香港糖尿科護士協會
Association of Hong Kong Diabetes Nurses

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FEBRUARY 2016
AHKDN
11th NEWSLETTER

編者的話

In the past fruitful 2015, our members have continued contribution to the active health promotion from hospital to community. A newly developed Community Diabetes Centre "8765" is introduced to allow us a better understanding of community based service. As before, we co-organized in various international and local Diabetes symposiums: 17th East Meet West – "Lay Program" and 1st Asian Chinese Nurses Symposium.

Moreover, we published the Chinese version of Evidence-based Clinical guideline of insulin injection-"糖尿病循證臨床護理指南－糖尿病患者皮下注射胰島素" that allow wide application of guideline and allow quality assurance of clinical practice in Chinese culture. Hope all of us a prospective 2016.

"Knowledge & Technology Transfer" – 8765 Hours Self-management from research to practice

Ms Harriet Chung Hau Yee
Nurse Consultant, Clinical Services In-charge
8765 Diabetes Assessment Centre

1. Background

Since 1960s, more and more large-scale studies had identified the primary causes of chronic diseases and further established some known behavioral causes were affecting humans to the leading causes of death of these life-threatening diseases[1]. Over 50 years passed, The World Health Organization has identified four main types of chronic diseases/ noncommunicable diseases: **Cardiovascular Diseases** (*heart attacks and stroke)*, **Cancers, Chronic Respiratory Diseases** *(chronic obstructive pulmonary disease and asthma)* and **Diabetes**[2]. Indeed, they are commonly caused by high blood pressure and unhealthy lifestyle factors including cigarette smoking, unhealthy diet and lack of physical activity[1,3]. These chronic diseases explained 50% of all cause death over the past decades.

Reflected in some local surveys, unbalanced diets, physical inactivity, high mental stress, inadequate sleeping hours, long working hours, and neglect of regular health check-ups are common issues in Hong Kong[4,5,6]. These health-threatening risk factors cause a multitude of chronic diseases, such as diabetes, obesity and other metabolic disorders.

2. Impact of diabetes and related complications

According to the latest information of International Diabetes Federation (IDF), globally 1 in 11 adults have diabetes (415 million) whereas 1 in 7 births is affected by gestational diabetes. Today, 37% of all adults with diabetes live in the Western Pacific region. Projected there will be an increase of diabetes with a higher ratio of 1 in 10 adults (642 million) by 2040. In China, 1 in 3 people with diabetes (PWD) develop life-threatening complications in 6 years[7]. In Hong Kong, estimates 10% has diabetes and half of them is undiagnosed[4]. Based on the statistics of IDF, PWD in Hong Kong is 1.6% higher than other countries.

Terribly, the recent estimation showed every 6 seconds a person dies from diabetes that is more than 5.0 million deaths per year[7]. Western Pacific region had the highest number of 1.9 million in diabetes related deaths among all the IDF regions, and over 44.9% of these victims were under 60 of age. China alone had 1.3 million diabetes related deaths in 2015, with 40.8% of them occurring in people under 60.

Nowadays, near 0.39 million of PWD in Hong Kong are under the management of public health care system[8]. There is an increase of 18% of patient load in the system when compared with 5 years ago. Actually 30-60% of people suffered from stroke, heart disease and kidney failure in PWD. Among 20-40% of PWD missed the golden period of prevention action in time and developed complications within 5 years. Treatment costs for complications treatment increase by 3-5 fold when diabetic complications present. With the cost for daily admission is HKD 3,000 per each patient, there has an estimated HKD 0.3-0.5 million for one heart attack, stroke or cancer and a year of dialysis for survival. That keeps an up-trend of healthcare expenditure in society therefore it needs an urge action for primary and secondary prevention of diabetic complications as well as an effective disease management.

3. Knowledge & Technology Transfer from research to practice

◆ ***New concept – 8765 Hours Self-management***

In 2002, Professor Deveugele with her team carried out a large scale observational study in six European countries to explore the length of a medical consultation provided by general practitioners from different healthcare systems. They found that the average length of medical consultation was only around 10 minutes each visit (Mean: 7.6-15.6; SD: 4.3-8.7) with maximum up to 15 minutes only in Belgium and Switzerland[9].

According to some exploratory studies on the number of consultation of a chronic disease, most people with chronic diseases have an average of 4 consultations in a year and accumulated only 1 hour per year to be taking care by their doctors[10]. The rest of the 8765 hours are self-care, patients have to taking up the challenge of self-management when they are on their own. Therefore the magic number "8765" is completely reflects the essence of self-management in chronic diseases, such as diabetes.



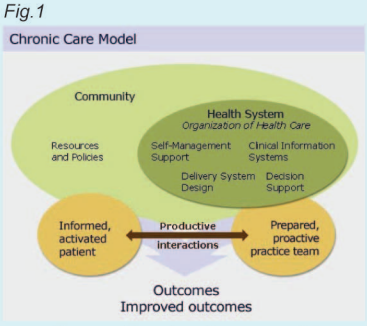
Another meaning of "8765" in the field of diabetes care is "5678". It represents the index of glycaemic control for PWD. The reading of 5-6 mmol/L is the ideal fasting and pre-meal blood glucose level whereas 7-8 mmol/L is the target control for 2 hours post-meal.

Today, the concept of "8765 Hours Self-management" is widely promoted and become more popular in diabetes management in many countries.

◆ ***Chronic Care Model***

Almost over half of the people with chronic illness such as diabetes, heart disease, hypertension and depression have multiple conditions affecting their clinical outcome. As discussed before, chronic illnesses are significant to individuals and cost burden to society.

Fig.1



Source: The chronic care model (Edward H. Wagner)

Over the past decades, the **Chronic Care Model** (CCM) ***Fig 1*** has been proven and demonstrated as a useful framework in various chronic diseases. It has 6 key interdependent components including [1] Community Resources and Policies, [2] Health System with four domains ([3] Self-management Support, [4] Delivery system Design, [5] Clinical Information, [6] Decision Support). The Model emphasized on patient empowerment, self-management support, and improving clinical and behavioral outcomes[1,11,12,13].

"Knowledge & Technology Transfer" – 8765 Hours Self-management from research to practice

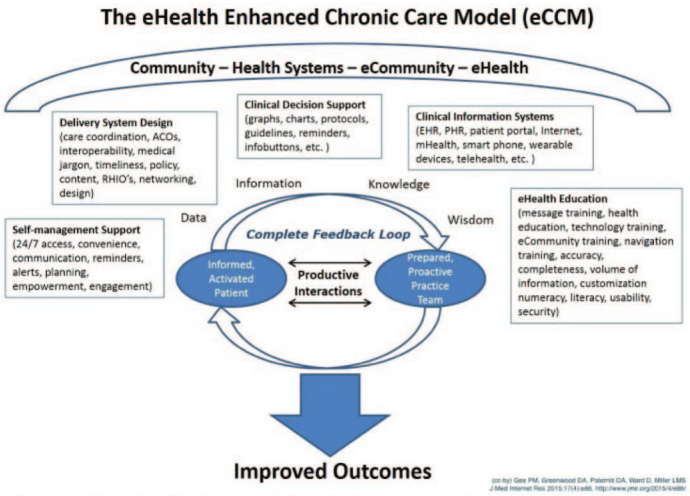
The heart of the CCM was illustrated through each domain of the Health System. They emphasized on managing a chronic disease to improve the outcomes of care and keep a person as healthy as possible[14]:

Self-Management Support	• To equip patient with knowledge, confidence, and skills for self-management of their condition.
Delivery System Design	• To promote a patient-centered care with an interdisciplinary team approach
Decision Support	• To assure patients and their healthcare providers have access to the most current and relevant evidenced-based guidelines for care
Clinical Information Systems	• To provide access to data, information, and knowledge needed to improve health

◆ ***eHealth Enhanced Chronic Care Model***

Regarding a quantity of information of management, communication and technology advancements have been established through the original CCM. A group of researchers paid much effort to review 260 relevant research studies and develop a revised care model, **eHealth Enhanced Chronic Care Model** (eCCM) in recent years. This new Model ***Fig 2*** showed an eHealth tools can make important contributions to manage and well utilize these clinical data in self-management in supporting people with chronic diseases[14].

Fig.2



Source: The eHealth Enhanced Chronic Care Model. Created by Gee PM et al (JMIR, 2015).
Adapted from The Chronic Care Model

The eCCM highlights 3 findings about the eHealth in caring chronic diseases (cited in Gee PM et al, 2015)[14]:
(1) eHealth education is critical for self-care
(2) eHealth support needs to be placed within the context of community and enhanced with the benefits of the eCommunity or virtual communities
(3) a complete feedback loop is needed to assure productive technology-based interactions between the patient and provider.

4. Implement the concept of "8765 Hours self-management" and eHealth Enhanced Chronic Care Model in community

The **"8765 Diabetes Assessment Centre"** was set up in 2014 and it took the theory of "8765 Hours of Self-management" into real practice. It is the first social-enterprise community based nurse-led diabetes centre in Hong Kong. This innovative concept that strived to bring positive changes to the society through a novel model of health management. It provides comprehensive health assessment and continuous monitoring for PWD, prediabetes or concerns about their risk of chronic diseases.

The Centre focuses on the reduction of the disease burden in the community, decrease the rates of premature death and disabilities. Protocol driven comprehensive assessment, systematic risk stratifications and estimated risk of major clinical events can help those with health concern to prevent complications as a benchmark quality of community care.


Community Diabetes Awareness Outreach Programme



Promotion of 8765 Hours of Self-management



Raise Public Awareness on Diabetic Peripheral Neuropathy

Backed by scientific researches, the Centre uses evidence-based model in diabetes risk assessment to support proactive self-management, facilitate collaborative care and shared decision making through a multidisciplinary team of healthcare professionals. Diabetes nurse, dietitian and podiatrist of the Centre support the most important 8765 Hours of Self-management and backing the primary healthcare providers in the community. Through a multidisciplinary and holistic eCCM for chronic diseases in addition to raise public awareness on disease prevention and control. This approach enables early detection of chronic diseases and assessment of 5-year risk of diabetes major complications such as coronary heart disease, stroke, heart failure and end stage kidney disease[15,16,17,18,19] as well as a 10-year risk prediction of cardiovascular diseases for those without diabetes[20].



On top of that, the Centre also empowers those with diabetes, chronic diseases or health concern to resume a leading role in their healthy lives by equipping them with the latest knowledge and skills in health management through customized recommendations, eHealth continuous monitoring platform and various well-structured health-/disease- management programmes. Furthermore, considering the power of peer support, the Centre provides related peers sharing and supporting activities to maximize the beneficial outcome from mutual communication and motivation in their healthcare journeys[13, 21, 22].

Based on the experience in past year, there is much room for more nurse-led community centres to coordinate chronic care and quality assurance in Hong Kong so as to enable people with chronic diseases to have a quality, longer, happier and healthier life.

For more information, please visit the web site http://www.8765diabetes.com.hk

Reference:
1. *Centre for Disease Control and Prevention. Fifty Years of Progress in Chronic Disease Epidemiology and Control. Supplements. 2011 October 7/60(04):70-77*
2. *http://www.who.int/topics/noncommunicable_diseases/en/*
3. *http://www.who.int/mediacentre/factsheets/fs355/en/*
4. *http://www.diabetesrisk.hk/*
5. *Ko G, et al. Association between sleeping hours, working hours and obesity in Hong Kong Chinese: the 'better health for better Hong Kong' health promotion campaign. International Journal of Obesity. 2007; 31, 254–260*
6. *Tuomilehto J, Lindström J, Johan GMS, et al for the Finnish Diabetes Prevention Study Group. Prevention of Type 2 Diabetes Mellitus by Changes in Lifestyle among Subjects with Impaired Glucose Tolerance. N Engl J Med. 2001 May 3; 344:1343-1350*
7. *http://www.diabetesatlas.org/*
8. *Health Facts of Hong Kong 2015 Edition. http://www.dh.gov.hk/english/statistics/statistics_hs/files/Health_Statistics_pamphlet_E.pdf*
9. *Deveugele M et al. Consultation length in general practice: cross sectional study in six European countries. BMJ. 2002;Aug 31; 325(7362): 472.*
10. *NHS Information Centre for health and social care. Final Report to the NHS Information Centre and Department of Health. Trends in Consultation Rates in General Practice 1995 to 2008:Analysis of the QResearch®database.*
11. *Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. Managed Care Quarterly. 1996; 4: (2) 12-25*
12. *Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Quarterly. 1996; 74:11-544*
13. *Fisher EB, Boothroyd RI, Muchieh Coufal M, et al. Peer Support For Self-Management Of Diabetes Improved Outcomes In International Settings. Health Aff (Millwood). 2012 Jan; 31(1): 130–139*
14. *Gee PM, Greenwood DA, Paterniti DA, et al. The eHealth Enhanced Chronic Care Model: A theory derivation approach. J Med Internet Res. 2015 Apr 1;17(4):e86*
15. *Yang X, So WY, Kong APS, et al. Development and validation of a total coronary heart disease risk score in type 2 diabetes mellitus. AM J Cardiol 2008;101:596-601*
16. *Yang X, Ma RC, So WY, et al. Development and validation of a risk score for hospitalization for heart failure in patients with type 2 diabetes mellitus. Cardiovascular Diabetology 2008;7:9*
17. *Yang X, So WY, Kong APS et al. Development and validation of stroke risk equation for Hong Kong Chinese patients with type 2 diabetes. Diabetes Care 2007;30:65-70*
18. *Yang X, So WY, Kong APS, et al. Modified end-stage renal disease risk score for Chinese type 2 diabetic patients – the Hong Kong Diabetes Registry. Diabetologia 2007;50:1348-1350*
19. *Yang X, So WY, Tong PC, et al. Development and validation of an all-cause mortality risk score in type 2 diabetes. Arch Intern Med 2008;168:451-457*
20. *Goff DC Jr, et al. 2013 ACC/AHA Cardiovascular Risk Guideline. Journal of the American College of Cardiology. DOI: 10.1161/01.cir.0000437741.48606.98.*
21. *Yin JM, Wong R, Au S, et al. Effects of Providing Peer Support on Diabetes Management in People With Type 2 Diabetes. The Annals of Family Medicine 08/2015; 13 Suppl 1(Suppl 1):S42-9*
22. *Chan JCN, Sui Y, Oldenberg B, et al, for the JADE and PEARL Project Team. Effects of Telephone-Based Peer Support in Patients With Type 2 Diabetes Mellitus Receiving Integrated Care: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(6):972-981*

7th AHKDN AGM Outstanding Achievement Award

Subcutaneous Insulin Injection Audit Experience in Queen Elizabeth Hospital

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Diabetes Center, Queen Elizabeth Hospital



Introduction

Accurate insulin administration is indispensable to ensure patients' safety and achieving effectiveness of insulin therapy. Inappropriate injection may adversely affect the metabolic control and thus patients' quality of life. However, we find many patients not able to give insulin injection accurately over time.

We conducted a subcutaneous insulin injection audit in the Diabetes Center, Queen Elizabeth Hospital in November 2014 to January 2015. The audit has two aims. The first one is to reveal patients' subcutaneous insulin injection technique and problems. The second one is to evaluate the effectiveness of targeted insulin injection education in maintaining accurate insulin injection techniques by patients. The following shares the process and results of the project.

Process

1. Instrument development

First of all, the 4-person research group, based on the AHKDN Evidence-based Clinical Guideline on Subcutaneous Insulin Injection for people with diabetes mellitus (2014), drafted two subcutaneous insulin injection checklists for assessing patients' injection with insulin pen and insulin syringe. Each checklist has 4 sections. Section one asks information about years of insulin injection experience, sites of injection and the needle length being used by patients. Section two contains 11 items to review the injection technique. Section three is injection site inspection to detect any abnormalities including i) bruising, ii) lipohypertrophy, iii) lipoatrophy and iv) discoloration; and the severity. Any site abnormality is to be recorded in the diagrams of the section. Section four contains 8 items to elicit time of injection, site rotation pattern, storage of insulin and disposal of needle after use.

The draft was then discussed among all 9 diabetes nurses in 2 center meetings. Refinements were made to ensure the items are valid, comprehensible and reliable.

2. Pre-education assessment

Two diabetes nurses in the Center were assigned for pre-education data collection after a brief training on using the checklist. Either one nurse was designated in each complication screening clinic to review consented patients' injection technique and sites.

Patients receiving insulin therapy returned for complication screening clinic during the audit period were invited to participate in the audit. Verbal consent was obtained before data collection. Information in section one was elicited by asking the patients or retrieval from the Clinical Management System. To assess injection technique in section two, patients were asked to demonstrate how s/he gives an injection using the appliances provided to them. For site abnormalities in section three, patients were asked to illustrate the sites they have been injecting and the nurse inspected the sites to grade the level of severity of the abnormalities if any. For the last session four, patients were asked on how they rotated from injection to injection, how they disposed the used needle and when to inject the insulin.

3. Targeted education

The 2 assigned nurses were also trained to provide targeted education using the "made simple tool" designed by the research group. The tool extracted 11 items from the Center's Insulin Injection Steps Guide and a site rotation diagram. According to the faulty skills and site problems identified, the nurse gave corrective advice to the patients. The average time spent on each patient for both review and education was 20 mins. Patients were then invited to return for post-education assessment in 2 to 3 months' time using the same checklists.

4. Post-education assessment

In the post-education assessment, section two to four information were collected again by technique review, site inspection and asking patients. Targeted education was provided again based on the incorrect practice identified. Patients found to have other problems associated with self-management were referred to subsequent individual education.

Results

1. Insulin injection practice

We have reviewed 176 patients in this audit exercise, 124 (70%) are pen users while 52 (30%) are syringe users. Ninety four (54%) are male and 82 (46%) are female. Majority (92%) of patients gave themselves injection.

	Syringe users (SD)	Pen users (SD)
Age	62.8 (±11.9) years	58.2 (±15.2) years
Duration of diabetes	21.2 (±8.9) years	18.5 (±8.9) years
Mean no. of shots	2.22 (±0.8)	2.15 (±0.9)
No of shots	QD = 20 %	QD = 20%
	BD = 61 %	BD = 61 %
	MDI = 19 %	MDI = 26%

Analysis of the pen user group data reflected the following:

- Injection experience: 8% of them had used insulin for ≤ 1 year, 60% of them had injection experience of 1-10 years while 32% of them had > 10-year experience of injection.
- Total daily insulin dose given ranged from 6 units to 178 units. Over 75% of them gave > 20 units daily and 44% gave > 40 units per day.
- Needle use: majority of them use 6-8 mm needles (13% using 4 mm, 11% using 5mm, 43% using 6mm, 33% using 8mm).

2. Injection problem

Problems with injection techniques and sites were enormous. Lipohypertrophy in injection sites is common, it occurred to 75% of patients. The top five injection problems for pen users included i) in-adequate mixing of cloudy insulin by tipping (81%); ii) massage site following injection (69.8%); iii) maintain hold time less than 10 seconds (61.5%); iv) reuse needle (60.4%); v) unsystematic rotation of injection sites (54.2%).

3. Education effect

Improvement after education by patients was impressive. Except for re-use of needle (patients' reuse needle behavior increased by 2.1%), patients made significant improvement in terms of: i) systematic point rotation (45.9%), ii) maintaining a 10-second hold time (41.7%), iii) mixing of cloudy insulin by tipping for 20 cylces (39.5%), iv) no more massage of site after injection (20.4%).

4. Patient feedback

Most patients appreciated the review and specific education provided to them in the audit. Two aspects of education appreciated by patients most are i) tipping of insulin for 20 cylces to mix cloudy insulin well, and ii) systematic rotation of points and areas to prevent hypertrophy in injection sites.

Reflection and recommendation

We learned from this audit that majority of patients have multifaceted problems with subcutaneous insulin injection and local sites reactions. This audit experience also reflected our loophole in educating patients on subcutaneous insulin injection and a lack of regular support in monitoring patients' injection skills and sites.

Therefore, we advocate strongly that regular review and reinforcement education of injection technique and site inspection should be provided to enable accurate injection by patients over time.

We recommend a mechanism to be established in all diabetes education services so that such monitoring and education can be done on a regular basis. Diabetic complication screening activity may provide a good opportunity for this review.

7th AHKDN AGM Outstanding Achievement Award for the Green

Structured-approach early insulin titration program (a continuous quality improvement program)

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Diabetes and Endocrine Centre (DMEC), Prince of Wales Hospital

Background

Studies to date have shown that aggressive forced titration of basal insulin can attain targeted glycemic goals. Nurse clinic plays an important role in co-titrating insulin for the patients. However, in the current practice, there is not a structured titration program for the nurse clinic to have early titration for these insulin naive patients.

Aims

To develop a structured insulin titration program.

To achieve the optimal glycemic control as early as possible after initiation of insulin therapy.

Methodology

A pre-post test design was adopted in this quality improvement program. T2DM patients aged 18 or above initiated on insulin for the first time in the form of supplementary insulin due to secondary OAD failure or due to other concomitant illness rendering OAD treatment unsafe were recruited from 3/2014 to 1/2015. A structured-approach program of which consisted of 4 nurse clinic visits and 4 telephone calls were arranged. For the first two nurse clinic visits, they were on a group basis with a group size of 2 to 6 patients for the sake of via group dynamic and peer sharing and support to clarify patients' misconceptions, fear of insulin injection as well as to master the injection skills and to share their experience in lifestyle modification. While for the 3th and 4th nurse clinic visits, the one-to-one individual visits would be provided. During these last two visits, nurses would pinpoint to each patient's problems and deliver the tailor-made nursing care to them. In between each nurse clinic visit, a telephone call would be provided to follow patients' 3 consecutive days of fasting plasma glucose (FPG) control and to solve the problems they might encounter. During this structured-approach program, insulin titration in accordance with an algorithm would be adjusted both in the nurse clinic visits and over phone follow-ups after patients' first clinic visit. A one-page written material about insulin injection would be provided to patients so as to give them some solid information about insulin and to empower them the brief concept about insulin titration. Outcome measures included a change in HbA1c, fasting plasma glucose (FPG) levels, weight gain, hypoglycemia events as well as the insulin related anxiety level before and after the program by employing a validated Chinese version insulin injection anxiety scale. (For details of the program outline, insulin titration algorithm, the take home written material and the insulin injection anxiety scale, please see Appendix 1, Appendix 2, Appendix 3 and Appendix 4 respectively).

Results

From 3/2014-1/2015, there were 53 patients having completed this titration program. In the mean follow up of 20-weeks, there were average of 2.79 phone calls made by nurses, while most of the calls were made before patients' second visit (i.e. week3). For the frequency of insulin titration done by nurses, 2.23 times of titration of which including both over phone and in the nurse clinics were made by nurses. During these 20-weeks, 66.7% of insulin dose increment was made (0.12units/kg at 0 week to 0.21units/kg at 20 weeks). For the HbA1c result, significant absolute changed was observed (9.0 ± 1.2% at 0 week to 7.7 ± 0.8% at 20 weeks, p <0.001). For the Fasting Plasma Glucose (FPG), statistically difference was noted (10.4 ± 0.99mmol/L at 0 week to 7.2 ± 0.87mmol/L at 20weeks, P <0.001). While for the weight gain, there was no statistically significant weight gain after this program (73.3 kg at 0week to 73.9kg at 20week, p=0.098). As for the hypoglycemia event, 45% patients had experienced mild hypoglycemia but none of them had ever had severe hypoglycemia attack. Regarding to patients' injection-related anxiety level, moderated level of insulin-related anxiety was noted before the program whereas this anxiety level was reduced by half after the program.



Conclusions

Encouraging glycemic control improvement as well as reducing insulin related anxiety level were observed in this program. There was statistically significant 1.3% reduction of HbA1c in the mean follow-up of 20weeks while did not associate with significant weight gain and severe hypoglycemia. Therefore, mutual understanding and supporting environment among peers was cultivated during peers sharing. This structured-approach active early insulin titration program merited continuous implementation for the betterment of diabetes management.

Appendix 1. Program Outline

	Visit 1	Phone	Phone	Visit 2	Phone	Visit3	Phone	Visit4	Post-program
	Day 0	Day 3	Day 10-13	Week3		Week8-12		Week 12-16	Week 16-20
Body Height	✓								
Body Weight	✓			✓		✓		✓	
Blood pressure	✓			✓		✓		✓	
Blood test	✓								✓
Questionnaire	✓								✓
Education	✓	✓	✓	✓	✓	✓	✓	✓	
Teaching injection	✓								
Teaching SMBG	✓								
Phone FU**		✓	✓		✓		✓		
Insulin titration ***		✓	✓	✓	✓	✓	✓	✓	
Documentation	✓	✓	✓	✓	✓	✓	✓	✓	

** The frequency of phone follow up subject to patients' glycemic control and in agreement with patients
***The frequency of insulin titration subject to patient's glycemic control

Appendix 2. Insulin titration algorithm guideline for bedtime insulin regime plus OHA

Fasting Plasma Glucose (FPG) mmol/L	Insulin dose
≤ 3.9 or symptomatic hypoglycaemia	Decrease by 2 units
3.9 < FPG ≤ 6.5	No change
6.5 <FPG ≤ 8.7	Increase by 2 units
8.7 <FPG ≤10	Increase by 4 units
>10	*Discuss with doctor before increasing dose by 6 units*

Activities: July to Dec 2015

Educational Seminar & Training

7th AHKDM AGM & Seminar " Combating Obesity : The New Move 控重新動向 " on 4 July 2015

Keynote Speech (1)
Speaker: Dr Elaine Cheung
Senior Medical Officer,
Department of Medicine and
Geriatrics, United Christian Hospital
Topic: Medical perspective:
Local experience in GLP1





Keynote Speech (2)
Speaker: Dr Daniel KH Tong
Consultant, Department of Surgery,
Queen Mary Hospital
Topic: Surgical perspective:
The effectiveness of Bariatric surgery

91 members enjoyed the informative lectures.
(Lecture slides were upload to AHKDN website member zone)

7th AHKDN AGM

Business report and financial report were given by President Dr. Jo Jo Kwan and Treasurer Mr. Leung Sum Ming in sequence. 48 members in site adopted the report.



Diabetes Dialogue Card Training Workshop

3 Training workshops were held on 13 June, 8 August & 10 October 2015 with 34 ,39 & 48 participants attended respectively.



The 19th AHKDN Educational Seminar was held on 27 August 2015

Topic: Similarities and Differences of gliptins in the management of type 2 diabetes?
Speaker: Professor Stefano Del Prato
M. D. Professor of Endocrinology and Metabolism,
University of Pisa, Italy



Lunch in the Dark

The workshop was held on 9 September 2015 with 18 participants



AHKDN as supporting organization for 7th AASD Scientific Meeting and Annual Scientific Meeting of HKSEMR 21 & 22 November 2015
20 members were nominated to join the meeting

The session of "DM educational Seminar: Advancing Practice in Diabetes: Nurse- patient partnership" was held on 21 November 2015.
36 Asian diabetes Educators from China, Singapore, Taiwan, Macau & Hong Kong participated with fruitful discussion.



Afterward, AHKDN invited the Asian Diabetes Educators to have a "華人糖尿科護士研討會暨晚宴" . 34 Diabetes Educators joined the banquet with rich experience sharing, happy games and delicious food.



Activities: July to Dec 2015

Promoting Health Awareness in Community Education

Diabetes Conversation Map Community Program was held at Kwun Tong Christian Family Service Centre on 18 July 2015 with about 70-80 participants.



DM Exercise Song "舞動健康"community workshop was held on 15 August 2015 with 32 patient participated



AHKDN co-hoisted DM Lay Education Program at East Meets West Symposium on 3 October 2015



International Congress

East Meets West Symposium 2015 was held on 3 &4 October 2015
5 members were nominated to join the meeting

Partner in Patient Health Asian Pacific Forum 2015 was held on 15 &16 October 2015
"Working Together with One Voice" with 1 member from our AHKDN's representative at the meeting



IDF World Diabetes Congress Vancouver 2015 on 30 November - 4 December 2015
10 members were nominated to join the meeting



Activity

Macau Trip: visiting Kiang Wu Hospital, experience sharing and sight-seeing on 24 October 2015 with 29 participants



Diabetes Centre Round

Introduction of Diabetes and Endocrine Centre at Tuen Mun Hospital

Veronica Hung (Nurse Consultant in Diabetes, NTWC)

Diabetes and Endocrine Centre (DMEC) has started service at Tuen Mun Hospital since August 2014. The Centre is located on the 7th Floor of Rehabilitation Block in Tuen Mun Hospital, where allied health professionals such as podiatrist, dietitians, physiotherapists and medical social workers are located.

The bamboo-look landscape with natural sunlight design at the lift waiting area provides a relaxing garden-feel environment. On the walls of the waiting area in the Centre, different education theme boards are posted up to arouse patients' interest in self-management of diabetes.

DMEC provides comprehensive diabetes education and anti-diabetic drug adjustment under protocol co-formulated with endocrinologists. Therapeutic education aims at self-care of diabetes in the community sustainably. Patient empowerment can be in the form of individualized counselling or interactive small group discussion. On the other hand, we employ continuous glucose monitoring system (CGMS) on patients with brittle diabetes control to demonstrate their variability of blood glucose levels. This advanced technology assists both health care professionals and patients in understanding the effect of diet and lifestyle on glycaemic control.



Kick-off Opening Ceremony Photo



Bamboo-like landscape at lift waiting area

Our Centre also performs diabetes and metabolic risk assessments periodically in patients with diabetes followed in our hospital including blood and urine tests, feet assessments and retinal photographies. For patients requiring major change in treatment regimen, they are arranged to see endocrinologist clinic in our Centre for timely expert interventions. Furthermore, DMEC is actively involved in the diagnosis and management of patients with endocrine diseases and morbid obesity patients undergoing bariatric and metabolic surgery.

In addition to the conventional referral mechanism, our Centre has initiated a targeted active intervention project since January 2015, trying to overcome the clinical inertia phenomenon which is common in the diabetes care in Specialist Outpatient Clinics. We collaborate closely with and offer support to partners in the community, in particular the Family Medicine Specialist Clinic, General Outpatient Clinics, Patient Empowerment Programme (PEP), smoking cessation service and seasonal influenza vaccine programme.

Last but not least, DMEC is not only a training centre for doctors and nurses in diabetes and endocrine disease management but serves as help-desk for various health care professionals on these chronic illnesses.

Professional Promote

Conference/Seminar	Date	Web-site
18th European Congress of Endocrinology; Munich, Germany	28 - 31 May 2016	http://www.ese-hormones.org
76th Scientific Sessions of American Diabetes Association (ADA); New Orleans, Louisiana	10 - 14 June 2016	http://www.diabetes.org
Annual Meeting & Exhibition, American Association of Diabetes Educators (AADE); San Diego, California	12 - 15 August 2016	http://www.diabeteseducator.org
52nd Annual Meeting of the European Association For The Study of Diabetes; Munich, Germany	12 - 16 September 2016	http://www.easd.org
11th International Diabetes Federation Western Pacific Region Congress 8th Scientific Meeting of the Asian Association for the Study of Diabetes; Taipei, Taiwan	27 - 30 October 2016	http://www.idf.org
Courses	**Date**	**Web-site**
Update on Diabetes Education and Management Course 2016	5 April - 31 May 2016	http://www.ahkdn.com

「澳門鏡湖」行

羅展珊
糖尿科資深護師

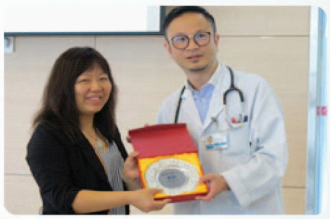


2015年10月24日，本會28位會員一同前往澳門鏡湖醫院糖尿病防治中心作交流，當天得到該中心之護士主管吳燕儀進階專科護士及其同事熱情的招待，吳護士帶領我們參觀了糖尿病防治中心，該中心之等候區陳設給人溫暖的感覺，還有擺放糖尿病護理物品的展覽櫃及糖尿病教育小冊子。吳護士還向我們介紹了糖尿病防治中心的發展及服務範疇，讓我們了解到該中心對糖尿病護理的各項服務。

澳門鏡湖醫院糖尿病防治中心於2011年1月29日舉行了開幕典禮，在開幕當日，還邀請了本會主席關綺媚博士作嘉賓及參予研討會。該中心服務發展迅速，服務包括：

一、 糖尿病專科門診、內分泌及其他代謝病專科門診
二、 糖尿病護理指導門診
三、 營養師門診
四、 糖尿病足部護理

澳門鏡湖醫院糖尿病防治中心亦致力於社區推廣糖尿病教育，除了舉辦糖尿病教育工作坊外；為了響應世界糖尿病日，於2014年11月舉辦了「世界糖尿病日嘉年華」，與糖尿病病友及其家屬分享了健康生活與糖尿病的知識。









Chinese version of Evidence-based Clinical guideline of insulin injection was published on November 2015

ANNOUNCEMENT

8th AHKDN Annual Symposium & AGM
老幼談「胰」
5/F Diamond Room
CityView Hotel
25 June 2016 14:00 – 17:00

