

## Starship Diabetes Transition Programme

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The Starship Transition Programme is part of the Diabetes Clinics at Starship. The programme is integrated into regular clinics on Tuesday mornings at Greenlane Clinical Centre; monthly on a Friday at Botany Super Clinic and monthly on a Tuesday afternoon at the Whanau Health Centre in Henderson for all young people aged 14+. The programme aims to support young people to learn more about their condition during adolescence and provide coaching in young people developing strategies to take more responsibility. Pamphlets about managing specific aspects of diabetes through adolescence are provided at each clinic and young people are encouraged to ask any questions about things they want more information on within their clinic consultation. Further resources can also be found at the Starship Transition website:

<https://www.starship.org.nz/patients-parents-and-visitors/youth-transition/diabetes-service/>

The Transition programme utilises a “Youth Health” approach. This approach values the need for young people to be treated with respect, to be made aware of all health choices and understand that all health information will be kept confidential (unless there are safety concerns for the young person or others). Young people will be reminded of this each time they meet with the diabetes team within the clinic. Part of preparing young people and their families for an adult model of care, is having young people spend some time at clinic appointments talking to the doctor alone without their parents present in order to develop confidence in becoming more independent. Parents/caregivers/support persons will always be encouraged to join young people part-way through each clinic consultation.

Clinical Psychologist support is generally not provided within the clinic environment but can be accessed by discussing psychological needs with the adolescent team at clinic.

The active process of preparing young people for transition to Adult based services (Transition Planning) commences one year before the actual anticipated date of transfer, which is generally around the age of 15 years. During this preparation phase appointments may take longer than usual. The actual move to adult diabetes care will generally happen around the age of 16 years.

### **How will the diabetes team support emerging independence of the young person**

- Supporting parents in a changing role from full responsibility towards a gradual transition to cooperative care with the adolescent.
- Identifying and advising on which parental styles are likely to be more successful than others.
- The “HEADSS” (acronym for Home, Education, social Activities, Drugs, Sexual activities and Safety) interview is helpful when screening for concerns which may affect health management. This is undertaken by the doctor at each clinic appointment once young people are 14 years
- Encourage the young person to participate with parents and health care team in making decisions about diabetes management.
- Enabling the young person to learn from mistakes without moral judgement.
- Offering a variety of educational opportunities including open-ended discussion and negotiation, discussing health-related quality of life issues, problem solving, target setting, and age appropriate written materials.

### ***Strategies Health Care Teams may use to develop an optimal health care relationship with young people and their families***

- Developing a trusting relationship
- Helping the young person to set small achievable targets
- Providing education to help understand the physiological changes of puberty, their effect on insulin doses, issues around weight management and eating for health
- Organising regular screening for complications of diabetes ensuring young people understand and enjoy the benefits of improved metabolic control
- Allowing clinic consultations to be increasingly directed towards the young person but also involving and retaining the trust and support of parents
- Helping the young person and parents to negotiate changing levels of parental involvement in diabetes care

*Patient Sticky goes here*

Date of Clinic: \_\_\_\_\_  
Transition 1 or 2  
Insulin Regimen:

## Carbohydrate Questionnaire

**This is not a test!** This is a questionnaire to help us assess your current knowledge and how you go about the dietary management of your diabetes. This is to ensure you are up to date before you are transferred from our service. Please **circle** the foods that contain carbohydrate

Meat	Fruit	Peanut butter	Green leafy vegetables	Corn
Bread	Chicken	Yoghurt	Tomatoes	Margarine
Milk	Cheese	Fruit Juice	Potato	Rice
Pasta	Biscuits	Honey/Jam	Baked Beans	Diet coke

When you were **diagnosed**, how were you taught to work out your carbohydrate intake?

- 1) Can't remember
- 2) 10gram portions
- 3) 15gram portions
- 4) Carb counting using grams

Which method do you **currently** use?

- 1) None I just eat what I like
- 2) I look at my meals and judge on the size of them
- 3) I still use 10gram portions
- 4) I still use 15 gram portions
- 5) I carb count using grams.

Please **circle** the appropriate answer

**1) Carbohydrate Counting**

Never heard of  
Heard of but don't use  
Use occasionally  
Use often

**2) Carbohydrate to insulin ratio's**

Never heard of  
Heard of but don't use  
Use occasionally  
Use often

**3) Correction Factors/Insulin sensitivity factors**

Never heard of  
Heard of but don't use  
Use occasionally  
Use often

**4) When was the last time you saw a Dietitian?**

Can't remember  
In the last 12 months  
Other (please state)

# Transition Pathway Flow Chart



