers, custodians, lunchroom supervisors, resource staff, and any casual employees, including substitute teachers present in the school at the time of the training session;</li> </ul>
	Casual employees (d) measures are in place to help ensure student safety when the student is under the supervision of an untrained casual employee, including a substitute teacher.
	Casual employees shall be provided with written instructions concerning the care of the student.
	Where appropriate, a trained member of the school personnel who will be able to intervene rapidly in the case of



Responsibilities of Parent	Responsibilities of Superintendent/ Principal
	anaphylactic shock will be designated to assist;
	<ul> <li>Medication management</li> <li>(e) that the medication, such as an EpiPen<sup>®</sup>, is stored and handled according to the student's <i>Extreme Allergy Management and Emergency Plan Form</i> (Appendix D);</li> </ul>
	Limit allergens (f) in a school attended by a student with a life-threatening allergy, work towards creating:
	when it is possible to restrict the identified allergen (e.g. peanuts, nuts, fish and shellfish)
	<ul> <li>i. school buildings and school vehicles which are free of the substance(s) identified as placing the allergic student at risk of anaphylactic shock;</li> <li>ii. school practices that reduce the possibility of exposure to the substance(s) identified as causing anaphylactic shock, including desisting from using food containing the allergen for fundraising and for class projects and implementing special precautions when the student attends special events or field trips.</li> </ul>
	where the allergen is such that it CANNOT be restricted from being brought to school (e.g. milk and egg products)
	<ul> <li>i. classrooms used by the student(s) which are free of the substance(s) identified as placing the allergic student at risk of anaphylactic shock;</li> <li>ii. school practices that reduce the possibility of exposure to the substance(s) identified as causing anaphylactic shock;</li> <li>iii. a specific area within the cafeteria (or</li> </ul>



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Responsibilities of Parent	Responsibilities of Superintendent/ Principal
	Iunchroom) designated as allergen- free that is treated according to AAIA standards; and iv. special precautions on school vehicles and when the student attends special events or field trips and when food or other potential allergens are brought into the school or used for fund-raising or class projects.
	Letter to parents (g) a letter is sent annually to parents of all students in the school, advising them of health concerns and requesting co- operation ( <u>Appendix E-1</u> for products which it is possible to restrict such as peanuts, nuts, fish and shellfish; <u>Appendix E-2</u> for products which may be admitted to certain areas of the school such as milk and egg products);
	Communicate (h) that all concerned are informed and respect the established preventive measures at all times, understanding that it is not possible to ensure a 100% allergen-free environment.

#### 7.0 Guidelines / Recommendations

#### 7.1 Parent Non-Compliance

POLICY 704

- 7.1.1 Lack of Precautions for Own Child: In cases where the parent, despite notification, does not
  - provide care, medication or other items required for the health and safety of his/her child (e.g. an EpiPen<sup>®</sup>),
  - b. participate in developing an individual care plan with the school as necessary for the health and safety of the child,
  - c. complete required forms, or
  - d. provide up-to-date contact information

the principal is advised to send a letter to the parent:

POLICY 704		Page 13 of 14
	<ul> <li>notifying the parent that his/her actions may be placing the sedevelopment of the student at risk, according to subsection <i>Family Services Act</i>; and/or requesting the parent to sign-of the school has developed to care for the student, and/or</li> <li>requesting the parent to sign an acknowledgement that his/h compliance may impede the school's ability to adequately castudent (<i>Parent Letter – Non-Compliance</i>, <u>Appendix E-3</u>).</li> </ul>	security or 31(1) of the ff on any plan her lack of are for the
7.1.2	Lack of Precautions for Allergic Child: In cases where an all introduced into an area where it is prohibited, the principal should be a set of the principal set of the	ergen is ld:
	<ul> <li>ensure appropriate measures are in place to remove/restrict and see to the security of the allergic student;</li> <li>remind those responsible of the precautions to be taken reg allergen;</li> <li>when a student brings the specified allergen into an area wh prohibited, remind the student of the rules about the allerger if the incident is repeated, remind the student and the student writing, of the great risk to the allergic student and the precataken regarding the allergen;</li> <li>at a subsequent occurrence, send a letter informing the pare the seriousness of the risk, the school is obliged to remove the seriousness of the risk, the school is obliged to remove the life of a student;</li> <li>continued failure to take precautions regarding an allergen sin the same way as any other behaviour that threatens the life.</li> </ul>	t the substance arding the here it is n; nt's parent, in lutions to be ent that, due to the allergen or n order to protect should be treated fe of a student.
7.1.3	In cases where a parent of a child requiring service has an obje requirement stated in this policy or deemed necessary by the pr security of a student, the parent should be requested to sign the <i>Variance of Procedure Form</i> ( <u>Appendix F</u> ).	ction to a specific incipal for the Request for
3.0 DISTR	CT EDUCATION COUNCIL POLICY-MAKING	

#### 9.0 REFERENCES

Appendix A – <u>Student Data Collection Form</u> Appendix B – <u>Medication Log Form</u> Appendix C – <u>Essential Routine Services and Emergency Plan Form</u> Appendix D – <u>Extreme Allergy Management and Emergency Plan Form</u> Appendix <u>E-1</u>, <u>E-2</u> & <u>E-3</u> – Parent Letters Appendix F – <u>Request for Variance of Procedure Form</u>

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Policy 214 - Indemnification of Employees, District Education Council Members, Parent School Support Committee members, Volunteers and Student Teachers

Policy AD-3108 - Personal Liability Protection - New Brunswick Administration Manual

Canadian School Boards Association, <u>Anaphylaxis: A Handbook for School Boards</u>, September 2001.

Allergy/Asthma Information Association Anaphylaxis Reference Kit

#### 10.0 CONTACTS FOR MORE INFORMATION

Student Services – (506) 453-2155 Policy and Planning – (506) 453-3090

**ORIGINAL SIGNED BY** 

MINISTER

# September 29, 2011 Inter-ministerial Meeting regarding Insulin Administration in Schools Minutes (draft)

# Attendees

- MCFD
  - Arif Lalani (chair)
  - Aleksandra Stevanovich
  - Anne Fuller (recorder)
  - Leah Dobell
- MoE
  - Lenore Gibbons
  - Roderick Allen
- MoHs
  - o Nancy South
  - Katie Hill
  - Cheryl de Boer
  - o Lauren Wallace
  - Arlene Paton
- 1. Discussion Paper
  - A brief overview was provided of the paper and the options that were explored. Cost and policy implications were briefly outlined but an in-depth analysis was not possible given the time frame.
  - It was agreed that an urgent response was not required but that next steps need to be identified.
- 2. Scope of issue
  - Discussion followed about how many young children with T1D require assistance with multiple daily injections during the school day. BC Children's Hospital reports that there is a 3% rise per year of children diagnosed with T1D, with a disproportionate number of them below five years of age. Action: Leah will canvass the NSS Coordinators to get a sense of the scope of the issue (i.e. requests from parents for assistance).
  - There was discussion about the need to better understand the level of clinical consensus among endocrinologists concerning the need for multiple daily injections of insulin for young children. Action: Working group will contact Dr. Ahmed and Dr. Perry Kendall to further discuss.

- 3. Memorandum of Understanding
  - The option of supporting MOUs was discussed. It was seen as a mechanism to support locally-derived solutions. Challenges identified included how a provincial program such as NSS would be involved and the possibility of perception that a solution is not being sought.
  - Action: The working group was asked to further explore MOUs and how they could be supported with the development of provincial guidelines and what resources/training would need to be available.
- 4. Next Steps
  - Action items above with a follow-up meeting of the cross-ministry group in late October.

# August 24, 2011 Minutes

# Inter-ministerial Meeting regarding Insulin Administration in Schools

### Attendees

- MCFD
  - o Arif Lalani
  - o Aleksandra Stevanovich
  - o Gail North
  - o Anne Fuller
  - o Leah Dobell
- MoE
  - o Susan Kennedy
  - o Lenore Gibbons
- MoHs
  - o Heather Davidson
  - $\circ \quad \text{Joan Geber}$
  - Effie Henry (?)

# Introductions

### Discussion

S. 13

Pages 84 through 85 redacted for the following reasons: s. 13

# Ministerial Order 149/89

Thursday, November 24, 2011 4:32 PM

SUPPORT SERVICES FOR SCHOOLS ORDER
BC Ministry of Education
Governance and Legislation Branch E-93 August 5, 2011
Authority: School Act, sections 88(1) and 168 (2) (t)
Ministerial Order 149/89 (M149/89) Effectiv e
September 1, 1989
Order of the Minister of Education
Community health nurses in schools
1. Every board shall
(a) equip and maintain a room that can be used as a medical room in each school
within the district, and
(b) make that medical room available to the community health nurse assigned to the
school during scheduled and special visits.
Auditory systems
2. (1) Each board is responsible for referring any of its students who are hearing impaired to
the Ministry of Health for a needs assessment to determine if the student requires auditory
training equipment for classroom use.
(2) On request of a board, the minister shall loan to the board auditory training
equipment for each student who has been assessed under subsection (1) as needing the
equipment.
(3) The minister is responsible for routine maintenance of auditory training equipment
loaned to a board.
Speech and language services
3. A board of a school district shall provide speech and language therapy services for
students of school age who attend a school in the district and whose education is adversely
affected by oral communication difficulties.
Medical assessment
4. A board shall refer for medical assessment and subsequent referral for occupational or
physiotherapy consultation any students who have ongoing physical conditions or disabilities
serious enough to cause interference with the attainment of the goals of education.
Specialized health services
5. (1) If complex health procedures are carried out in schools, the board shall ensure that
staff designated to carry out these procedures have been trained, and are supervised, by
appropriate health professionals.
(2) For purposes of subsection (1) complex health procedures include but are not limited
to, gastrostomy care and tube feeding, administration of oxygen, catheterization and suctioning.
(3) School staff trained to carry out health procedures for a specific student shall not
<mark>perform those procedures on other students.</mark>
SUPPORT SERVICES FOR SCHOOLS ORDER
BC Ministry of Education
Governance and Legislation Branch E-94 July 1, 2011
Duty to report
6. On or before June 30, every superintendent of schools for a school district shall notify the
school medical officer for the school district of the name and location of each school in the
district and the projected enrollment for each school in the following school year.

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# Horn, Elizabeth M CITZ:EX

From:Gibbons, Lenore EDUC:EXSent:Friday, December 14, 2012 11:26 AMTo:Lieberman, Audrey JAG:EXSubject:FW:Attachments:Proposal for EP, December 2012.pdf; Meeting Minutes Dec. 7.docx

# Lenore Gíbbons

Coordinator-Special Education Learning Division Ministry of Education phone 250-886-2083 fax 250-387-6315

# BC's EDUCATION PLAN

ON THE WEB: WWW.BCEDPLAN.CA ON TWITTER: @BCEDPLAN

From: S. 22 Sent: Monday, December 10, 2012 11:42 PM To: Gibbons, Lenore EDUC:EX Cc: Sharon . Subject: School District 43 references to you in a letter and meeting

Hello Lenore,

I have also left you a voice-mail but am following up with an e-mail as well.

My name is S. 22 and my S. 22 is attending kindergarten at elementary school in S. 22 We have been trying to get an independent care plan for S. 22 to better manage S. 22 diabetes while at school as we believe, and medical evidence supports, that the current policies of the various ministries involved and NSS are unsafe.

It was never my intent to involve you in our ongoing dispute with school district 43 about the diabetic care they deem appropriate and safe fo  $g_{S.22}$  In fact I did not know who you were and asked the district to clarify your role in our recent meeting with them. In the attached letter to us from the district and the minutes they have provided from our recent meeting the have made specific references to you and your position on ministerial order 189-89: regarding specialized health service paragraph 5 (1). Please review the documents and comment as you deem appropriate on whether the district has represented your comments and opinion accurately.

Also on a different note, I would love to discuss the regional CASE meetings and the ongoing process of updating the standards of care for diabetic children while at school. It is my belief that type one diabetic children are the biggest stakeholders involved in this issue and that their voice expressed by parents should be heard during this process. I sincerely appreciate any efforts to raise the standards of care in this province to reflect the standards endorsed by the CDA and that are federal law in the U.S. and the U.K., specifically insulin

and glucagon administration by appropriate school staff.

I look forward to your response

S. 22

Page 89 redacted for the following reason: not responsive

- 4. Other steps:
  - Child Health BC: An update on the progress will be provided to Dr. Maureen O'Donnell. MCFD will follow-up
  - Government Communications and Public Engagement (GCPE): MCFD will be keeping their GCPE office informed of progress
- 5. Next Steps
  - Further edits to be made to SP document by Friday, May 25. Anne will book a
    conference call in case it is needed to further discuss but it is likely the changes can be
    managed by e-mail.
  - Ministries will brief their Directors/Executive Directors on progress, in particular the consultation plan.

Pages 91 through 95 redacted for the following reasons: s. 13

# Link to SPC

Tuesday, November 27, 2012 3:50 PM

Subject	Minutes from the last Insulin Administration Working Group and next steps
From	Fuller, Anne MCF:EX
То	Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Henson, Carolyn D HLTH:EX; Lieberman, Audrey JAG:EX; Martin, Cheryl HLTH:EX; Standeven, Bill J EDUC:EX; Stevanovic, Aleksandra MCF:EX; Thompson, Donna M MCF:EX; Wallace, Lauren HLTH:EX
Sent	Tuesday, November 27, 2012 3:43 PM

Hello. I have uploaded minutes from our last meeting held on November 22nd - see link below Although we did not discuss it in detail, it makes sense for us to develop a brief background document for ChildHealthBC so that they have a sense of the issue, the discussions to date, and the questions we have for them. If you agree, I will begin to generate this on the SP site and we can edit it via LiveMeeting on our next call. I will send out a meeting invitation shortly.

As we discussed, I am conducting another cross-jurisdictional scan - in particular how Ontario is utilizing Community Care nurses to give one bolus of insulin at lunch time to children at school. I will provide an update. We can also discuss the Terms of Reference for the ADM and Working Groups.

https://specialneeds.gov.bc.ca/insulin/Shared%20Documents/Forms/AllItems.aspx?RootFolder=% 2Finsulin%2FShared%20Documents%2FWorking%20Group%20Minutes&FolderCTID= 0x012000363B17B25ED9B94E9E516EE7634983B7&View={F17130BA-C8D7-424D-B27A-162474573F43}

Anne Fuller Provincial Consultant - FASD and Nursing Support Services Children and Youth with Special Needs Policy Ministry of Children and Family Development Victoria BC Phone: (250) 387-5947 Cell: (250) 588-4458

# Insulin Working Group - notes from April 11

Thursday, April 12, 2012 1:09 PM

Subject	Insulin Working Group - notes from April 11
From	Fuller, Anne MCF:EX
То	Gibbons, Lenore EDUC:EX; Steva novic, Aleksandra MCF:EX; Dobell, Leah MCF:EX; Henson, Carolyn D HLTH:EX
Sent	Wednesday, April 11, 2012 4:10 PM
Attachments	
	Minutes
_	Delegatio

Hello everyone. Here are some quick notes from today's call.	
Attendees: Lenore, Leah, Carolyn, & Anne. Aleks sent regrets	S. 22
S. 22	

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Inter-Ministry Protocols

All agreed that there is no logical place in the protocols in which to make a reference to insulin administration. It was seen as too specific given the scope of the protocols.

Next Steps

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Anne will schedule the next meeting to discuss a possible plan to develop the guidelines.

Anne Fuller Provincial Consultant - FASD and Nursing Support Services Children and Youth with Special Needs Policy Ministry of Children and Family Development Victoria BC Phone: (250) 387-5947 Cell: (250) 588-4458

# Insulin working group - next steps

Thursday, April 5, 2012 9:31 AM

Subject	Insulin working group - next steps
Date and Location	Thursday, April 5, 2012 10:00 AM - 11:00 AM, Conference cal S. 17 Conference S. 17
Attendees	Fuller, Anne MCF:EX; Wallace, La uren HLTH:EX; Gibbons, Lenore EDUC:EX; Dobell, Leah MCF:EX; Stevanovic, Aleksandra MCF:EX
Message	When: Thursday, April 5, 2012 10:00 AM-11:00 AM (GMT-08:00) Pacific Time (US & Canada). Where : Conference call S. 17 onferenc S. 17 Note : The GMT offset a bove does not reflect daylight saving time adjustments. *~*~*********************************

Link to Outlook item

Notes was a meeting last mon. Joan Gabar initiated. Joan Euston, Arif, alex

S. 13

Joan will connect W Maureen V'Donnell. Lo discuss. M.OD is interested in continued discussion

S. 13

Human rights tribunal has still not made a ruling.


# Insulin notes-Oct 18

Tuesday, October 18, 2011 10:36 AM

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Anne will contact Child Health BC and the provincial endocrinologist group to discuss the practise standards and see if we can get help with guidelines as a foundation.

- Look at notes from the meeting
- Summarize what the field has said in the surveys we did
- CHBC connection

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# **Cross-Ministry Insulin Administration Working Group**

## Terms of Reference January 7, 2013

# Introduction

Increasingly, children with Type 1 Diabetes (T1D) are being placed on intensive treatment regimes necessitating administration of insulin via an insulin pump or insulin pen during the school day. This creates challenges for families of young school-aged children who cannot yet administer their own insulin.

Insulin is a potentially dangerous medication, with significant risk of serious harm or death if an error is made. Ministerial Order 148/89 Support Services for Schools Order provides for the administration of specialized health services within school settings if, "staff designated to carry out these procedures have been trained, and are supervised, by appropriate health professionals." Finding a safe solution to the issue is further complicated by a lack of a consistent approach to diabetic management for young children while they are in school. There is no single program currently responsible for direct administration of insulin to students, delegation of the task to school staff, or providing training and supervision of school staff to provide injection of insulin via insulin pump or pen to students in schools.

# Purpose

The purpose of the Cross-Ministry Insulin Administration Working Group is to identify and recommend options to support insulin administration to young children with T1D during the school day. Considerations include safety issues, the development of guidelines, roles and responsibilities and an evaluation strategy.

# **Reporting Relationship**

The Working Group members assume responsibility for reporting-out to their respective Assistant Deputy Ministers (ADMs) on an as-required basis. ADMs consider options and make joint solutions and recommend linkages with other organisations and/or individuals as needed.

# Membership

Membership includes representatives from the Ministries of Health, Education and Children and Family Development.

## **Frequency of Meetings and Communication**

The Insulin Administration Working Group meets on an ad hoc basis to ensure progress and will exist for the length of time required to develop recommended approaches for consideration by senior officials.

Page 1 of 1

# **Insulin Administration Working Group**

Minutes – Oct. 10, 2012

### Present

Anne Fuller, MCFD (chair and minutes) Leah Dobell, MCFD Aleksandra Stevanovic, MCFD Lenore Gibbons, Education Lauren Wallace, MoH Michael Egilson, MoH

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4. Next Steps:

- Another meeting of the Insulin Working Group will be scheduled in 3 weeks' time. By then, it is anticipated the Ministries of Education and Health will have more clarity about next steps.
- MCFD reps voiced support for a meeting to be convened soon with the cross-ministry ADMs. All agreed.

### Present

Anne Fuller, MCFD (chair and minutes) Leah Dobell, MCFD Aleksandra Stevanovic, MCFD Lauren Wallace, MoH Carolyn Henson, MoH Audrey Lieberman, Justice Cheryl Martin, Health

### **Regrets:**

Bill Standeven, Education Donna Thompson, MCFD Lenore Gibbons, Education

- 1. Updates from MCFD
  - Aleks, Anne, and Leah reported on a briefing held with Executive Directors Arif Lalani and Joan Easton in early November
  - Arif and Joan were provided with a status update on the working group's accomplishments
  - It was agreed that another ADM meeting should be held to update them on current status and possible next steps
  - Also agreed that Child Health BC will be engaged to develop clinical guidelines on ways to support children with T1D that balances what is safe and appropriate in the school setting.
  - Terms of Reference for the ADM group and the Insulin Administration Working Group are to be developed as well as a PowerPoint presentation for the ADM meeting.
  - Action: Anne will draft initial ToRs and PowerPoint for input from group.
- 2. Update from Health
  - Cheryl Martin and Carolyn Henson lead a conference call with all Health Authority Child Health Leads on November 15<sup>th</sup>. It was also attended by representatives from School District 5 Southeast Kootenay and Ministries of Education and Children and Families. See notes attached.
  - Current practice is that no Pediatric Diabetes Clinic is able to delegate insulin administration to school staff due to extremely tight resources, scope of practice and the fact that some communities do not utilize diabetic clinics or access services in Alberta.

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- All agreed that clinical guidelines
  S. 13
  It was noted on the call tha
  S. 16
- 3. Meeting of ADMs
  - All agreed that ADMs should be brought together in the near future for a status update and confirm next steps.
  - Action: MCFD will coordinate the meeting preferably for sometime in December.
- 4. Child Health BC
  - All agreed to engage Child Health BC.
  - Action: The Working Group will generate a background document and questions for the group.

Next meeting: In next few weeks to review Terms of Reference, PowerPoint and document preparation and questions for Child Health BC.

S. 13

Page 105 redacted for the following reason: not response

# Insulin Administration Working Group Minutes – December 5, 2012

### Present

Regrets: none

Anne Fuller, MCFD (chair and minutes) Leah Dobell, MCFD Aleksandra Stevanovic, MCFD Lauren Wallace, MoH Carolyn Henson, MoH Audrey Lieberman, Justice Cheryl Martin, MoH Lenore Gibbons, Education Donna Thompson, MCFD

- 1. Minutes from Insulin Administration Working Group Oct. 10<sup>th</sup> and Nov. 22nd
  - Corrections made and posted on SP site.
- 2. Child Health BC

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- Ministry of Health representatives will arrange a planning meeting with Dr. Maureen O'Donnell and Mary Lou Mathews for early January. It was decided to not involve the clinical lead for BCCH Pediatric Clinic at this time.
- Members of the Working Group will be invited.
  - S. 13
- Action: Ministry of Health representatives will draft a letter, using some of the content from the background document currently on SP. For discussion at next Working Group meeting

3.

S. 16

4. Suite of health professionals to potentially provide support

S. 13

• Action: This work is in process and the group will be updated.

- 5. Incidence and prevalence
  - MoH staff are connecting with colleagues in epidemiology to obtain more accurate statistics of young children on intensive insulin regimes
  - Action: Updates at future meeting

Meeting adjourned at 10 AM.

Next meeting December 14, 2012 8:30 am - 10:00 am

Deferred items: Terms of Reference for ADM and Working Group

# Insulin Administration Working Group

Monday, October 29, 2012 10:01 AM

Subject	Insulin Administration Working Group			
Date and Location	Monday, October 29, 2012 10:00 AM - 11:30 AM, conference call S. 17 Participant Conference ID: S. 17			
Attendees	Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Steva novic, Aleksandra MCF:EX; Wallace, Lauren HLTH:EX; Egilson, Michael HLTH:EX; Thompson, Donna M MCF:EX; Lieberman, Audrey JAG:EX; Gibbons, Lenore EDUC:EX			
Message	When: Mon, October 29, 2012 10:00 AM-11:30 AM (GMT-08:00) Pacific Time (US & Canada).Where: conference caS. 17articipant ConferenceS. 17			
	Note : The GMT offset a bove does not reflect daylight saving time adjustments.			
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	Conference call dial- S. 17 Participant Confere			

### Link to Outlook item

#### Notes

S. 13

Diabetes educators - Anne and Leah- NSS coordinators are requesting multiple interventions over the course of the school day to make sure kids are in the target range all of the time but this is a significant level of care.

S. 13

Leah is in touch with NSS supervisors and managers. VIHA (Jasmine Tuff)

The issue is who would be providing the administration training. Health wants to have a larger conversation about what would be practical and safe.

What is clinical best practice in a school setting?

S. 13

S. 13

S. 13

- 1. 1. Discussion about who is available at a local level in health and regions.
- 2. 2. Need some clarity about guidelines from the clinical people and Maureen to mitigate expectations.

Want to engage CHBC formally and generate some questions. Provide clear guidelines to the school setting.

Ontario - nurse comes once a day. What do they base it on? What can be safely provided?

Leah-Parent call. The group of parents would like to meet with us. Should they come to make a presentation. To whom? Need to be heard.

S. 14

Lenore, Send Michael a couple names for the call. Michael will send a list of who is involved in the phone call. (Peter Molloy)

Still want to know what kinds of questions for Child Health BC.

Framework document is still on the table.

S. 13

Check with ADM- re update by the end of November. Will explore a date by email to save the date. See if they want to meet.

# Insulin administration working group

Thursday, January 12, 2012 9:29 AM

Jubject	Insulin administration working group			
Date and Location	Thursday, January 12, 2012 10:00 AM - 11:00 AM, Conference call			
Attendees	Fuller, Anne MCF:EX; Dobell, Leah MCF:EX; Gibbons, Lenore EDUC:EX; Eligh, Connie MCF:EX; Wallace, Lauren HLTH:EX; Stevanovic, Aleksandra MCF:EX			
Message	When: Thu, January 12, 2012 10:00 AM-11:00 AM (GMT-08:00) Pacific Time (US & Canada). Where: Conference call			
	Note : The GMT offset a bove does not reflect daylight saving time adjustments.			
	*~*~*~*~*~*~*			
	Revising meeting to a conference call			
	S. 17 Particinant Conferen S. 17			
	Agenda:			
	Agendu.			
	S. 14			
	S. 13			
	Lauren has not yet costed out for diabetes nurse educators to be trained. Anne will assist Lauren.			
	S. 13			
	If provincial guidelines are developed, MCFD/NSS are willing to participate in development of the guidelines.			
	Next stens: Need to get an idea from our directors a bout what next stens could be			
	Next steps. Need to get all deallothour directors about what next steps could be.			

Notes

Pages 111 through 117 redacted for the following reasons: S. 13

November 2012

## Background

- The treatment modality for young children with Type 1 Diabetes has changed in recent years and now reflects a preference for multiple daily injections (MDI) through a pen or continuous insulin infusion via an insulin pump. Both a literature review and discussions with clinical experts from BCCH and VIHA indicate that MDI and insulin pumps can lead to better control of blood glucose, decrease the frequency of wide swings in blood glucose levels and can have long term positive implications for children's health.
- The incidence of Type 1 diabetes (formerly known as juvenile onset diabetes) is increasing around the world. Approximately 2,200 children in BC (approximately .003 % of the 649366 [headcount] students enrolled in public and independent schools) receive insulin therapy1. 391 children aged 5 9 years old are prescribed insulin; however it is not possible to ascertain how many of those require insulin injections during the school day.
- Children are being diagnosed at a younger age and globally, there is an 11% increase per year for children under the age of 5 years.
- Advanced clinical knowledge of pediatric diabetes is necessary to be competent in the delegation and monitoring of insulin administration by UCPs. The task of insulin administration is clinically complex with the potential for serious harm if performed incorrectly.
- Because of the trend towards intensive insulin therapy, more parents are requesting that school staff be taught to administer insulin at lunchtime and occasionally at other times in the school day if their young child is not old enough to be independent. This trend is compounded by the fact that children attend all day kindergarten throughout the province and could also be impacted by the increased availability of insulin pumps.
- Many typically developing children are able to administer their own insulin with comprehensive supervision by school staff around the age of 6 or 7 years. Most children are able to administer insulin independently, or with minimal supervision, between 9 and 12 years of age.
- The Insulin Administration Working Group is aware of 8 instances where individual agreements between parents, school staff, medical professionals or other individuals have been arranged.

## Timeline

Early 2010: In depth policy discussions including a discussion guided by the CRNBC examining the four factors to be considered in safe delegation of a nursing task; client, environment, task, and the provider involving;

- practice consultants from the College of Registered Nurses of BC (CRNBC)
- nurse clinicians from BCCH and VIHA diabetes clinics

<sup>&</sup>lt;sup>1</sup> Ministry of Health data

- representatives from NSS coordinators and supervisors
- Principals and Vice Principals Association
- BC Council of Administrators for Special Education

Summer 2010: A jurisdictional review was conducted across Canada in No provincial or territorial policies and guidelines could be located which explicitly support the delegation of the administration of insulin in the school setting by UCPs.

Winter 2011: intensive review of the complexities of this issue staff including review of roles of various programs within Ministries of Health, and CFD to explore options and implications.

S. 13

It was determined that locally developed solutions would be the best way to meet the unique needs of regions across the province.

Spring 2012: after from Ministries of Education, Children and Family Development and Health began to design a framework to support further development of local agreements.

Summer 2012: MEd concluded

S. 13

S. 13

Upon further investigation, it was determined that according to the Canadian Diabetes Association website, S. 16

S. 16

The Ministry of Education staff contacted Dr. Perry Kendall to discuss current provincial resources, capacity and other issues from a provincial perspective, and to seek his support to proceed with a collaborative solution between Ministries of Health and Education.

Winter 2012:

Currently the Working Group is:

- Working with Child Health BC to determine clinical practice standards in schools
- Updating the jurisdictional review previously completed in 2010 (apparently Ontario is now contracting for nurses to administer to a student once a day at lunch time)
- Meeting with Assistant Deputy Ministers to brief and receive further instruction
- Determining a Terms of Reference for the Working Group

S. 17

• Drafting a

S. 17

## **Schools and Districts**

Districts report to us that:

More and more parents and advocacy groups are asking for administration of insulin to their children while in school. Some school districts are making local arrangements (such as contracting services, making connections with local resources) to meet those demands.

Concerns revolve around ensuring safe delegation given the life-threatening nature and complexities of the task, and a variety of factors regarding school environment, the student, parents, capacity and scheduling and availability of school staff to perform the task, training and monitoring of staff, placement of trained staff (this is not an exhaustive list).

Educators want children to be able to attend school with their peers and to be safe while attending school. We also want to work from a strengths based approach to determine a solution that meets the needs of all as much as possible; balancing the needs of the child, safety, rights, capacity, roles and responsibilities.

MCFD reports that some parents are asking to intensive care of their children.

S. 13

## **Ministry Advice**

Ministerial Order 149/89 (M149/89) provides for administration of health related tasks by school staff if staff designated to carry out these procedures have been trained, and are supervised by appropriate health professionals and provided that the training, monitoring and administration are child-specific.

**Questions/Comments:** 

Pages 122 through 124 redacted for the following reasons: s. 13

#### Attachment 1: Excerpt from Nursing Support Services Program Guidelines November 2009 Pages 14 - 16

#### **Diabetes Management**

The NSS Coordinator delegates nursing tasks, as per the responsibilities and accountabilities of the College of Registered Nurses of BC (CRNBC) policy, for children/youth with the following diabetes management needs:

- 1. Assistance with routine blood glucose monitoring (BGM) required during their time at school/preschool/child care. All children/youth with Type 1 diabetes require routine blood glucose monitoring (BGM) before lunch. Some children/youth who receive insulin via insulin pump may also require routine BGM at recess and/or during the afternoon. The child/youth's parent and/or diabetes health care team will provide direction regarding when routine blood glucose monitoring is required. Assistance with routine BGM may include any or all of the following:
  - Caregiver performing routine BGM and intervening appropriately based on results
  - Caregiver assisting with routine BGM and /or supervising a child/youth performing routine BGM, and intervening appropriately based on results
  - Caregiver assisting a child/youth, who is independent in the psychomotor skill of blood glucose monitoring, with interpreting the results of routine BGM and intervening appropriately.
- 2. Assistance with monitoring for signs and symptoms of hypo/hyperglycemia, and/or with emergency BGM (in response to symptoms of hypo/hyperglycemia), when at least one of the following applies:
  - A child/youth is already receiving delegated care for routine BGM, and the trained caregiver is immediately available to the child/youth to provide emergency BGM and intervention.
  - A child/youth diagnosed with diabetes within the last year requires accurate documentation of any suspected hypo/hyperglycemia to adjust the child/youth's insulin and diet and to assist the child/youth in learning to identify symptoms of hypo/hyperglycemia.
  - A very young child is unable to recognize symptoms of hypoglycemia, and the child's usual signs/symptoms of hypoglycemia are ambiguous and could easily be confused with other issues, such as fatigue or hunger.
  - A child treated frequently for suspected lows based on symptoms. Delegation of
    monitoring for signs and symptoms of hypoglycemia and emergency BGM would
    likely be short-term, until the child/youth's diabetes management team is able to
    stabilize the child/youth's diabetes and/or the child/youth's caregivers get to know

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child/youth better, and are better able to identify signs and symptoms of hypoglycemia.

- A child/youth has a developmental or behavioural disability, and it is difficult to distinguish signs and symptoms of hypoglycemia from behaviour related to the child/youth's developmental/behavioural disability.
- Other situations, which may pose a health and safety risk if a trained caregiver is not available to monitor a child/youth for signs and symptoms of hypo/hyperglycemia and perform emergency BGM.
- 3. Supervision of self-administration of an insulin bolus dose via insulin pump, or insulin pen, where the child/youth is independent in the psychomotor skills involved in insulin pump or pen operation.
  - Assistance with carbohydrate counting, when the parent has labelled the total
    grams of carbohydrate in the child/youth's lunch/snack and the child/youth eats
    all of it, or the parent has labelled each item in a child/youth's lunch/snack
    individually, and the child/youth eats all or none of each item.
  - Parent must communicate dosage to the child/youth and caregiver by telephone before the child/youth administers an insulin bolus dose. The caregiver will confirm and document that the insulin dose programmed into the pump or insulin pen is the dose indicated by the parent and that the dose was administered.
  - Confirming and documenting that a child/youth has accurately entered his/her blood glucose, and carbohydrates consumed, into an insulin pump that calculates an insulin bolus dose, and that the dose was administered. (The parent may not need to be involved in determining the insulin dose on a daily basis in this case.)

#### Nursing Tasks Not Typically Delegated by NSS

At this time, NSS does not typically delegate the following nursing tasks related to insulin administration, due to the variables involved in carrying out these tasks safely, the need for caregiver judgement, and the potential risks if an incorrect insulin dose is administered (refer to additional background information found in Diabetes Management and Blood Glucose Monitoring Education Module):

- Determining an insulin dose using a mathematical formula or flow sheet. This is the responsibility of the parent or designate, in collaboration with the child/youth.
- Administering an insulin dose. This is the responsibility of the child/youth and/or the parent or designate.
- Any insulin pump operation, including helping the child/youth to troubleshoot
  pump operation. If a child/youth encounters difficulty with pump operation, it is
  the responsibility of the parent or designate to be available by phone, or to
  respond to the school in person, to assist the child/youth.
- Any insulin pump site care.
- Supervision of self-administration of an insulin bolus dose via syringe.

**NOTE:** When an insulin pump is funded by PharmaCare, parents must sign a PATIENT/FAMILY AGREEMENT FOR AN INSULIN PUMP, which includes the following statement: "If the patient is a younger child, you [parents] acknowledge that

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school and daycare personnel will not operate the pump. You will have a plan for pump operation when the Patient is out of your care and you will be available at all times in case there is a problem."

Subcutaneous or intramuscular administration of glucagon to treat severe hypoglycemia is delegated **only** in situations when this is determined to be in an individual child/youth's best interests. Severe hypoglycaemia is rare in school settings. Glucagon administration is a complex task that school caregivers would have to carry out in an emergency situation, likely without having had the opportunity to perform the task previously. There is potential risk of harm to the child/youth if the task is performed incorrectly. Delegation of glucagon administration in the school setting *may* be in a child's best interests when Emergency Medical Services (EMS) are unavailable or unable to respond within a reasonable time, when a child is at increased risk of severe hypoglycaemia, or in other unusual or exceptional circumstances. The NSS Coordinator will work with each child/youth, family, school and health care team to determine whether glucagon administration is in an individual child/youth's best interests.

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Pages 128 through 139 redacted for the following reasons: s. 13 Provincial Health Officer 1301-865 Hornby St. Vancouver, BC, V6Z 2G3

Attention: Dr. Perry Kendall

Dear Dr. Kendall

Re: Insulin and Glucagon Administration for Type 1 diabetics in BC Schools

I am a parent of a child with Type 1 diabetes who goes to school in North Vancouver BC. I am also a member of a group that advocates for the health and human rights of children with Type 1 diabetes in Canada.

I am writing to you to confirm statements made in relation to your office regarding Provincial policies for type 1 diabetes care. These statements occurred on or about November 30, 2012 at the Lower Mainland Directors of Special Education conference.

Briefly:

- 1. That the Ministries of Education, Health, and Children and Family Development have been meeting for the past three years to resolve the issue of administering insulin and/or glucagon to children with type 1 diabetes.
- 2. That the Ministry of Health is to develop guidelines and practice standards to be used by school districts.
- 3. That until these guidelines are developed, schools are required to follow Nursing Support Services medical care policies developed by MCFD/Nursing Support Services and do not have to consider implementing individual care plans (ICPs) until the Ministry of Health has completed its policy review.
- 4. That you or your office endorses or advises this plan.

We would like you to clarify what, if anything was endorsed and what the implications are for children who need insulin and/or glucagon as part of their care at school. We reject these statements or interpretations which were made without public or caregiver input and which put our children's health at risk. Current Nursing Support Services policies do not address the obvious medical necessity of administering insulin to children who need it while at school, or

administration of glucagon when it has been prescribed.

We believe that effective policies and supports for children with Type 1 diabetes are long overdue and we support efforts to improve Provincial policies. However, three years has been too long to wait, and children should not be forced to wait any longer and endure substandard diabetes care at school, when safe, physician authorized individual care plans are in use today in many BC school districts. With the exception of Quebec and New Brunswick, Canadian schools are among the worst in the world for providing supports to children who require insulin or glucagon as part of their prescribed individual care plans.

Our group would be happy to discuss any medically or legally relevant concerns about diabetes care in BC schools. Members of our group published a peer-reviewed article on this very subject in the BCMJ which I have enclosed for your convenience.

We believe that the health and human rights of BC children is seriously at risk if Nursing Support services is allowed to override or ignore a child's physician ordered diabetes individual care plan.

Sincerely,

John Paul Morrison

cc: Dr. Lila Yewchuk, MD, RCPSC Dr. Sue Stock, MD, RCPSC - Endocrinology and Metabolism

# special feature

# Unsafe at School: Advocating for children with type 1 diabetes

Recent research has confirmed the deleterious effects that glucose extremes have on a child's learning, yet BC still has no province-wide standard of care for diabetic students.

### Lila Yewchuk, MD, FRCPC, John Paul Morrison, Scott Yewchuk, BPE, BEd, MEd Admin

ype l diabetes (T1D) is a chronic, life-threatening autoimmune disorder that affects children of all ages. Before the discovery of insulin, T1D was fatal. Today children with T1D face a lifetime of insulin injections and require daily monitoring and treatment to keep blood glucose levels as close to normal as pos-

Unsafe at School is a group of parents concerned about the lack of support in BC schools for children with type 1 diabetes. Lila Yewchuk is a pediatric radiologist at BC Children's Hospital in Vancouver and a clinical instructor in the Department of Radiology at the University of British Columbia. John Paul Morrison is a technology consultant and children's rights advocate committed to helping children with diabetes receive the support they require in school. Scott Yewchuk is a teacher of English and physical education at Semiahmoo Secondary School in Surrey, BC.

This article has been peer reviewed.

sible. Although there is an abundance of promising research, the cause of T1D is unknown and there is currently no cure.

Worldwide, T1D affects millions of adults and at least 440 000 children under the age of 14, with 70 000 children newly diagnosed each year.<sup>1</sup> More than 300 000 Canadians live with type 1 diabetes.<sup>1</sup> Its incidence is increasing by 3% to 5% annually, with the greatest rise occurring in children aged 5 to 9.1 In Ontario alone, the incidence of T1D increased by 48% between 1992 and 2002.<sup>2</sup> In British Columbia in 2004, the prevalence of T1D was estimated to be 0.15%, or 1477 children aged 0 to 18.3 According to researchers, incidence is expected to double in children younger than 5 by 2020.4

The goal in diabetes management is to optimize blood glucose control using hemoglobin A1c targets—a more precise measurement of blood glucose that tracks changes over 3 to 4 months. The aim is to avoid hyperglycemia (high blood glucose) and its well-documented, long-term microvascular consequences (including heart attack, stroke, kidney failure, blindness, amputation) while minimizing hypoglycemia (low blood glucose). Encouragingly, recent studies reveal that a 1% reduction in A1c lowers the risk of microvascular complications by 40%.<sup>4</sup>

# Glucose extremes in children with T1D

In adults with T1D, the detrimental effect of acute glucose extremes on motor function and cognition is well documented.5 Until recently, however, few studies were undertaken to examine the effects of acute blood glucose fluctuations in children, likely because of a reluctance to induce extreme glucose levels, and possible neurological insults, in younger patients with developing brains. However, glucose fluctuations more extreme than those induced in studies occur routinely outside of the laboratory; these naturally occurring episodes of acute hypo- and hyperglycemia during daily routine have been shown to cause cognitive-motor disruptions in school-aged children.<sup>6</sup>

Recent research is uncovering the deleterious effects that glucose extremes have on a child's learning. Repeated hypoglycemia has been found to reduce spatial intelligence and delayed recall in children with T1D.<sup>6,7</sup> In these same children, increased exposure to hyperglycemia reduces verbal intelligence and slows mental efficiency.7 Hyperglycemia, not hypoglycemia, is "associated with adverse effects on the brain polyol pathway activity, neuronal structural changes, and impaired long-term spatial memory. This finding suggests that the hyperglycemic component of diabetes mellitus has a greater adverse effect on brain functioning than does intermittent hypoglycemia."8-10 This is echoed by the Canadian Diabetes Association (CDA) statement: "studies have found chronic hyperglycemia in young children [is] associated with poorer cognitive performance."11

Correcting high blood glucose is therefore essential for a child's longterm health and learning needs.

# Managing T1D in school-aged children

The Canadian Diabetes Association's 2008 clinical practice guidelines describe insulin therapy as the mainstay of medical management of type 1 diabetes and emphasize tight glycemic control for patients with T1D.<sup>11</sup> The guidelines make special mention of the pediatric population living with T1D: "regardless of the insulin regimen used, all children should be treated to meet glycemic targets."<sup>11</sup>

A statement from the American Diabetes Association (ADA)<sup>12</sup> also stresses the need to manage diabetes in children aged 6 to 12, which is described as a "particularly challenging" age group:

Many require insulin administration while at school, which demands flexibility and close communications between the parents, the health care team, and school personnel.<sup>13</sup> The lack of abstract thinking in most children of this age limits management choices and dictates that parents or other adults make most of the treatment decisions. While children in this age group may be more able to recognize and self-treat hypoglycemia, close adult supervision is still required... The ability of most children of this age to recognize, report, and seek treatment for hypoglycemia, combined with an absence of insulin resistance and psychological issues associated with puberty, makes this age group perhaps the most amenable to intensive glucose control. An A1c goal of  $\leq 8\%$ ... is recommended.<sup>12</sup>

While the Canadian Diabetes Association also recommends an A1c goal of < 8% in 6- to 12-year-old children, the International Society for Pediatric and Adolescent Diabetes recommends < 7.5% for all age groups.<sup>11,14</sup> In all cases, children should have their A1c targets determined individually.

For young Canadian children with T1D, receiving assistance with insulin administration while at school is rare, meaning that hyperglycemia can go untreated. This increases the risk for long-term chronic complications of the disease as well as for neurocognitive learning impairments that may appear immediately.<sup>6</sup>

# Canada's contribution to T1D management

In 1922, Canadian surgeon Frederick Banting and his colleagues discovered insulin, which led to one of the most important health care advances of the 20th century. Since that time, Canada has been a leading country in the area of diabetes research.15 The first continuous glucose monitor (CGM), a sensor and transmitting device used to communicate with the insulin pump, was developed in Toronto in the mid 1970s. In conjunction with the US, Canada conducted the ground-breaking Diabetes Control and Complications Trial (DCCT), a comprehensive 10-year study ending in 1993 that clearly demonstrated the importance of glycemic control in preventing microvascular complications of T1D. This control was attained through intensive insulin therapy (more frequent insulin dosing), not conventional treatment (twice-daily insulin dosing).<sup>16</sup> This trial has been referred to as "the study that forever changed the nature of treatment of T1D"<sup>17</sup> by revealing the need for better management.

It is through intensive insulin therapies, such as the insulin pump and multiple daily insulin injections, that many children with T1D now experience the best glycemic control. When insulin is administered at a low level all day long by either of these methods, it is possible to do as the DCCT recommends: Improve glycemic control with the "reproduction of physiological insulin secretion."16 The 2010 landmark STAR 3 trial, a 1-year multicentre randomized controlled trial that compared the efficacy of sensoraugmented pump therapy with that of multiple daily insulin injections in 485 adults and children with type 1 diabetes, concluded that "in both adults and children with inadequately controlled type 1 diabetes, sensor-augmented pump therapy resulted in significant improvement in [(A1c)] levels, as compared with injection therapy."18 STAR 3 is the first study that confirms sensor-augmented insulin pump therapy provides superior glucose control for children and adolescents, an age group that is particularly challenging to treat because of the social and physiological changes caused by growth and maturation. In STAR 3, nearly 44% of pediatric patients using sensoraugmented insulin pump therapy achieved the American Diabetes Association's age-specific glucose control targets, compared with only 20% of patients in the multiple daily injection group.<sup>18</sup> It is the longest and largest diabetes device trial of its kind, redefining what should be the standard of care for diabetes management. "For the first time, with the sensoraugmented insulin pump, adults, Continued on page 234

# special feature

#### Continued from page 233

children and teens had a sustained improvement in A1c levels, which can greatly reduce the risk of complications from diabetes."<sup>19</sup>

While both the CDA and ADA promote optimal glycemic control in diabetes, only American children receive the support they need at school.20 The American Diabetes Association initiated the Safe at School campaign, which resulted in a statement of principles to ensure children with T1D are guaranteed freedom from discrimination and access to medically necessary support while at school. Recognizing that "diabetes must be managed 24 hours a day, 7 days a week," this support includes the administration of insulin and glucagon (a life-saving medicine used to treat emergency hypoglycemic reactions) and school assistance for young children not able to care for themselves.<sup>21</sup> Meanwhile, Canada has the fourth highest incidence of T1D, ranking ahead of Norway, the United Kingdom, and the US,22 and yet to date, no Canadian diabetes organization has actively endorsed the Safe at School principles.

Although Canada is on the cutting edge of diabetes research and has made astounding contributions toward improving diabetes care, and although the CDA continues to lobby at the provincial and territorial levels for legislative change regarding safety at school,<sup>20</sup> children with T1D still do not receive the medical treatment they require while at school. It is common to find Canadian children on traditional insulin therapies and not on newer intensive regimens just so that they can attend public school. Traditional regimens have fewer insulin injections and do not require a lunchtime insulin bolus; the result of this is convenience for school personnel. But this means children must fit into the school, instead of the school meeting their care needs. The insulin strategies currently promoted by Canadian schools (twice-daily dosing) "rarely achieve optimal glycemic control because... they do not provide physiological or flexible insulin replacement... and may increase the risk of hypoglycemia."<sup>16</sup>

Given Canada's high incidence of T1D and the country's legacy as a world innovator in diabetes treatment, it is both ironic and tragic that Canadian policy has not kept pace with medical recommendations to ensure children receive care essential to them while at school.

# The cost of inadequate care at school

If children with T1D do not receive proper medical support during school hours, the impact of this substandard care can reach beyond the child to the family, the classroom, and society. Families can suffer hardship as one parent is required to leave the workforce to attend to the child at school. Classrooms can be disrupted by the regular visits that diabetes care requires, and teachers can be distracted by the need to monitor the safety of the diabetic child. In addition, the cost to the health care system is substantial. Diabetes and its complications cost the Canadian economy more than \$17.4 billion a year, with type 1 diabetes being the leading cause of adult blindness, stroke, heart disease, nerve damage, and amputation.<sup>1</sup> In addition, diabetic nephropathy occurs in 20% to 40% of patients.23 For those diabetics with kidney disease, the average cost of dialysis treatment is \$50000 a year. The one-time cost of a kidney transplant in BC is approximately \$20 000, with an additional yearly cost of about \$6000 for antirejection medications.<sup>24</sup> Proper glycemic control, something not independently achievable in young children, is proven to reduce or eliminate these complications.

# The right to reasonable accommodation

Apart from the medical implications, there are legal implications should a

diabetic student be harmed or die because of insufficient care at school. Although children with T1D are considered disabled by the federal government, and classified by the BC Ministry of Education as "physically disabled, chronic health impaired" (Level 2 D),<sup>25</sup> these children do not always receive the accommodation they need. Until policy change occurs and a better standard of care is set. children with T1D will continue to face discrimination. Schools must provide appropriate medical treatment for each diabetic child to achieve glycemic target goals regardless of what insulin regimen is used. The health, safety, educational potential, and emotional well-being of these children depends on it.

Under the Canadian Charter of Rights and Freedoms, every citizen, including those with disabilities, has the right to equal protection and benefit without discrimination.<sup>26</sup> In the case of female firefighter Tawney Meiorin, the Supreme Court of Canada outlined steps to eliminate discriminatory conditions and satisfy the "duty to accommodate."27 In another case involving a 9-year-old boy with autism, Hewko v. BC, Madame Justice Koenigsberg stated that "reasonable accommodation is an integral part of the [school's] duty to consult"28 and found that the Abbotsford School District did not "meaningfully consult" with the boy's family. Reasonable accommodation, as demonstrated in this case, involves providing a standard of care at school that reflects the care provided at home to ensure a "consistent educational program" for the child.28

For children with T1D, a "consistent educational program" would have staff trained in diabetes care to complement the care that the children receive at home. However, this is presently not the case. Current provincial Nursing Support Services (NSS) policy asserts that the care children with T1D need to safely attend school, namely the provision of insulin and glucagon administration, cannot be provided safely by an education aide. While this policy may be the result of licensure concerns, the larger question raised is: Does such a policy directly or indirectly negatively affect children with T1D in a way prohibited in the Canadian Human Rights Act?29 Another case involving disabilities and the duty to accommodate, the Grismer case, suggests it is reasonable to ask if the argument that aides cannot "safely" care for a child with T1D has a bona fide justification, especially in light of the fact that some BC school districts currently permit staff to be trained in the administration of insulin and glucagon. Has the policy put forth by the NSS taken into account how these services could be provided safely, or is this belief based on "impressionistic assumptions"?<sup>30</sup>

For students with T1D, the present NSS care plan policy does not consider the negative impact on learning or health that results when aides cannot give insulin promptly to treat hyperglycemia. The current policy is unreasonable in that it forces families with young diabetic children to attend their children at school regularly, and if this is not possible, to choose an insulin regimen for their children that they might not choose otherwise. The potential loss of glycemic control and, consequently, "instructional control,"28 raises the question asked in Grismer: Must all students "meet a single policy standard, or could varying standards be adopted"<sup>30</sup> to meet the diverse needs of students? If varying standards can be adopted, then all children with type 1 diabetes could be accommodated at school and see cognitive and health benefits that would ultimately allow them to be more receptive to learning.

In March 2010, Canada's Parliament ratified the United Nations Convention on the Rights of Persons with Disabilities. All provinces and territories are now bound by the convention, which among other rights ensures that "effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion."<sup>31</sup>

### **Barriers to care**

Being a student with type 1 diabetes in a BC school brings with it many risks. For those too young to self-manage, the risks are even greater. Currently, there is no province-wide standard of care for diabetic students and therefore no province-wide safety plan to ensure their well-being. Although the School Act includes general principles regarding care for children with health designations, and NSS has guidelines for training school personnel to deliver care in elementary schools, care is delivered inconsistently and limited provisions are made for those unable to self-manage.

As a result, the care that children with T1D currently receive depends on five things:

- Which school district they are in.
- Which school within the district they attend.
- The nursing support available for that school.
- The principal in charge of that school.
- Whether the parents can advocate effectively for their child.

Overall, children receive vastly different care, with many receiving none. Most serious is the provincewide denial of the two critical components of diabetes care: insulin and glucagon administration. Consequently, parents often fear for the safety of their children while at school.

Current NSS guidelines do not reflect the seriousness of the impact diabetes can have on children's health and learning. Compounding this problem, the policy for health designations in schools falls under three ministries: Health, Education, and Children and Family Development. In addition to these challenges, BC's endocrinologists do not agree on school care, with some concerned that supporting insulin therapy and glucagon administration at the school level will directly tax their clinical resources. Consequently, parents who want intensive therapies, such as an insulin pump, must prove they have the means to personally support a child at school. Otherwise, they must wait several years until a child can self-manage—years when irreversible damage may occur.

Another barrier to care involves concerns for the liability of those administering insulin to children, and the belief that insulin therapy and glucagon injection are "too dangerous" for school personnel. Although aides provide medical support for students with physical disabilities and administer other injectable medications such as epinephrine, a life-saving injection for severe allergic reactions, the perception is that diabetes management is "too difficult." In fact, insulin administration is a skill that can be easily taught to school personnel; the cost is negligible as extra funding is provided for the care of diabetic children. Glucagon administration, a skill parents typically learn in one teaching session lasting 10 to 15 minutes, can also be taught.

### A possible solution

In an effort to improve support at school, a small number of BC families have already effected change for their children and proven that a new standard of care is possible. In five school districts, six students aged 6 to 8 now have working care plans that were negotiated independently. In these plans, insulin therapy is administered by an aide trained by a nurse who is a certified diabetes educator. The aide is covered under current liability insurance provided to CUPE members. Management is clearly delineated with phone support from the parent. The result is that students have greater independence, classes have fewer disruptions, parents can remain in the workforce, and students have the best

Continued on page 236

# special feature

#### Continued from page 235

possible conditions for health and learning.

This solution could be a provincewide one, since funding is already attached to students with diabetes, and the number of students requiring aides to administer insulin is relatively small —likely only 300 of the 600 children aged 5 to 12 on insulin pumps (written communication from Dr Daniel Metzger, endocrinologist at BC Children's Hospital, and Dr Sue Stock, endocrinologist at Lions Gate Hospital, 22 February 2012).

A policy that (1) allows school personnel to be trained to administer insulin and glucagon, and (2) requires the NSS to hire or train nurses who are certified diabetes educators, would give school districts the capacity to properly support diabetic students. If this is not possible, using outside agencies for medical care, an existing practice in BC schools, could meet this need.

In the past, children diagnosed with T1D lived highly regimented lives. They used "assigned fixed doses of insulin and had to follow a fixed meal schedule to fit the insulin regime."<sup>16</sup> However, as shown by the DCCT, glycemic control was rarely optimal using these traditional therapies. With the advent of methods that reproduce physiological insulin secretion, those living with type 1 diabetes today can have better quality of life and improved glucose control, through insulin therapies that fit their individual needs.

If schools will accommodate individual needs, then young children who have the greatest number of years to live with diabetes and incur its complications—can live longer, healthier lives. Ultimately, improving the care that school-aged children with T1D receive in Canada will result in a healthier and more prosperous nation.

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# special feature

# pulsimeter

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### BCMA insurance: Defining "earned income"

Your earned income is a factor in determining how much coverage you are eligible to receive when you apply for disability insurance, and it is also used in calculating your entitlement to disability benefits at the time of claim. Earned income is calculated differently for insurance purposes than it is for income tax purposes.

Our disability insurer (Sun Life Financial) has well-established procedures in place to calculate earned income, which take into consideration the amount paid to you by your professional corporation (salary and bonus) and the net income or loss of the professional corporation, which is attributable to you. This calculation assumes that the performance of your professional services is the sole source of revenue to the corporation. If you change from a sole practitioner to an incorporated practice with no change in expenses it will not alter your earned income for the purposes of disability insurance.

# What about corporate dividends paid to a physician?

When calculating earned income for disability insurance, dividends are not considered earned income since they are paid from the professional corporation's retained earnings. Dividends are just the distribution of the net income of the professional corporation that has already been included as income to you. See the Table for a sample calculation.

### Earned income for the Physicians' Disability Insurance plan (PDI)

To determine your eligible monthly PDI benefit, both your practice type and your earned income are considered. Earned income is calculated annually as of 1 April and includes your prior calendar year earnings, consisting of fee-for-service billings, sessional payments, or non-salaried income under a service contract.

The information provided here is not legal or financial advice; you should consult your attorney or accountant with any questions about professional corporations.

For a complimentary review of your insurance coverage by a noncommissioned BCMA insurance advisor, please contact Ms Julie Kwan at 604 638-8745 or 1 800 665-2262 ext. 8745 or e-mail jkwan@bcma .bc.ca.

> —Sinden Malinowski Manager, Insurance

#### Table. Sample calculation of earned income.

Income for insurance purposes vs. income for tax purposes		Year 2
A Corporate income before owner compensation and tax.		150 000
<b>B</b> Physician's draw (salary plus bonus).		100 000
C Net corporate income before tax.		50 000
<b>D</b> Physician's actual dividends from retained earnings.		20 000
Earned income for insurance purposes (B plus C)		150 000
Physician's income for tax purposes (B plus D)		120 000

Pulsimeter continued on page 252

Page 148 redacted for the following reason: S. 13

## Horn, Elizabeth M CITZ:EX

From: Sent: To: Subject: Gibbons, Lenore EDUC:EX Tuesday, November 6, 2012 10:03 AM 'Darcy Verbeurgt' RE: Diabetes in Schools

Great to hear from you! Thanks for your response. I will pass on your name and contact information.

Sounds like you might be on the mend. It's hard to get back and catch up, isn't it?

Take care. -L

# Lenore Gibbons

Coordinator-Special Education Learning Division Ministry of Education phone 250-886-2083 fax 250-387-6315

# **BC's EDUCATION PLAN**

ON THE WEB: WWW.BCEDPLAN.CA ON TWITTER: @BCEDPLAN

From: Darcy Verbeurgt [mailto:Darcy.Verbeurgt@fc.sd5.bc.ca] Sent: Tuesday, November 6, 2012 9:59 AM To: Gibbons, Lenore EDUC:EX Subject: Re: Diabetes in Schools

Hello Lenore,

I have though about it and would love to be involved. Thanks for including me.

We have had a very busy startup this year and I have been sick for about a week (flu season)

Darcy

Mr. Darcy Verbeurgt District Principal of Student Services SD5 (Southeast Kootenay) 250-417-2089 (w) 250-421-0427 (c) Sent from FirstClass with my iPad

# "Gibbons, Lenore EDUC:EX" <<u>Lenore.Gibbons@gov.bc.ca</u>> writes:

Hi there Darcy, I hope you are well. I wonder if you have had a chance to think about my request that you listen in on a conference call with the Heath Regions about providing diabetes education training and follow up to education staff in the province. One of the roadblocks to being able to provide a provincial response to the issue of the insulin pump operation by school staff has been availability of training by an appropriate health care provider. The teleconference is intended to discuss that particular aspect with Health Regions in the province. I have an urban perspective through Julie Parker in North Vancouver, but need someone from a rural perspective to be on the call, as there are particular challenges for rural communities. Bill had suggested asking you. Could you please let me know whether or not you are able to participate and I will pass your name of to Michael Egelston from Health and he will be in touch with you about time and other details, or I will ask someone else. Thank you. Lenore Gibbons sdiv>

## Nursing Support Services (NSS) Eligibility Related to Diabetes Management Tasks:

The NSS Coordinator delegates nursing tasks, as per the responsibilities and accountabilities of the College of Registered Nurses of BC (CRNBC) policy, for children/youth with the following diabetes management needs:

- 1. Assistance with routine blood glucose monitoring (BGM) required during their time at school/preschool/child care. All children/youth with Type 1 diabetes require routine blood glucose monitoring (BGM) before lunch. Some children/youth who receive insulin via insulin pump may also require routine BGM at recess and/or during the afternoon. The child/youth's parent and/or diabetes health care team will provide direction regarding when routine blood glucose monitoring is required. Assistance with routine BGM may include any or all of the following:
  - Caregiver performing routine BGM and intervening appropriately based on results
  - Caregiver assisting with routine BGM and /or supervising a child/youth performing routine BGM, and intervening appropriately based on results
  - Caregiver assisting a child/youth, who is independent in the psychomotor skill of blood glucose monitoring, with interpreting the results of routine BGM and intervening appropriately.
- 2. Assistance with monitoring for signs and symptoms of hypo/hyperglycemia, and/or with emergency BGM (in response to symptoms of hypo/hyperglycemia), when at least one of the following applies:
  - A child/youth is already receiving delegated care for routine BGM, and the trained caregiver is immediately available to the child/youth to provide emergency BGM and intervention.
  - A child/youth diagnosed with diabetes within the last year requires accurate documentation of any suspected hypo/hyperglycemia to adjust the child/youth's insulin and diet and to assist the child/youth in learning to identify symptoms of hypo/hyperglycemia.
  - A very young child is unable to recognize symptoms of hypoglycemia, and the child's usual signs/symptoms of hypoglycemia are ambiguous and could easily be confused with other issues, such as fatigue or hunger.
  - A child treated frequently for suspected lows based on symptoms. Delegation of monitoring for signs and symptoms of hypoglycemia and emergency BGM would likely be short-term, until the child/youth's diabetes management team is able to stabilize the child/youth's diabetes and/or the child/youth's caregivers get to know child/youth better, and are better able to identify signs and symptoms of hypoglycemia.
  - A child/youth has a developmental or behavioural disability, and it is difficult to distinguish signs and symptoms of hypoglycemia from behaviour related to the child/youth's developmental/behavioural disability.

- Other situations, which may pose a health and safety risk if a trained caregiver is not available to monitor a child/youth for signs and symptoms of hypo/hyperglycemia and perform emergency BGM.
- 3. Supervision of self-administration of an insulin bolus dose via insulin pump, or insulin pen, where the child/youth is independent in the psychomotor skills involved in insulin pump or pen operation.
  - Assistance with carbohydrate counting, when the parent has labelled the total grams of carbohydrate in the child/youth's lunch/snack and the child/youth eats all of it, or the parent has labelled each item in a child/youth's lunch/snack individually, and the child/youth eats all or none of each item.
  - Parent must communicate dosage to the child/youth and caregiver by telephone before the child/youth administers an insulin bolus dose. The caregiver will confirm and document that the insulin dose programmed into the pump or insulin pen is the dose indicated by the parent and that the dose was administered.
  - Confirming and documenting that a child/youth has accurately entered his/her blood glucose, and carbohydrates consumed, into an insulin pump that calculates an insulin bolus dose, and that the dose was administered. (The parent may not need to be involved in determining the insulin dose on a daily basis in this case.)

# Nursing Tasks Not Typically Delegated by NSS

At this time, NSS does not typically delegate the following nursing tasks related to insulin administration, due to the variables involved in carrying out these tasks safely, the need for caregiver judgement, and the potential risks if an incorrect insulin dose is administered (refer to additional background information found in Diabetes Management and Blood Glucose Monitoring Education Module):

- Determining an insulin dose using a mathematical formula or flow sheet. This is the responsibility of the parent or designate, in collaboration with the child/youth.
- Administering an insulin dose. This is the responsibility of the child/youth and/or the parent or designate.
- Any insulin pump operation, including helping the child/youth to troubleshoot pump operation. If a child/youth encounters difficulty with pump operation, it is the responsibility of the parent or designate to be available by phone, or to respond to the school in person, to assist the child/youth.
- Any insulin pump site care.
- Supervision of self-administration of an insulin bolus dose via syringe.

Subcutaneous or intramuscular administration of glucagon to treat severe hypoglycemia is delegated **only** in situations when this is determined to be in

an individual child/youth's best interests. Severe hypoglycaemia is rare in school settings. Glucagon administration is a complex task that school caregivers would have to carry out in an emergency situation, likely without having had the opportunity to perform the task previously. There is potential risk of harm to the child/youth if the task is performed incorrectly. Delegation of glucagon administration in the school setting *may* be in a child's best interests when Emergency Medical Services (EMS) are unavailable or unable to respond within a reasonable time, when a child is at increased risk of severe hypoglycaemia, or in other unusual or exceptional circumstances. The NSS Coordinator will work with each child/youth, family, school and health care team to determine whether glucagon administration is in an individual child/youth's best interests.

## Discharge:

Discharge will be based on:

The child/youth's knowledge, comprehension, and independent skill performance related to diabetes management. Typically, most children/youth are independent with diabetes management tasks by 9-10 years or Grade 3-4. NOTE: Eligibility may continue beyond this age for children/youth with additional chronic health needs or developmental delays.
### Diabetes Education in BC

• Approximately 2200 children in BC receive insulin therapy. 391 children aged 5-9 are currently being prescribed insulin; however it is not possible to determine how many of those receive injections during the day. Children under the age of 9 and those who have intellectual, emotional or physical barriers may require assistance administering insulin.

• Availability of and access to Certified Diabetes Educators in BC are cited as a barrier to providing the appropriate instruction, monitoring and supervision to school staff.

• The Canadian Diabetes Association website;

http://www.diabetes.ca/for-professionals/des/diabetes-education-centre provides locations across BC where a Certified Diabetes Educator is available. Centers include regional and general hospitals, community health centres, pharmacies, diabetes education programs, and specific care facilities (like GF Strong).

### Certification as a Diabetes Educator

### Eligibility:

Individuals who have not previously taken or passed the CDE® examination or whose CDE® designation have lapsed must meet ALL of the following requirements:

- Be registered with a regulatory body in Canada as a health professional.
- A minimum of 800 hours of practice in diabetes education.
- The minimum of 800 hours of practice in diabetes education must be obtained within any duration or combination of time within the three year period that is immediately preceding the February 1 application deadline. Such experience must be obtained while the individual is fully licensed with a regulatory body as a Canadian health care professional.
- ALL of the above must be attained while the individual is fully registered with a regulatory body in Canada as a health professional.

There will NOT be any exceptions regarding eligibility criteria.

Fee - \$450.00

The CDECB does not endorse any course or educational events related to diabetes care/education, or purporting to be designed to prepare individuals to write the examination. Participation in these educational sessions is not an assurance or guarantee that a passing mark will be achieved on the examination.

Designated examinations occur in the Fall at the following sites in British Columbia: North Island College Thompson Rivers University Okanagan College University of Northern B.C. Northwest Community College Langara College University of Victoria

(From The Canadian Diabetes Educator Certification Board Examination Handbook 2012 at http://cdecb.ca)

Diabetes Educator Course is offered through UBC. This four-day course is specifically designed to prepare health professionals with a solid foundation in diabetes education and management. It is for health professionals from a variety of disciplines who face diabetes in practice. The goal is to update understanding of the complexities of diabetes care, and learn effective approaches to educate those affected by diabetes. It is an ideal course if entering the dynamic, specialty field of diabetes education. This course is not specifically designed as preparation for the CDE examination; however it will serve a review in preparation to become a certified diabetes educator.

# Fee - Approximately \$800 per person. http://www.interprofessional.ubc.ca/IN9564

# Recommendations

Thursday, September 13, 2012 9:52 AM

Diabetes Education in BC

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- A minimum of 800 hours of practice in diabetes education.
- The minimum of 800 hours of practice in diabetes education must be obtained within any duration or combination of time within the three year period that is immediately preceding the February 1 application deadline. Such experience must be obtained while the individual is fully licensed with a regulatory body as a Canadian health care professional.
- ALL of the above must be attained while the individual is fully registered with a regulatory body in Canada as a health professional.

There will NOT be any exceptions regarding eligibility criteria.

Fee - \$450.00

The CDECB does not endorse any course or educational events related to diabetes care/education, or purporting to be designed to prepare individuals to write the examination. Participation in these educational sessions is not an assurance or guarantee that a passing mark will be achieved on the examination.

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# Figure 1. Pediatric Type 1 Diabetes in British Columbia

Proportion at Goal & Age-Standardized Incidence Rates Five-Year Aggregate (2002/03 - 2006/07)

By Residence of the Patient (Health Service Delivery Areas)



### Background

Thursday, August 4, 2011 1:26 PM

#### Background

The incidence of Type 1 Diabetes (T1D) in children under 5 years is increasing at a disproportionate rate and is expected to double between 2005 and 2020. In 2008, there were an estimated 1600 children and youth in BC with T1D. Increasingly, T1D in children is being managed with intensive insulin therapy, either by multiple daily injections or via insulin pumps, which entails insulin administration at lunchtime, accompanied by frequent blood glucose testing (5-10 times/daily) and carbohydrate counting. These treatment modalities can significantly improve blood glucose (BG) control in children and avoid or reduce long term debilitating complications of diabetes.

Increasingly, parents whose young school-aged children are not old enough to administer their ow insulin are requesting that school staff be taught to give it at lunchtime. Since Nursing Support Serv (NSS) Coordinators delegate the more routine diabetes-related tasks of monitoring blood sugar and managing low and high blood sugar to school staff, the NSS Coordinators are under increasing presi from parents to add the delegation of insulin administration. More parents are also expecting scho staff to check blood glucose levels and follow complex instructions regarding snacks and insulin administration.

#### Ministry Roles and Responsibilities

Nursing Support Services support children and youth with complex health care needs and their par by providing nursing services in home, school, preschool and child care settings. This service is provided through either direct or delegated care. NSS transferred from the Ministry of Health to N in 1996. The budget for NSS for fiscal year 2010/11 was \$11.61M; however, the Ministry is forecast expenditures of \$17.9M an increase of 8.10% for year-over-year expenditures.

The Ministry of Health is responsible for the medical management of diabetes including diabetic cli administered by Regional Health Authorities and the provision of insulin pumps via PharmaCare (fo children covered under Fair PharmaCare and Plan C (income assistance).

The Ministry of Education sets educational standards, allocates funds and monitors student achievement. Decisions regarding the planning and delivery of supports and services for all student are made by local boards of education and school district administrators.

#### **Discussion and Current Situation**

Addressing this need safely is not possible within the current structure and capacity of the NSS program. While NSS Coordinators are experienced pediatric nurses, the majority do not have the advanced clinical knowledge of pediatric diabetes necessary to be competent in the delegation and monitoring of insulin administration by non-nurse care providers. The task is also clinically complex with the potential for serious harm if performed incorrectly.

Delegation is a formal process which involves child specific training of unlicensed care providers to perform certain tasks that would typically be performed by a nurse, and ongoing monitoring of the



# Aug 12 notes

Monday, August 15, 2011 9:29 AM

# Gibbons, Lenore EDUC:EX From: Kennedy, Susan E EDUC:EX Monday, August 15, 2011 8:29 AM Gibbons, Lenore EDUC:EX Sent: To: FW: Insulin admin - prep for next mtg Insulin Administration Discussion Paper August 2 2011 docx(3).docx; Eligibility criteria Subject: Attachments: for NSS.docx; NSS Policies related to insulin.doc Lenore: Is there anything here we need to discuss before the meeting next week? Susan Kennedy, Executive Director Diversity, Equity, and Early Learning Ministry of Education Box 9158 Stn Prov Govt, Victoria BC V8W 9H3 telephone: (250) 356-1265 facsimile: (250) 356-8322 From: Mjolsness, Randi L MCF:EX Sent: Friday, August 12, 2011 5:04 PM To: Henry, Effie HLTH:EX; Glynn, Keva MCF:EX; Lalani, Arif MCF:EX; Geber, Joan HLTH:EX; Seller, Leigh Ann HLTH:EX; Kennedy, Susan E EDUC:EX; Davidson, Heather (ADM) HLTH:EX; Allen, Roderick EDUC:EX; Stevanovic, Aleksandra MCF:EX; Fuller, Anne MCF:EX; Dobell, Leah MCF:EX Cc: Tran, Kim C (Victoria) MCF:EX Subject: FW: Insulin admin - prep for next mtg Hi all,

S. 13

I have asked for another meeting on August 24<sup>th</sup>,

S. 13

1

Effie, thanks for the materials you forwarded today. I believe the training you identified that was being developed by BCCH is intended for school personnel, not NSS staff; but will confirm and be able to discuss at the next meeting. Thank you all for your attention to this issue.

### Randi Mjolsness

Assistant Deputy Minister Policy, Legislation and Specialized Provincial Services Ministry of Children and Family Development PO Box 9738, STN PROV GOV Victoria BC V8W 9S2 Phone- 250-387-7090 / Fax- 250-387-2481 E-mail Address: <u>Randi.Mjolsness@gov.bc.ca</u>

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Sent:	Fuller, Anne MCF:EX Thursday, April 5, 2012 10:48 AM
То:	Wallace, Lauren HLTH:EX; Stevanovic, Aleksandra MCF:EX; Henson, Carolyn D HLTH:EX; Gibbons, Lenore EDUC:EX: Dobell, Leah MCF:EX
Subject:	Insulin administration working group - notes from April 5, 2012
Follow Up Flag: Flag Status:	Follow up Completed
Here are some quick	a notes:
Attendance on today Gibbons, Leah Dobe	r's meeting: Aleks Stevanovic, Lauren Wallace, Carolyn Henson, Lenore II, Anne Fuller
1. Aleks provide Arif Lalani, Jo	d an update on a brief conference call held a few weeks ago among Joan Geber, an Easton and Aleks.
<ul> <li>Discussion</li> <li>Working G</li> </ul>	n of the background of the project, the ADM meeting/s and the work of the Group so far
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Next steps	χ.
a. Joan E	aston will connect with Maureen O'Donnell to discuss the issue; potentially, a
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2 3. Leah has ask light of the HE	S. 13 S. 13 ed Audrey Lieberman and Donna Thompson for suggestions on next steps in
2 3. Leah has ask light of the HF 4. Next steps:	S. 13 S. 13 ed Audrey Lieberman and Donna Thompson for suggestions on next steps in RT case.
2 3. Leah has ask light of the HF 4. Next steps: • Anne will s • Meeting of	S. 13 S. 13 ed Audrey Lieberman and Donna Thompson for suggestions on next steps in RT case. send out link to current protocols signed off (see below). f working group to be scheduled for next week. S. 13
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2 3. Leah has ask light of the HF 4. Next steps: • Anne will s • Meeting of • Aim is to p set up with From: Fuller, Anne MCF Sent: Thursday, April 5, To: Wallace, Lauren HLT Dobell, Leah MCF:EX Subject: Protocols	S. 13 S. 13 ed Audrey Lieberman and Donna Thompson for suggestions on next steps in RT case. Send out link to current protocols signed off (see below). f working group to be scheduled for next week. S. 13 S. 13 orovide a summary/suggestion that could be shared with upcoming meeting being maureen O'Donnell.
2 3. Leah has ask light of the HF 4. Next steps: • Anne will s • Meeting of • Aim is to p set up with From: Fuller, Anne MCF Sent: Thursday, April 5, To: Wallace, Lauren HLT Dobell, Leah MCF:EX Subject: Protocols	S. 13 S. 13 S. 13 Med Audrey Lieberman and Donna Thompson for suggestions on next steps in RT case. Send out link to current protocols signed off (see below). f working group to be scheduled for next week. S. 13 S. 13 Trovide a summary/suggestion that could be shared with upcoming meeting being maureen O'Donnell.

#### Here is the link

# http://www.bced.gov.bc.ca/specialed/docs/interministerialprotocols.pdf

Anne Fuller Provincial Consultant - FASD and Nursing Support Services Children and Youth with Special Needs Policy Ministry of Children and Family Development Victoria BC Phone: (250) 387-5947 Cell: (250) 588-4458

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-Ronead file Diahoi Prepare for Foi- presentation - timeline to date: policy + quidelines; Results of phone call w Healt Date distution polition 1. w Health Julie + Darcy . (Michael). Nov 15 ~ | ---- E Email: Re Kathy - what they want. S. 13 Page



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Pages 174 through 178 redacted for the following reasons:

S. 14 S. 13 S. 14 Legislative Office Room 201, Parliament Buildings Victoria, British Columbia V8V 1X4 Tel: (250) 387-3655

Community Office 3 – 11161 84<sup>th</sup> Avenue Delta, British Columbia V4C 2K4 Tel: (604) 597-1488 Fax: (604) 597-1466 Email: guy.gentner.mla@leg.bc.ca

September 28, 2012

Province of British Columbia Legislative Assembly

□M.O. #

DDRAFT REPLY

COTHER

MINISTER OF EDUCATION RECEIVED

OFILE

MAC

Guy Gentner, MLA (Delta North)

DEY

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DDM

The Honorable Dr. Margaret MacDiarmid Minister of Dealth Room 446, Parliament Buildings Victoria, British Columbia V8V 1X4

Dear Minister MacDiarmid:

Insulin administration in schools is a shared responsibility by the Ministry of Education, Ministry of Children and Family Development and Ministry of Heath. The "Unsafe At School Advocacy Group" has requested changes be made to accommodate better support services for students with diabetes in schools by appropriate health professions or improved training for school staff to carry out procedures that will ensure diabetic children with quick, proper, and safe responses. In a letter dated January 12, 2012, from then Minister of Education, George Abbott, in a response to "Unsafe At School Advocacy Group" Minister Abbott stated that "discussions among senior ministry representatives" [in the above-mentioned ministries] "have been underway throughout the summer of 2011 to review policy and service delivery options for the administration for the administration of insulin to children in school".

Would you kindly confirm that your Ministry has completed the review promised by Minister Abbott, and if so, what changes are underway?

Sincerely,

Guy Gentner, MLA Delta North Enclosure cc: The Honoral

The Honorable Don McRae, Minister of Education The Honorable Stephanie Cadieux, Minister of Children and Family Development Robin Austin, MLA (Skeena), Opposition Education Critic Mike Farnworth, MLA (Port Coquitlam), Opposition Health Critic Claire Trevena, MLA (North Island), Opposition Children &Family Development Critic Ms. Lila Yewchuck Mrs. Shirley-Anne Parsons

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January 12, 2012



Ref: 150488

Unsafe At School Advocacy Group c/o Lila Yewchuk 3530 Rosemary Heights Cres Surrey BC V35 0M4 S. 22

Dear Ms. Yewchuck:

Thank you for your letter dated November 8, 2011, to the Honourable Mary McNeil, Minister of Children and Family Development, regarding children who have Type 1 Diabetes and attend a public school in British Columbia. Minister McNeil has forwarded your letter to me and requested that I reply on her behalf.

The Ministry of Education takes student safety very seriously. Diabetes is a complex disease and the task of insulin administration is clinically complex, with a potential for serious harm if performed incorrectly. Providing safe, appropriate supports for students with diabetes involves careful consideration.

Currently, the school system operates in accordance with Ministerial Order 149/89 (M149/89), the Support Services for Schools Order which was enacted in 1989. With regard to providing safe, appropriate supports for students with diabetes, section 5, Specialized Health Services (1) and (3) of the Order apply. Section 5(1) states, "If complex health procedures are carried out in schools, the board shall ensure that staff designated to carry out these procedures have been trained, and are supervised, by appropriate health professionals". Section 5(3) states, "School staff trained to carry out health procedures for a specific student shall not perform those procedures on other students".

Due to its complexities, the issue of insulin administration in schools has been identified as an inter-ministerial responsibility. As such, discussions among senior ministry representatives in the Ministry of Education, Ministry of Children and Family Development and Ministry of Health have been underway throughout the summer of 2011 to review policy and service delivery options for the administration of insulin to children in school.

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Ministry of Education Office of the Minister

Mailing Address: PO Box 9045 Stn Prov Govt Victoria BC V8W 9E2 Location: Parliament Buildings Victoria Although no change to policy or service delivery has been decided upon at this time, this work continues to be a priority of government.

Again, thank you for taking the time to write.

Yours truly,

George abbott

George Abbott Minister

pc: Honourable Michael de Jong, Minister of Health Honourable Mary McNeil, Minister of Children and Family Development

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