

HSE Interim Clinical Guidance on Management of Diabetes during the COVID-19 Pandemic

Date	21 April 2020	
Version	Version 1.	
	The National Clinical Programme (NCP) for Diabetes will continue to update this guidance as new information becomes available.	
Guidance Development Group:	Prof. Sean Dinneen	Clinical Lead, NCP Diabetes; Consultant Endocrinologist, Saolta Hospital Group
	Dr. Diarmuid Quinlan	ICGP Lead for Diabetes; GP in Glanmire, Cork
	Margaret Humphreys	National Lead Self-Management Education
	Assumpta Coyle	Podiatry Representative, NCP Diabetes; Senior Podiatrist, UL Hospitals Group
	Yvonne Moloney	Registered Advanced Midwife Practitioner, UL Hospitals Group
	Cathy Breen	Senior Dietitian, St. Columcille's Hospital, Loughlinstown
	Linda Culliney	Clinical Specialist Dietitian, Cork University Hospital
	Lorna Hurley	Community Diabetes Facilitator, Community Healthcare West.
	Mary O'Scannail	Diabetes Nurse Specialist, St. Columcille's Hospital, Loughlinstown
	Sinead Powell	Regional Development Officer/ Dietitian, Diabetes Ireland
	Clíodhna O'Mahony	Programme Manager, NCP Diabetes
Contributors:	Prof. Fidelma Dunne	Consultant Endocrinologist, Saolta Hospital Group
	Prof. Mensud Hatunic	Consultant Endocrinologist, Mater Misericordiae University Hospital & Holles Street
	Dr. Diarmuid Smith	Diabetes CAG Chair, RCPI; Consultant Endocrinologist, Beaumont Hospital
	Patricia Murray	Registered Advanced Nurse Practitioner, Diabetes Integrated Care, Sligo University Hospital
	Frances Gibbons	Data Quality Supervisor for Individual Health Identifier, HBS.
Approved by:	Dr. Orlaith O'Reilly	National Clinical Advisor and Group Lead for Chronic Disease
Target Audience:	Healthcare Professionals	

Contents

Overview	4
The importance of Covid-19 prevention.....	4
Impact of the pandemic on diabetes services	4
Patients with newly diagnosed diabetes	5
Patients with known type 1 diabetes	5
Patients with known type 2 diabetes	6
Mental health during the pandemic	7
Diabetes in Pregnancy	7
Management of Pre-existing Diabetes	7
Screening for Gestational Diabetes (GDM).....	8
Management of GDM	8
The Diabetic Foot	9
Foot Screening	9
The At Risk Foot	9
Active Foot Disease: Not Limb threatening	9
Active Foot Disease: Limb threatening	10
Other considerations	10
Podiatry Service Delivery	10
RetinaScreen	11
Delivering a ‘virtual’ diabetes consultation during the Covid-19 crisis	12
Preparation is the key to success:.....	12
During the consultation:	12
After the consultation:.....	13
References	14

Overview

Delivery of high quality diabetes care requires a well-informed patient with good self-management skills to work with a knowledgeable and well-staffed specialist team who can advise the patient on how to manage their condition to avoid the (short and long-term) complications of diabetes. During this time of unprecedented pressure on health systems and society, achieving and maintaining optimal blood sugar control can be a real challenge. Patients and their loved ones feel stressed and we know stress can have a deleterious effect on self-care behaviours and on blood sugar control. Healthcare staff are also feeling stressed and many diabetes team members are being redeployed to the pandemic response. Data from other countries would suggest that diabetes is one of the conditions that carries an increased risk of poor outcome if COVID-19 infection develops. The purpose of this document is to highlight for frontline staff involved in delivering care to patients with diabetes some issues that may help with achieving good outcomes during the COVID-19 pandemic. This guidance should be used in conjunction and in line with guidance issued from the Health Protection Surveillance Centre (www.hpsc.ie).

The importance of Covid-19 prevention

The advice relating to social distancing, hand hygiene, self-isolation and other measures to prevent the spread of the virus is important for everyone in society but the advice is especially important for people living with diabetes. In the absence of a vaccine or effective anti-viral therapy, avoiding getting the infection is the best form of defence. Where possible people living with diabetes should avoid attending hospitals, pharmacies and other facilities where their risk of acquiring the infection is increased. Diabetes Centres around the country are delivering 'Virtual Clinics' and patients should prepare themselves for these visits as they would a face-to-face outpatient clinic by having an up-to-date record of their blood sugars, uploading any diabetes technology they use and where possible, having recent laboratory results available. Patients may also want to write down any issues they want to discuss with the doctor or nurse during a virtual clinic consultation.

Impact of the pandemic on diabetes services

- All self-management education courses such as Discover Diabetes, DAFNE, DESMOND, CODE, etc. have been postponed due to social distancing regulations however, online courses are available, free of charge:
 - Diabetes Ireland: Diabetes SMART education for Type 2 Diabetes (available at www.diabeteseducation.ie)
 - Diabetes UK: Learning Zone includes education for Type 1 Diabetes (available at <https://cutt.ly/ltHDo1O>)
- Many healthcare professionals working in diabetes teams have been redeployed to the COVID-19 response.
- Virtual clinics or telemedicine consultations have replaced outpatient face-to-face clinics.
- Diabetic RetinaScreen has suspended all screening clinics until after the pandemic.

- Screening for Gestational Diabetes using the OGTT presents problems as pregnant women may not wish to visit the hospital and spend 2-3 hours awaiting a second blood test.
- Diabetic Foot Services have been significantly curtailed in some parts of the country due to redeployment of Podiatrists

Patients with newly diagnosed diabetes

Patients presenting with newly diagnosed diabetes during the pandemic should be assessed and managed (where possible) outside of hospital.

General Practitioners and/or Practice Nurses should refer to the ICGP Guidelines for Management of newly diagnosed Type 2 diabetes (<https://cutt.ly/5tHDRR8>). Delivery of face-to-face self-management education programmes (DESMOND, CODE and Discover Diabetes) has been paused. However, patients should still be referred to these programmes on diagnosis, and will be contacted directly with an appointment once these programmes resume. In the meantime, patients can access self-management education for type 2 diabetes online through the Diabetes online programme (www.diabeteseducation.ie) which is offered free of charge by Diabetes Ireland.

For patients with newly diagnosed type 1 diabetes a key determinant of the need for hospitalisation will be the degree of ketosis and acidosis. It may be possible to manage patients with new type 1 diabetes entirely in the outpatient setting. Close contact between the patient and the Specialist Team will be a critical part of achieving optimal blood sugar control. Online education and information for those with type 1 diabetes is available from Diabetes Ireland (www.diabetes.ie) and through Diabetes UK Learning Zone (<https://cutt.ly/lHDo1O>) and is free of charge.

Patients with known type 1 diabetes

It is critically important that healthcare professionals admitting patients with diabetes to hospital can distinguish between patients with type 1 diabetes (who require insulin for survival) and patients with type 2 diabetes (who may be using insulin for treatment). Important features that can help identify patients with type 1 include:

- A diagnosis in childhood or adolescence
- The need for insulin treatment from initial diagnosis
- A history of diabetic ketoacidosis (DKA)
- The presence of other autoimmune conditions in the patient or first degree family members

The reason it is so important to identify patients with type 1 diabetes on admission relates to their risk of DKA which seems to be a feature of COVID-19 infection. If DKA develops in the setting of COVID-19 infection, then a modification to the hospital DKA protocol (minimising intravenous fluid administration) will be required. To prevent DKA and avoid hospitalisation patients should be reminded of 'sick day rules' and if they develop symptoms of COVID-19 (or any severe illness) they should implement these guidelines at home and get in touch with a member of the diabetes team for advice.

A summary of key features of sick day rules for patients to remember:

- Keep well hydrated and convert calories to liquid if unable to eat solid food
- Monitor for ketones (in blood or urine)
- Monitor blood glucose at least every four hours and (in the presence of ketones) as frequently as every two hours
- Take quick-acting insulin based on an algorithm driven by level of glucose and ketones
- Never stop your long acting insulin
- Recognise that total daily insulin requirements on sick days are typically similar to that required when well
- If you are still not improving despite implementing all of the above measures then call for help from family members or from the Specialist Diabetes Team

For patients managing their type 1 diabetes with a continuous subcutaneous insulin infusion pump supplies should be readily available throughout the pandemic. However, it is still wise for pump patients to have a backup supply of pens with quick-acting and long-acting insulin in case of pump malfunction. Some insulin pump manufacturers plan on extending the warranty period through the COVID crisis and can make replacement pumps available if necessary. Some manufacturers of blood glucose meters have made software that facilitates sharing of glucose readings between patient and provider available free of charge during the pandemic. The Association of British Clinical Diabetologists and Diabetes UK have produced guidance for healthcare professionals in managing inpatient diabetes during the COVID pandemic:

https://abcd.care/sites/abcd.care/files/site_uploads/COvID_Front_Door_v1.0.pdf

Patients with known type 2 diabetes

In general patients should continue to take their glucose lowering medication as prescribed. If feeling unwell (e.g., abdominal pain, vomiting, flu-like symptoms) patients should contact their GP for advice. If requiring hospitalisation, patients on SGLT-2 inhibitor drugs should stop taking these tablets but continue other glucose-lowering agents. All patients with diabetes on a SGLT-2 inhibitor admitted to hospital should have a blood ketone checked on admission. Drugs in the SGLT-2 inhibitor class include:

- Dapagliflozin (Forxiga)
- Empagliflozin (Jardiance)
- Canagliflozin (Invokana)
- Ertugliflozin (Steglatro)

The fixed dose combinations that include an SGLT-2 inhibitor are:

- Xigduo (Dapagliflozin/Metformin)
- Synjardy (Empagliflozin/Metformin)
- Vokanamet (Canagliflozin/Metformin)
- Segluromet (Ertugliflozin/Metformin)

The recommendation to stop SGLT-2 inhibitors while in hospital relates to the risk of euglycaemic DKA. On stopping the SGLT-2 inhibitor patients may need an alternative agent to maintain blood sugar control. In a hospital setting the preferred agent should be insulin. Patients should continue taking ACE inhibitors/ARBs which are proven to help manage Blood Pressure and maintain kidney function.

Mental health during the pandemic

The links below are useful resources for mental health issues that may arise during the COVID-19 crisis. Although some of the information is geared towards people who have type 1 diabetes, most of the advice is relevant to all of us (patients and healthcare professionals alike) during this challenging time.

- Mental Health Ireland: (<https://www.mentalhealthireland.ie/get-support/covid19/>)
- Type 1 Resources: (<https://www.t1resources.uk/resources/item/dr-rose-stewart-coronavirus-toolkit/>)

Diabetes in Pregnancy

Management of Pre-existing Diabetes

Where possible antenatal visits should be undertaken remotely. If a face-to-face review is needed it should coincide with booking scans and blood tests. This review should cover:

- HbA1c, renal and thyroid function, and urinary PCR
- Blood glucose monitoring (continuous monitoring or sensor or finger prick) and the process for remote review of blood glucose control
- Appropriate prescriptions for blood glucose and/or ketone monitoring
- Information on hypoglycaemia avoidance and awareness for women using insulin
- Prescription for 5mg folic acid for all women with Type 1 or 2 Diabetes in Pregnancy
- Prescription for low dose aspirin for all women with Type 1 or 2 Diabetes in Pregnancy if appropriate following assessment by the Obstetric team
- Care planning which involves the diabetic specialist nurse or midwife and dietetic consultation
- To reduce the number of hospital visits, consider recommending retinal screening only to women with known retinal changes prior to pregnancy
- Consultations by the diabetes team for the purpose of reviewing home capillary blood sugar levels should be done remotely, wherever possible
- All women should continue to have antenatal care with their team (e.g. to include blood pressure and urinalysis), remotely where possible

If further face-to-face antenatal clinic reviews are required, these visits should coincide with planned ultrasound appointments at 34-36 weeks gestation, to comprehensively assess maternal and foetal condition, and plan timing and mode of birth. Women affected by COVID-19 and who are symptomatic should be aware of the potential effects of infection on blood sugar control and should be advised that they will need more frequent review of blood sugars and ketones (where appropriate), which can be arranged remotely by the diabetes team.

(O'Donoghue & McKernan, 2020, p.13)

Screening for Gestational Diabetes (GDM)

Because a 75g OGTT requires a woman to visit the hospital and spend over 2 hours waiting for the test to be completed alternative modes of screening for GDM could be considered during the COVID pandemic (see below). If an OGTT has to be carried out then women should be asked to wait in their car between sampling.

Based on recent guidance from the Royal College of Obstetrics and Gynaecologists in the UK the following alternative method of screening for GDM should be considered as an alternative to the OGTT:

At the booking visit, women at risk of GDM (based on risk factors already in place) should (in addition to routine booking bloods) have an HbA_{1c} and random blood glucose checked. These should be interpreted as follows:

- Women with HbA_{1c} ≥ 48 mmol/mol or a random plasma glucose ≥ 11.1 mmol/L at booking should be managed as having type 2 diabetes
- Women with borderline HbA_{1c} 41-47 mmol/mol at booking or with a history of previous GDM should be managed as having GDM
- If HbA_{1c} < 41 at booking these women are considered to have normal glucose tolerance

At 28 weeks gestation, all remaining high-risk women should have repeat HbA_{1c} and fasting (preferable) or random plasma glucose alongside their 28-week routine antenatal bloods. Women should be diagnosed with GDM if they meet the following criteria:

- HbA_{1c} ≥ 39 mmol/mol
- Fasting plasma glucose ≥ 5.1 mmol/l
- Random plasma glucose ≥ 9.0 mmol/l

Management of GDM

All women diagnosed with GDM should have an appointment with the diabetes midwife/nurse, who will provide training in the use of a glucose meter. Where feasible, this should be done remotely via video call. This visit should also be used as an opportunity to provide women with dietetic information and contact details for the dietician, where one is available. Women should be followed-up remotely in the week after the meter training by the diabetes midwife/nurse and for all appointments where home capillary blood sugar levels are to be checked by the diabetes team. In women who have GDM that is diet-controlled, with blood glucose levels consistently in the target range no further hospital visits or ultrasound scans for foetal growth are needed. Women should be provided with clear guidance on who to contact if they have >3 abnormal blood glucose levels in a week or $>10-15\%$ of all readings – this will usually be the diabetes antenatal team. It is possible that services may not be able to contact all women with GDM who are self-monitoring. It is therefore essential that women understand the responsibility of contacting the diabetes team if their readings are outside of the specified targets. In women who have GDM and are taking metformin and/or insulin, offer obstetric review remotely at 28 and 32 weeks' gestation to reassess the risk status. If face-to-face obstetric reviews are needed, for example in women with additional risk factors or poorly controlled blood sugars, ensure that these reviews coincide with any planned ultrasound appointments. Offer obstetric review at 36 weeks, to comprehensively assess maternal and foetal condition, plan timing and mode of birth, and plan follow-up care until birth.

(O'Donoghue & McKernan, 2020, p.14)

The Diabetic Foot

The Model of Care for the Diabetic Foot calls for foot screening to happen in General Practice with patients identified as having at risk feet managed by Community Podiatrists in Foot Protection Teams and patients with active foot disease referred to Multidisciplinary Foot Teams (MDfT) in the hospital. The COVID-19 pandemic is impacting hugely on the delivery of this Model of Care due to:

- Lack of screening in General Practice due to competing priorities during this pandemic
- The requirement to avoid sending patients to hospital (unless absolutely required)
- Widespread re-deployment of Podiatrists (to the pandemic response) in some parts of the country.

This set of circumstances puts a very vulnerable group of patients with (or at risk for) diabetic foot disease in danger of adverse outcomes including limb loss.

Foot Screening

Similar to the situation with retinal screening it will be necessary for routine foot screening to be deferred until our health service returns to face-to-face (as opposed to virtual) visits. Different from the situation with retinal screening we do not have a central call-recall system in place for ensuring that diabetic foot screening happens. It will be up to individual practices to keep track of this for their patients with diabetes.

The At Risk Foot

Community Podiatrists who are part of Foot Protection Teams are likely to be dealing with active foot disease during the pandemic and routine appointments for patients with at risk feet may need to be deferred. Patient education in self-management including foot inspection will be important to reinforce. Early contact with a Podiatrist in the event of a new foot ulcer should also be emphasised.

Active Foot Disease: Not Limb threatening

Patients in this category may have diabetic foot ulceration that is being off-loaded and healing; a Charcot foot that is resolving but not yet in custom-fitted footwear; a recent foot infection doing well on antibiotics. While patients in this category may (prior to the pandemic) have received care from the hospital-based MDfT all efforts should be made to deliver care outside of hospital to reduce the risk of transmission of the virus. Close liaison between healthcare professionals in the hospital and community (including Podiatrists, Tissue Viability Nurses, Public Health Nurses and Specialist Nurses in Diabetes and Vascular Surgery) will be required to co-ordinate care for these patients to ensure that their foot problems do not deteriorate during the COVID crisis. Telemedicine options (where available) should be explored.

Active Foot Disease: Limb threatening

Patients in this category may present with symptoms and signs of severe infection including rapidly spreading cellulitis from a foot ulcer, changes of wet gangrene and/or gas in the tissues, a new discharge from a foot wound or crepitus in the surrounding skin. Urgent referral to hospital is required. Some patients with severe foot infection may have fever associated with respiratory symptoms and their presentation can mimic that of COVID-19 infection. The other major category of limb-threatening foot disease is severe ischaemia. Rest pain may or may not be present depending on the degree of associated neuropathy. Patients with critical limb-threatening ischaemia need urgent referral to a Vascular Surgery Team in the hospital.

Other considerations

Off-loading in a total contact cast (TCC) may be hazardous when regular review is not guaranteed and consideration should be given to off-loading with a removable cast for the duration of the COVID crisis. Hospitals around the country are establishing protocols for telemedicine (remote) review and Podiatrists and other members of Diabetic foot teams should explore these options for case discussion and review.

Podiatry Service Delivery

During this pandemic, podiatry services around the country will have to change the way they deliver services to people with (or at risk for) diabetic foot disease. Local podiatry services (acute and community) should co-ordinate their care and work together to provide a safe and effective service to these patients. The following guidance may be useful in this regard:

- Insofar as possible, podiatry staffing should not be redeployed to other roles during the Covid-19 pandemic in order to maintain essential services for people with (or at risk for) diabetic foot disease.
- Podiatry services should re-prioritise all patients using the priority guidelines outlined below (Table 1). Essential services (priority 1 and 2) should continue to be provided where possible.
- Taking into account current staffing levels and operational restrictions, discuss and outline with your line manager and clinical governance lead the level of service delivery that can and cannot be provided during this pandemic.
- Where possible and appropriate, use available technology, including video conferencing, telephone and telemedicine where possible to connect with patients, colleagues and other multidisciplinary team members remotely.
- Where staffing is limited, service provision could be provided from hubs (1-2 podiatry clinics) which cover larger geographical areas. If staff are providing care outside of their contracted area, local agreements may need to be reviewed and updated in relation to line management and clinical governance.
- Keep patients up-to-date and informed about any changes to podiatry service delivery relevant to them.
- As per routine care, ensure that the person with diabetes once diagnosed and assessed:
 - receives education and has an understanding of their foot Risk Status
 - is able to perform regular foot inspection and implement appropriate self-management strategies;
 - is aware of and has contact details for the appropriate services that they need to access.

COVID -19 Podiatry Service Priorities	Conditions/ Duties
Priority 1 Services Critical / Urgent: No interruption to service. These services require continuity for the duration of the pandemic.	<ul style="list-style-type: none"> • Severe and some Moderate infection • Gas gangrene • SIRS/Sepsis • Acute limb-threatening ischaemia • Triaging and prioritising of all referrals
Priority 2 Services High Priority / Vital: A short-term interruption is not likely to be critical, but within 3 to 5 days the service must be delivered.	<ul style="list-style-type: none"> • Mild and some moderate infections (osteomyelitis) • Chronic limb-threatening ischaemia • Dry gangrene • Worsening foot ulcers • Active Charcot foot offloading boot option maybe favoured over casting in COVID-19 • Emergency aids and appliance
Priority 3 Services Necessary: Delays or gaps in service of between 1 to 3 weeks before normal levels of functioning or activity levels must be resumed.	<ul style="list-style-type: none"> • Improving foot ulcer • Inactive Charcot foot (not yet in stable footwear) • Aids and Appliance
Priority 4 Services Desired: Services that can be suspended for the duration of the pandemic (15 weeks) before normal levels of functioning or activity levels must be resumed.	<ul style="list-style-type: none"> • Uncomplicated foot ulcers • Recently healed foot • Inactive Charcot foot (in stable footwear) • Healed amputation • Diabetic foot risk assessment • Aids and Appliances

*Table 1: Covid-19 Podiatry Service Priorities
(Adapted from Rogers, Lavery, Joseph & Armstrong, 2020)*

RetinaScreen

Diabetic RetinaScreen has temporarily been paused in line with the HSE's measures to stop the spread of COVID-19. They are continuing to review this decision and are providing updates on the programme website (www.diabeticretinascreen.ie).

Their commitment to service users, and to the safety of service users will be their principal concern at this time.

Advice for patients:

- If you are worried about symptoms, please contact your GP or Ophthalmology clinic.
- If you require any further information or have any other queries, please contact Global Vision on 1800 30 36 33, opening hours 9am - 5pm or Northgate on 1800 99 29 68, opening hours are 9am - 5pm. Freephone information line: 1800 45 45 55

Delivering a 'virtual' diabetes consultation during the Covid-19 crisis

Virtual clinics have limitations, for example, there is no face to face contact, blood pressure and feet cannot be examined and up to date blood tests or investigations may not be available to the clinician. However in the current crisis they are the most suitable method of clinical assessment we can offer to our patients. There are already lots of examples of healthcare teams delivering virtual clinics in Ireland – check with local management and your own professional body as they may already have developed specific guidance in this area. Telecommunication options include telephone calls, email threads or video consultations. Think about which option would work best for your team and the type of consultation you need to deliver e.g. access to technology (for you and your patient), the need for screen-sharing. Check which options can be accessed and used on your local phones, laptops or PCs. Ensure the option you use maintains, in so far as possible, the principles of security and confidentiality in accordance with HSE guidance and draw up a local guideline on this. More detailed information from HSE Digital is available on: <http://www.hsedigitaltransformation.ie>.

Preparation is the key to success:

- Contact patients (ideally with a letter) advising them *not* to travel to the healthcare site and explain that they should instead expect a telecommunication consultation on the day of their scheduled appointment
 - Give an approximate time to expect the call and ask patients to have any glucose self-monitoring record, uploads of diabetes technology completed and lists of medications available.
 - Give details on how to re-arrange the appointment if the time does not suit
- Prepare for the clinic as normal – have the usual medical records, clinical proformas and blood results available.
- It may be helpful in some settings to develop a modified clinic proforma that includes a Covid-specific checklist e.g. advice re: sick day rules, local podiatry and ophthalmology arrangements.
- Triage the charts if possible before the clinic to match up the chart as well as you can to the competencies and skills of the clinician undertaking the consultation
- Decide beforehand how you will get input to a consultation from another MDT member if required e.g. will you phone them to ask their opinion, or could they join the call with the patient or will they do a follow up call with the patient?
- Identify appropriately physically distanced rooms where there will not be interruptions (put a sign on the door) and patient confidentiality can be maintained.
- Have everything you may need at hand – telephone, computer, bloods, CGM data etc.
- Clean down your workspace in line with Infection Control recommendations
- Develop an SOP that outlines the steps to take the prepare and deliver the clinic

During the consultation:

- Check you are speaking to the correct patient (name/DOB), check contact details (address/GP). Ensure they understand the nature and limitations of non-face-to-face consultations and that they give consent to this.

- Document as usual using the agreed medical records. Use your clinical proforma to guide the consultation as you would face-to-face appointment but do expect additional Covid-specific questions from patients.
- Liaise with other MDT members as agreed beforehand.
- If you need to share resources e.g. dietary information with patients, check how they would like this done e.g. emailed during / after the consultation, shared on the screen if using video consultation or posted.
- Check the patients understanding and that all questions have been answered before concluding.
- If issues arise during the consultation that are not possible to resolve remotely then you may need to complete a risk assessment on the necessity to arrange to see the patient face-to-face.

After the consultation:

- Use your usual DNA policy if you have not been able to get in contact with the patient
- Post a new appointment, blood forms, prescriptions, resources etc.
- Liaise with other MDT members as necessary
- Clean down your workspace in line with Infection Control recommendations

References

- ABCD and Diabetes UK. COncise adVice on Inpatient Diabetes (COVID: Diabetes): Front Door Guidance: https://abcd.care/sites/abcd.care/files/site_uploads/COvID_Front_Door_v1.0.pdf
- Department of Health. (2018). Adult type 1 diabetes mellitus (NCEC National Clinical Guideline No. 17). Retrieved: 01 April 2020 from: <http://health.gov.ie/national-patient-safety-office/ncec>
- Health Service Executive. (2011). Model of Care for the Diabetic Foot. Retrieved: 01 April 2020 from: <https://cutt.ly/qtHBVfZ>
- Health Service Executive. (2018). Model of Integrated Care for Patients with Type 2 Diabetes: A guide for Healthcare Professionals (Clinical Management Guidelines). Retrieved: 01 April 2020 from: <https://cutt.ly/etHBGmN>
- International Working Group on the Diabetic Foot. (2020). Covid-19 and diabetic foot disease. Retrieved: 07 April 2020 from: <https://iwgdfguidelines.org/covid-19/>
- O'Donoghue, K. & McKernan, J. (2020). COVID-19 infection: Guidance for Maternity Services. Retrieved: 06 April 2020 from: <https://cutt.ly/FtHGa3f>
- Quinlan, D. (2019). Diagnosis and management of uncomplicated Type 2 Diabetes in Adults (T2DM): A succinct practical guide for Irish General Practice. Retrieved: 01 April 2020 from: <https://cutt.ly/5tHDRR8>
- Rogers, L. C., Lavery, L. A., Joseph, W. S., & Armstrong, D. G. (2020). All Feet On Deck—The Role of Podiatry During the COVID-19 Pandemic: Preventing hospitalizations in an overburdened healthcare system, reducing amputation and death in people with diabetes. Retrieved: 07 April 2020 from: <https://cutt.ly/StHNgiH>