DIABETES TRANSITION CONSENSUS STATEMENT

NZCYCN
New Zealand Child & Youth Clinical Network

As kaitiaki (carers/guardians) of diabetes related services, it is a collective responsibility to establish an environment that facilitates a pathway for people with diabetes to navigate te ao mate huka - the world of diabetes[1].

Ehara taaku toa i te toa takitahi, engari he toa takitini
My strength is not as an individual but as a collective.

Transition is "a planned, purposeful movement of the adolescent or young adult with a chronic disease from a child (and family) centred to an adult centred health care system." (ISPAD, 2018)

The transition from a paediatric to an adult orientated service should be an organised process of preparation and adaption, where care is delivered from a healthy youth development approach. The appropriate age for transfer from paediatric to adult care may vary due to the maturity of the young person/rangatahi, the availability of the appropriate service for the rangatahi and local service structures.

Whānau and the wider support network are considered the principal source of strength, support, security and identity hence their involvement is an important consideration in the planning and interaction with rangatahi.

Key Principles

PREPARATION

The transition process should occur with adequate timing and appropriate supports. Parents and whānau are vital to the process.

- Begin at least 12 months before transferring
- Parents/whānau role is emphasised through the whole process and their concerns discussed
- Rangatahi and whānau need to be aware of differences between paediatric and young adult/adult services and what to expect
- Rangatahi are given the opportunity for privacy and confidentiality unless there are safety concerns
- Identification of knowledge issues and diabetes distress so can be addressed as appropriate
- Identification of key stakeholders in the life of the rangatahi

Useful Documents

- What is transition - Diabetes transition flowchart
- Young Adult Service Contacts Across Aotearoa

COORDINATION

The goal of transition to encourage rangatahi to remain engaged in diabetes care and with diabetes care providers. This is achieved through clear communication between paediatric and young adult services, rangatahi and whānau.

- Written information made available about new service and team
- Written documentation summarising clinical and psychosocial assessment and cultural engagement.

[1] Te Kaiwhakahaere Māori te Roopu mate huka
Debbie Rawiri - Te Whatu Ora
Waitaha Canterbury

- Psychosocial Assessment including HEEADSSS - mnemonic for Home, Education and Employment, (eating and exercise), Activities and peers, Drugs, Sexuality, Suicide and depression, Safety, Spirituality
- Cultural Engagement including marae, connections to iwi, hapu and whānau
- Confirmation of receipt of information
- Caregivers/whānau are involved and aware
- Primary care are included in all correspondence
- Youth health information is provided by both services

Useful Documents

- Introduction to New Service and Team
- Transition Checklist
- Welcome to Young Adult Service Pack
- Transition Document including details on cultural engagement and HEADSS assessment

SUCCESS

Successful transition is determined by rangatahi being engaged with a service by attending appointments regularly or alternatively transferred to a health service that engages with them.

- Systematic review of accessibility to service as measured by "Did not attend rates"
- Clinicians are actively involved and interested in youth
- Rangatahi with diabetes continue to be seen by a specialist diabetes team every 3 months or more if required as recommended by ISPAD (2022).
- Member of the multidisciplinary team is designated the Transition Coordinator to support the transition process.

Useful Documents

- Satisfaction Survey

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