

An Integrated Career and Competency Framework for Diabetes Nursing



3rd Edition



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An *Integrated Career and Competency Framework for Diabetes Nursing* is the product of a collaboration between the professional bodies representing nurses who work in diabetes care, coordinated by TREND-UK (Training, Research and Education for Nurses in Diabetes-UK). The groups involved were the RCN Diabetes Nursing Forum, the National Diabetes Nurse Consultant Group, the Paediatric Diabetes Special Interest Group, the National Diabetes Inpatient Specialist Nurse Group and the Practice Nursing Forum, as well as Diabetes UK Task and Finish Group for Education, and people living with diabetes.

Representatives from these groups have reviewed and further developed the Framework, building on the first edition published in 2005. This third edition of the Framework was necessary to keep the document up to date. The development of the Framework was funded by

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I would also like to acknowledge the hard work and commitment of my TREND-UK Co-Chairs Jill Hill, June James and Grace Vanterpool. We welcome comments and suggestions from practitioners to ensure the Framework remains current and relevant to nurses involved in the care of people with diabetes.

Debbie Hicks
Co-Chair
TREND-UK

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Comment

“*People with diabetes and their families rely on their nursing staff for advice, education and emotional support, to support self-management. Practice nurses, diabetes specialist nurses, nurse consultants, diabetes facilitators and healthcare assistants all have a vital role to play in the commissioning, delivery and monitoring of diabetes services. They will often be the member of the multidisciplinary diabetes team that people with diabetes have most contact with.*”

Well-trained nurses are the lynchpin to delivering the care that people with diabetes should expect, and must have the protected learning time needed to remain up-to-date, confident and competent. This updated Framework is an important resource providing a career framework for all nursing staff facilitate skills development and should be used by all commissioners and providers of diabetes care to ensure all people with diabetes receive high quality, integrated and person-centred care in every part of the UK.”

Bridget Turner
Head of Policy, Care and Improvement
Diabetes UK

Competence can be defined as “the state of having the knowledge, judgment, skills, energy, experience and motivation required to respond adequately to the demands of one’s professional responsibilities” (Roach, 1992). This, the third edition of *An Integrated Career and Competency Framework for Diabetes Nursing*, addresses a number of political and professional issues, including:

- The documents *Agenda for Change: Modernising the NHS Pay System* (DH, 1999) and *Agenda for Change: National Job Profiles* (DH, 2005).
- The need to demonstrate fitness for purpose and meet service delivery requirements in diabetes nursing.
- The need for leadership in specialist nursing.
- The need for the development of professional standards for HCPs.
- The document *The NHS Plan: A Plan for Investment, a Plan for Reform* (DH, 2000), and its equivalent in Scotland, Wales and Northern Ireland.
- An increased focus on work-based, life-long learning and supervision.
- The focus on professional, rather than academic, accreditation for HCPs.
- The document *Towards a Framework for Post Registration Nursing Careers* (DH, 2007a).

While we know that multidisciplinary working underpins all diabetes care, this Framework focuses specifically on nurses providing diabetes care, but can be used together with other frameworks that highlight core nursing skills and competencies. Many of the specific competencies outlined here are common to the Skills for Health Project, a DH initiative to develop UK-wide, multidisciplinary occupational standards in diabetes care. Currently, the Diabetes UK Education Task and Finish Group is using this Framework as a template for other disciplines such as podiatry, dietetics and medicine.

A changing agenda

The DH’s (2005) *Agenda for Change* means that HCPs now have clear and consistent development objectives that should enable them to develop and apply the knowledge and skills appropriate to their level of responsibility, and will assist in identifying and acquiring the knowledge and skills that will support their career progression. HCPs’ knowledge and skills are assessed using the *Knowledge and Skills Framework* (NHS Employers, 2004).

Pay progression is linked to the demonstration of applied knowledge and skills (DH, 1999). The *Knowledge and Skills Framework* (NHS Employers, 2004) plays a key role in determining how nurses move through a pay band, although it does not indicate the pay band in which a nurse should be placed.

Nurses and commissioning

Diabetes is a common and complex condition affecting all aspects of the individual’s life, with potentially costly complications. Self-management skills are an essential part of diabetes care that should be exercised in conjunction with the support of well-trained HCPs working within an integrated framework, at the centre of which is the person with diabetes.

Commissioners aim to facilitate the delivery of excellent, safe and affordable diabetes care for the population for which they are responsible (DH, 2010). To achieve this, they need: an awareness of the healthcare needs of that population and the priority of those needs; to encourage innovation and service improvement; and to support integration of all aspects of diabetes care and promote mechanisms to support self-management.

Nurses working at all levels in diabetes care can contribute to the process of commissioning and delivering the ideal diabetes service for their population. They are at the forefront in delivering diabetes care at all levels, whether at the level of supervising the annual review and monitoring performed by the healthcare assistant, the prescribing, teaching and stabilisation of someone needing insulin therapy by the DSN, or leading a team of nurses delivering a comprehensive number of services including pump therapy, inpatient care and antenatal care.

Nurses are key in promoting self-management skills, either in one-to-one consultations or through the delivery of structured diabetes education and self-management programmes. From the person with diabetes’ perspective, the nurse is often the person who links many aspects of their diabetes care, sign-posting to other HCPs as required and explaining results and decisions made.

As well as delivering care, nurses can also contribute to the healthcare needs assessment process and the prioritisation of those needs. Commissioners and, in the new NHS, GP consortia, will need to get to know the clinicians delivering care in the population that they are commissioning for, including nurses. They need to have a realistic view of the resources available, the challenges of healthcare delivery, and to be receptive to innovative ideas that will meet those needs in a safe and affordable way.

Nurses are important people in the delivery of diabetes care, and can also influence the commissioning of those services. To do this, they need to be clear about what competencies are required to deliver high-quality diabetes care, and be able to demonstrate those competencies. Furthermore, experienced nurses should be able to assess need and be innovative, and to evaluate and demonstrate achievement of desired health outcomes.

This Framework supports the commissioning of appropriate levels of nurses to deliver diabetes services, and provides a clear definition of the nursing roles – and their expected competencies – within diabetes nursing. ■

The first edition of *An Integrated Career and Competency Framework for Diabetes Nursing* (Diabetes Nursing Strategy Group, 2005) was developed in stages. The first stage involved the use of the values clarification exercise, facilitated by Kim Manley of the RCN Institute. More than 40 participants – generalist and specialist nurses and people with diabetes – worked together to define their values and beliefs about diabetes nursing. They developed a key statement: “Diabetes nursing is essential for people with diabetes”. Furthermore, they outlined the purpose of diabetes nursing:

- To make a difference in the lives of people with diabetes.
- To promote and maintain the health of people with diabetes.
- To promote understanding and raise awareness of diabetes.
- To provide high-quality, person-centred care and services.
- To help people with diabetes to be confident to self-manage and to be as independent as possible.
- To maintain a good quality of life for people with diabetes.

The working group identified a range of interventions essential for achieving the stated purpose of diabetes nursing. These interventions were developed for each of the five levels of expertise within nursing and workshops were held in which these areas were refined. The draft Framework was sent to more than 250 nurses from all professional backgrounds, patient groups, civil servants and Diabetes UK representatives, inviting all potential users to contribute feedback. Comments received were considered and included where appropriate. Relevant groups, such as the Skills for Health Project and the Paediatric Diabetes Nursing Group, were kept informed during the Framework’s development. The result was a competency framework developed by nurses, for nurses.

Competency frameworks

Over the past few years, guidance has emerged that enables nurses to further their careers in a structured way via competency frameworks (DH, 2006). Within nursing, it is possible to have both specialist expertise (in terms of a specific patient group, e.g. people with diabetes) and generalist expertise (e.g. nursing practice, leadership; Manley and Garbett, 2000).

Every nurse has the following competencies at the core of their practice (Manley, 2001):

- Being person-centred.
- Undertaking evidence-based practice.
- Equality, diversity and rights.
- Multi-skilled interventions, treatments and therapies (i.e. specific interventions).

- Practice expertise.
- Improving patient experience and outcomes.
- Developing individual and team effectiveness.
- Developing a culture of effectiveness.
- Developing one’s own practice and that of others.
- Facilitating individual, group and team learning.
- Clinical leadership and management in practice.
- Managing settings and the service.
- Undertaking research and evaluation in practice.
- Providing expert and process consultancy.

These core competencies are built on by a consultant nurse, who brings (Manley, 2001):

- Expert practice.
- Practice development.
- Leadership.
- Lifelong learning.
- Research and development.
- Consultancy.

In 2010, a second edition of *An Integrated Career and Competency Framework for Diabetes Nursing* was revised by TREND-UK (2010), and has been developed further in this third edition to include new competencies covering pre-diabetes, residential care, mental health, prisons and young offender units, and end-of-life care. Each clinical area comprises a set of practical competencies from the fourth of the core nursing competencies (i.e. multi-skilled interventions, treatments and therapies), with the competencies grouped according to the role associated with that level of competency.

The five levels of competency are: (i) unregistered practitioner; (ii) competent nurse; (iii) experienced or proficient nurse; (iv) senior practitioner or expert nurse; and (v) consultant nurse.

It is acknowledged that in recent times, and following the introduction of *Agenda for Change* (DH, 2005), a new role has emerged – that of team manager. These posts span some elements of the senior nurse and nurse consultant competencies and encompass clinical care and management responsibilities for diabetes nursing teams. While there can be some blurring of professional boundaries between these roles, nurse consultants have additional clear responsibilities around expert clinical practice, leadership, education provision, research and strategic planning of services.

The Skills for Health (2009) competencies do not refer to a sixth level of competency and, as a result, this document remains in line with the five specified national levels. The competencies have the potential to work alongside the *Knowledge and Skills Framework* (NHS Employers, 2004) and the higher level of practice documents (Castledine, 2002).

Diabetes nursing and beyond

The DSN role was introduced more than 70 years ago. Since the 1970s, the DSN role has become increasingly

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common following the advent of differing strengths of insulin, and the introduction of self-monitoring of blood glucose (Davies et al, 2001). In 2008, there were 1363 DSNs in the UK, working in either primary or secondary care, or both (CMA Medical Data, 2009).

DSNs work wholly in diabetes care; they may be employed in primary or secondary care or work in both. The DSN clinical caseload might encompass the care of adults or children with diabetes, or both. DSNs usually form part of multidisciplinary teams (MDTs), however not all work with consultant colleagues providing expert clinical support, as recommended in the RCN report defining such roles (Castledine, 1991).

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. Clinical governance is therefore essential in the provision of good clinical care.

Two points in particular are cause for concern in the DSN specialty. First, the professional group is becoming more fragmented as DSNs are employed by various non-NHS healthcare providers (James et al, 2009). Second, not all DSNs are able to access specialist clinical support. This leads to inconsistencies in knowledge and skills – and, ultimately, competencies – within the professional group.

There is currently no single recognised qualification for the DSN role. Castledine (1991) gave minimum recommendations for DSNs new in post, saying that they: (i) should be registered nurses with a minimum of 3 years practice; and (ii) have a proven interest in diabetes management, teaching and counselling. Senior DSNs at that time would have been required to: (i) have practised as DSNs for a minimum of 3 years; and (ii) be willing to undertake a diabetes diploma or a related degree.

More recently, *Agenda for Change: National Job Profiles* (DH, 2005) and *Towards a Framework for Post Registration Nursing Careers* (DH, 2007a) identified core elements of training for all specialist nurses. Notably, all specialist nurses are now required to have, or be working towards, a degree-level qualification to fulfil the national job profile criteria. Senior nurses will be aligned to the advanced nurse profile and be expected to have, or be working towards, a masters degree (Diabetes UK, 2010).

All DSNs are assessed annually against specific competencies outlined in the *Knowledge and Skills Framework* (NHS Employers, 2004). *The Knowledge and Skills Framework* aims to identify the knowledge and skills required for an individual to be competent within a post, and further to guide professional development. Generally, nursing roles include six core dimensions (communication; person and people development; health, safety and security; service improvement; quality;

and diversity) and additional specific competencies are required for specialist nurse roles. These additional competencies may include promotion of health and wellbeing (HWB1), enablement to address health and wellbeing needs (HWB5), assessment and care planning (HWB6), interventions and treatment (HWB7), information collection and analysis (IK2), learning and development (G1; NHS Employers, 2004). Variations of these skill-sets exist, depending on the skills present within the wider MDT, of which the DSN should be a member.

DSNs influence care indirectly through education of healthcare professionals and through models of mentorship and professional development. These may incorporate case note review, reflective practice of clinical delivery, and telephone and email consultations being accessed as an expert resource. DSNs deliver person-centred care, wherever that care is required, and influence care delivery at every stage of the person's journey through life with diabetes.

The role of the DSN has evolved over the past decade in response to the shifting demands and expectations of people with diabetes, the introduction of new therapies and devices, and government directives influencing the health economy. For many DSNs, this has led to further specialisation into areas such as structured education programmes, insulin pump therapy, cardiovascular risk management and non-medical prescribing. Skills to enable people with diabetes to self-manage their condition, and the ability to support behaviour change through motivational approaches, are now integral to the DSN role (Diabetes UK, 2010).

A survey conducted by Diabetes UK and the Association of British Clinical Diabetologists (James et al, 2009) found that between half and two-thirds of DSN responders were independent prescribers. More than three-quarters conducted independent nurse-led clinics, and 93% of responders were involved in patient care. Furthermore, structured patient education was planned and delivered by 90% of the DSNs surveyed.

Specialist nurse-led care enables the person with diabetes to receive the care they require, in the right place and at the right time for them.

Other roles

As the number of people with diabetes has risen, so too has the number of nurses involved in delivering diabetes care and the variety of roles and titles within the specialty.

The community-based diabetes facilitator role emerged in response to the transfer of care of many people with diabetes to the community setting. Diabetes facilitators work mainly in primary care supporting, educating and enabling HCPs to manage diabetes care effectively. Commonly, diabetes facilitators are based in GP practices to establish standardised diabetes care and to deliver care

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closer to home for people with diabetes by offering, for example, patient education and self-management skills.

In 2000, the consultant nurse role was introduced to enable experienced nurses, wishing to progress their career, to advance their clinical practice (DH, 1998). These posts incorporate education, strategic leadership and research elements in diabetes nursing. These roles will be integral in the redesign and delivery of care within the health and social care setting, as advocated in the new *Health and Social Care Bill* (DH, 2011).

Another recent addition to the diabetes care team is the diabetes care technician. The diabetes care technician is an unqualified, but suitably trained, person who is competent to carry out effective routine screening of people for the complications of diabetes.

The practice nurse in diabetes care

Increasingly, diabetes care is being carried out in the community setting by practice nurses. All practice nurses are registered nurses, but few are employed under the terms and conditions of *Agenda for Change* (DH, 2005). Practice nurses are usually accountable professionally to the Nursing and Midwifery Council, managerially to their practice manager and clinically to their lead GP. The local PCT is responsible for assessment of the practice competencies.

The role of the practice nurse encompasses a wide variety of competencies around a range of clinical conditions. For the care of people with diabetes, practice nurses should:

- If new in post, undertake a tailored introduction to diabetes care programme. The need for further diabetes training should be accessed according to specific elements of diabetes care that the nurse will be expected to provide as part of the role.
- Have a minimum of 6–12 months experience in diabetes care. This includes those practice nurses for whom diabetes care is a small part of their total case load.
- Have access to diabetes-specific continuing professional development courses and training (dependent on their level of involvement and interest in diabetes care).

Those practice nurses working at a basic level in diabetes care are usually those who are new in post. These practice nurses will be involved in screening for diabetes and its associated complications and in the audit of diabetes outcomes. They should be able to:

- Provide appropriate materials for patient support and education and offer appropriate lifestyle advice.
- Recognise and treat diabetes emergencies (e.g. hypoglycaemia).
- Be aware of, and work within, agreed policies and procedures for diabetes care.

- Know when to refer on for specialist advice or for services such as structured patient education and smoking cessation.

A growing number of practice nurses provide a high level of diabetes care in their practice population. The role of the practice nurse at this level encompasses direct referral, assessment, care planning, teaching and clinical skills. Practice nurses delivering high-level diabetes care should have:

- Completed an accredited training course in diabetes care at the diploma level or higher.
- Undertaken an accredited training programme in the initiation and management of insulin.
- A minimum of 2 years experience in the practice environment.
- Accessed further training around management, leadership and teaching skills.

Many practice nurses are now non-medical prescribers and provide medication reviews and prescriptions as part of their daily duties. To ensure evidence-based best practice, it is essential that all nurses with prescribing skills access appropriate training and regular updates in medicines management. Many nurses report finding it difficult to access protected time and funding for study and continuing professional development. Guaranteed access to training needs to be built into the professional schedule of HCPs.

Modernising Nursing Careers: Setting the Direction (DH, 2006) sets out to describe a future that would enable nurses to maximise their contribution and meet the very real demands placed on the healthcare system by societal, political and technological changes. It also takes into account that nursing needs to be seen as a modern, dynamic and fulfilling career for a diverse range of new recruits to the profession. It recommends that a new career framework must reflect this, and patients' needs for care and the way services are changing, particularly bringing services closer to home, must be recognised. *Modernising Nursing Careers* must enable nurses to respond flexibly and progress up or along the career ladder at a pace appropriate to their skills, ability and aspirations. The framework consists of five key cross-cutting themes:

- Health promotion.
- Preventative, long-term conditions management or crisis monitoring, which diabetes nursing fits into.
- Safeguarding vulnerable people and those in need.
- End-of-life care.
- Holistic care.

Nurses will major in one pathway, but they will minor in others, to a level appropriate to the situation and their degree of competence. ■

The Framework can be used in a number of ways to develop nurses' knowledge and skills. For example, to provide:

- Help for individual nurses to plan their professional development in diabetes care.
- Guidance for employers on competency at the various levels of diabetes nursing.
- A reference for planning educational programmes.
- Information for commissioners in identifying appropriate staff to deliver services to meet local need.

The clearly defined competency levels make it possible for nurses delivering diabetes care to identify their level of practice. The Framework gives them the ability to plan their careers in a more structured way, and supports their continuing professional development by identifying individual development and training needs.

It is recognised that children and young people with diabetes have different needs to adults due to their level of physical, emotional, social and cognitive development. Nurses should provide information to the child or young person in a way that is appropriate to their age and understanding. They will need to work in partnership with the child or young person, their family, and those involved in their care to meet their specific needs (RCN, 2004; DH, 2007b). Many of the competencies provided within this Framework will complement those needed for the care of children and young people. For more information see the *ISPAD Clinical Practice Consensus Guidelines 2009* (ISPAD, 2009).

This Framework gives nurses the opportunity for creativity and flexibility. As an outpatient or practice nurse, one can complete core nursing competencies and use the Framework as part of a career portfolio in diabetes nursing. Similarly, the Framework can be used as a career path if a nurse wishes to specialise in diabetes care. The Framework should be used alongside the *Knowledge and*

Skills Framework (NHS Employers, 2004). Every nurse is responsible for developing their own portfolio of evidence that demonstrates each competency. Forms of evidence that can be used to demonstrate competency include case histories, self-appraisal via a reflective diary, 360-degree feedback, verification of practice and structured observation of practice. When gathering evidence to prove competency, it is important that nurses:

- Understand what each of the competencies is asking of them.
- Review any existing work that could demonstrate their competency.
- Identify whether the existing evidence is appropriate (e.g. if a nurse attends a study day to prepare to perform a particular intervention, but has not practised the skill in a clinical setting, the certificate of attendance is not evidence of competency. The nurse should consider making arrangements for supervised practice. However, if the nurse has undergone training and has evidence of supervised practice and performs the care on a regular basis the evidence should be sufficient to demonstrate competency).
- Consider what may be needed in developing evidence of competency (e.g. soliciting feedback on practice).
- Think about using evidence that covers several competencies (e.g. one case study may demonstrate the knowledge and skills commensurate with more than one competency).

This document, *An Integrated Career and Competency Framework for Diabetes Nursing*, is not about setting a series of task-orientated actions or practical activities for nurses to carry out. Rather, it describes the progression of knowledge and skills across the five competency levels, and suggests how a nurse can build a career in diabetes care. It lists specific competencies for a suitably trained person to deliver diabetes care at a particular level and assumes general care is given competently. ■



Useful websites

Department of Health www.dh.gov.uk
Diabetes UK www.diabetes.org.uk
National Assembly for Wales www.wales.gov.uk
Northern Ireland Office www.nio.gov.uk
Nursing and Midwifery Council www.nmc-uk.org
Royal College of Nursing www.rcn.org.uk
Scottish Executive www.scotland.gov.uk
Safe use of insulin www.diabetes.nhs.uk/safe_use_of_insulin
Skills for Health www.skillsforhealth.org.uk

5.1. SCREENING, PREVENTION AND EARLY DETECTION OF TYPE 2 DIABETES

For the prevention and early detection of type 2 diabetes you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Describe the risk factors for type 2 diabetes. ● Explain the importance of prevention or delay of onset of type 2 diabetes in individuals at risk. ● Explain the role of exercise in the prevention or delay in progression to type 2 diabetes. ● Explain the importance of weight control and the role of diet in the prevention or delay in progression to type 2 diabetes.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Make a comprehensive assessment of an individual's risk of type 2 diabetes. ● Direct people to information and support to encourage lifestyle changes to prevent or delay progression to type 2 diabetes. ● Identify individuals at risk of type 2 diabetes (e.g. long-term use of steroid and antipsychotic medication, previous gestational diabetes) and initiate appropriate screening/diagnostic tests. ● Provide advice to people at risk of type 2 diabetes with regard to lifestyle changes, including exercise programmes and dietary changes for the prevention of type 2 diabetes. ● Discuss the care pathway for individuals with newly diagnosed type 2 diabetes. ● Demonstrate knowledge of the available tests for the diagnosis of type 2 diabetes and understand the results. ● Outline the long-term health consequences of type 2 diabetes. ● Describe the symptoms of type 2 diabetes. ● Describe the links between type 2 diabetes and other conditions (e.g. cardiovascular disease). ● Be aware aware of local policy regarding vascular screening programmes.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Interpret test results and, if diagnostic, make appropriate referral. ● Educate other HCPs with regard to the risks of developing type 2 diabetes. ● Participate in, and refer people to, programmes in conjunction with other agencies that address the role of lifestyle intervention in the prevention or delay in progression to type 2 diabetes. ● Participate in, and refer people to, screening programmes in conjunction with other agencies for the early detection of type 2 diabetes (e.g. care/residential homes).
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Provide expert advice on the benefits of screening programmes/procedures for high-risk groups to HCPs, those at risk of developing type 2 diabetes and commissioners. ● Contribute to the evidence base and implement evidence-based practice in relation to the prevention of type 2 diabetes. ● Contribute to the evidence base and implement evidence-based practice in relation to type 2 diabetes screening in high-risk groups. ● Participate in the development of local guidelines and programmes of education and care for the screening/prevention and early detection of type 2 diabetes.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for early identification and management of IFG and IGT, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the numbers of people with IFG and IGT and outcomes of interventions, including contributing to national data collections and audits. ● Initiate and lead research in identification and management of IFG and IGT through leadership and consultancy. ● Identify service shortfalls in screening for, and management of, people with IFG and IGT and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of people at risk of developing type 2 diabetes. ● Lead on liaising with local and national public health networks and diabetes teams in the development of pre-diabetes integrated care pathways, including the development of integrated IT solutions and systems for IFG and IGT that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding early identification and management of people at risk of developing type 2 diabetes. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.2. PROMOTING SELF-CARE

To support the person to self-care for their diabetes you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Support the person to develop self-care skills with guidance from a registered nurse. ● Observe and report any concerns that might affect the ability of the person with diabetes to self-care. ● Encourage people to use their personalised care plans.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Assess the ability of the person with diabetes to self-care and work with them or their carer to optimise self-care skills. ● Direct people to information and support to encourage informed decision-making about living with diabetes and managing life events. ● Support the person with diabetes in setting realistic goals and in the achievement of those goals.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Assess the person with diabetes and their carer and provide tailored, structured education and support to optimise self-care skills and promote informed decision-making about lifestyle choices. ● Provide information and support to encourage the person with diabetes to make informed choices about controlling and monitoring their diabetes, including: choice of treatment and follow-up; risk reduction; monitoring control; and complications. ● Identify psychosocial barriers to self-care and refer on where necessary. ● Facilitate the development of an agreed care plan.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Demonstrate knowledge of theoretical frameworks and educational philosophies underpinning behaviour change. ● Demonstrate knowledge and understanding of bio-physical and psychosocial factors affecting self-management. ● Demonstrate knowledge and skills to facilitate behaviour modification. ● Develop and ensure delivery of educational materials, supportive networks and models of diabetes care that foster empowerment and lifelong learning about diabetes. ● Work with the person with diabetes to facilitate lifestyle adjustment in response to changes in their diabetes or circumstances. ● Provide education for other HCPs in diabetes self-care skills.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Identify service shortfalls and develop strategies with the local commissioning bodies to address them. ● Initiate and lead research through leadership and consultancy. ● Work with stakeholders to develop and implement local guidelines, promoting evidence-based practice and cost-effectiveness. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs. ● Work with stakeholders to develop a culture of patient-centred care and development. ● Influence national policy regarding the promotion of self-care. ● Identify and implement systems to promote your contribution and demonstrate the impact of advanced level nursing to the healthcare team and the wider health and social care sector. ● Identify the need for change, proactively generate practice innovations, and lead new practice and service redesign solutions to better meet the needs of patients and the service.

Competency statements

5.3. MENTAL HEALTH

To care for someone with diabetes and mental illness you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Have an awareness of how mental health issues, such as depression and anxiety, affect people with diabetes. ● Report any potential changes in the person's normal mental health (e.g. mood changes, changes in medications adherence, changes in appearance, anxiety) to a registered nurse or doctor.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Raise the issue of mental health/addiction problems sensitively during individual consultations. ● Conduct a mental health assessment using a recognised depression tool. ● Demonstrate awareness that some mental health medication can have a detrimental affect on glycaemic and lipid control. ● Support the person with diabetes and mental health problems in obtaining the appropriate investigations in a timely manner. ● Ensure people with diabetes and mental health problems understand how to take medication, recognise common side-effects and how to report them.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Assess mental health problems and how they impact on the risk of developing type 2 diabetes and diabetes management. ● Demonstrate knowledge of the psychological impact of diabetes and facilitate referral to psychological support or mental health services, as required. ● Demonstrate a basic understanding of the mental health issues commonly seen and how they may affect diabetes control (e.g. anxiety and depression, schizophrenia, bipolar disorder, dementia, obsessive-compulsive disorder, and addiction and dependence). ● Refer or ensure an appropriate mental health practitioner is involved in the person's care if they are demonstrating mental health difficulties. ● Manage and coordinate individual patient care and education programmes. ● Recognise the implications of mental health on lifestyle choices and support the person with small, achievable changes. ● If a registered prescriber, prescribe medications as required within own competencies and scope of practice.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Provide support and expert advice to other HCPs on the management of diabetes in people with complex mental health problems. ● Work in collaboration with other non-diabetes HCPs, such as GPs and community psychiatric nurses, in planning diabetes care plans for people with diabetes and mental illness. ● Have an in-depth understanding of additional complex issues of mental health (e.g. supporting someone in the manic phase of their bipolar disorder; supporting someone with diabetes and an eating disorder; the association of drug misuse and the impact this has on the diabetes control; the high prevalence of smoking in mental health sufferers and the impact this has on the CHD risk factors).
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for management of diabetes in those with mental illness, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care for those with mental illness, including contributing to national data collections and audits. ● Initiate and lead research in the management of diabetes in those with mental illness through leadership and consultancy. ● Identify service shortfalls in the care of people with diabetes and mental illness and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients with mental illness, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national mental health networks and diabetes and mental health teams in the development of diabetes and mental health integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding diabetes and mental illness. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.4. NUTRITION

To meet the person's individual nutritional needs you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Follow the nutritional plan and report any related problems. ● Recognise foods and drinks high in sugar. ● Measure and record waist circumference, height and weight accurately. ● Report if meals are not eaten, especially carbohydrates, if the patient is using insulin or oral antihyperglycaemic agents.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● List the principles of a healthy, balanced diet. ● Calculate and interpret BMI. ● Understand which foods contain carbohydrate and how these affect blood glucose levels. ● Identify people at risk of malnutrition and situations where healthy eating advice is inappropriate. ● Refer the person with diabetes to a dietitian where appropriate.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Work in partnership with the person with diabetes and with groups to identify realistic and achievable dietary changes to help individuals to manage their diabetes in the short- and long-term. ● Know the dietary factors that affect BP and lipid control. ● Be aware of local policy on the care of people undergoing enteral feeding. ● Ensure that nutritional advice includes food and drink that provides sufficient energy intake and nutrients for optimal growth and development in children and young people with diabetes.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Perform an assessment of how lifestyle (i.e. diet and physical activity) and pharmacological agents impact on glycaemic control. ● Facilitate the person with diabetes to make informed decisions about nutritional choices. ● Teach the person with diabetes or their carer the principles of carbohydrate counting and medication dose adjustment. ● Demonstrate knowledge and skills to facilitate behaviour change. ● Demonstrate knowledge of how to manage the specific needs of people with diabetes undergoing enteral feeding.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines, promoting evidence-based practice and cost-effectiveness with regard to appropriate nutrition advice. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes nursing contribution to nutrition care, including contributing to national data collections and audits. ● Initiate and lead research in effectiveness of diabetes nursing on nutritional needs through leadership and consultancy. ● Identify service shortfalls in the provision of adequate diabetes nutrition and advice and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of people with diabetes, the diabetes population as a whole and the diabetes service. ● Influence national policy regarding nursing contribution to provision of appropriate diabetes nutrition and advice. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HA5 and HA6.

Competency statements

5.5. URINE MONITORING

For the safe use of urine glucose or ketone monitoring and associated equipment you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Perform the test according to manufacturers' instructions and local guidelines. ● Perform the test unsupervised but at the request of a registered nurse. ● Document and report the result according to local guidelines.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Interpret the test result and, if outside the expected range for that person, make the appropriate referral. ● Teach the testing procedure to the person with diabetes or their carer. ● Identify situations where ketones testing is appropriate.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Use results to optimise treatment interventions according to evidence-based practice, and incorporate preferences of the person with diabetes.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Instigate further tests such as HbA_{1c} and random blood glucose. ● Develop specific guidelines for use in different situations. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Assess competencies of other HCPs.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for use of urine glucose and ketone monitoring, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures for use of urine monitoring, and be able to produce information on the outcomes of diabetes care, including contributing to national data collections and audits. ● Initiate and lead research through leadership and consultancy. ● Identify service shortfalls in provision of urine glucose and ketone monitoring and develop strategies with the local commissioning bodies to address them. ● Influence national policy regarding the use and availability of urine monitoring. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.6. BLOOD GLUCOSE MONITORING

For the safe use of blood glucose monitoring and associated equipment you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Perform the test according to manufacturers' instructions and local guidelines. ● Perform the test unsupervised, at the request of a registered nurse. ● Document and report the result according to local guidelines. ● Recognise and follow local quality assurance procedures, including disposal of sharps. ● Recognise hypoglycaemia and be able to administer glucose. ● Understand the normal range of glycaemia and report readings outside this range to the appropriate person.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Interpret the results and report readings outside the acceptable range to the appropriate person. ● Teach the test procedure to a person with diabetes or their carer. ● Identify situations where testing for ketones is appropriate.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Interpret results and assess other parameters and take appropriate action, including initiating further tests such as HbA_{1c} or urine/blood ketones. ● Teach people with diabetes or their carer to interpret test results and take appropriate action.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Use results to optimise treatment interventions according to evidence-based practice, while incorporating the preferences of the person with diabetes. ● Initiate further tests such as HbA_{1c} or random blood glucose. ● Initiate continuous blood glucose monitoring and interpret the results. ● Develop specific guidelines for use in different situations. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Assess the competencies of other HCPs.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines, promoting evidence-based practice and cost-effectiveness in the use of blood glucose monitoring. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of use of blood glucose monitoring, including contributing to national data collections and audits. ● Initiate and lead research into use of blood glucose monitoring through leadership and consultancy. ● Identify service shortfalls in the provision of appropriate blood glucose monitoring and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients, the diabetes population as a whole and the diabetes service. ● Influence national policy regarding appropriate blood glucose monitoring. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HA8 and HA9.

Competency statements

5.7. ORAL THERAPIES

For the safe administration and use of oral antihyperglycaemic medication you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Describe the effect of common oral antihyperglycaemic agents on blood glucose levels. ● Demonstrate an understanding of the ongoing nature of the therapy. ● Report identified problems appropriately. ● Recognise the signs of hypoglycaemia and administer glucose.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Demonstrate knowledge of the types of oral antihyperglycaemic agents and how they work. ● Demonstrate knowledge of therapeutic doses. ● Demonstrate knowledge of the timing of doses. ● Administer or supervise administration of prescribed medication and assess adherence. ● Complete documentation accurately. ● Describe common side-effects. ● Demonstrate knowledge of oral combination therapies, individual management goals and supply issues. ● Recognise that the progressive nature of type 2 diabetes may require changes in medication over time.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Describe indications for the initiation of oral antihyperglycaemic agents. ● Recognise when treatment needs to be adjusted. ● Describe lifestyle factors that may influence prescribing patterns. ● Demonstrate awareness of issues related to polypharmacy and drug interactions (e.g. steroids). ● Demonstrate knowledge of national and local guidelines (e.g. NICE guidance or equivalent). ● Demonstrate knowledge of treatment cost implications. ● Evaluate treatment outcomes and make appropriate referrals.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Facilitate and support structured evidence-based education relating to oral antihyperglycaemic agents for individuals or groups. ● Demonstrate awareness of current research in new oral therapies. ● Disseminate evidence-based information affecting practice. ● Assess the competency of other HCPs. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Adjust oral treatment according to individual circumstances, following local policies or individual clinical management plans.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines, promoting evidence-based practice and cost-effectiveness in the provision of oral antihyperglycaemic agents. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes nurses involvement in prescribing and use of oral antihyperglycaemic agents, including contributing to national data collections and audits. ● Initiate and lead research in diabetes nursing and use of oral antihyperglycaemic agents through leadership and consultancy. ● Identify service shortfalls in provision and effective use of oral antihyperglycaemic agents and develop strategies with the local commissioning bodies to address them. ● Influence national policy regarding the use and provision of oral antihyperglycaemic agents. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HD1 and HD2.

Competency statements

5.8. INJECTABLE THERAPIES

For the safe administration and use of insulin and GLP-1 receptor agonists you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none">● Describe the effect of insulin on blood glucose levels.● Be aware of local sharps disposal policy.● Show an understanding of the ongoing nature of the therapy.● Administer insulin competently where supported by local policy.● Report identified problems appropriately.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none">● Actively seek and participate in peer review of one's own practice.● Demonstrate a basic knowledge of insulin and GLP-1 receptor agonists (e.g. drug type, action, side-effects) and administration devices used locally.● Demonstrate a high level of competency in the safe administration of insulin or GLP-1 receptor agonists.● Demonstrate and be able to teach the correct method of insulin or GLP-1 receptor agonist self-administration, including:<ul style="list-style-type: none">– Correct choice of needle type and length for the individual.– Appropriate use of lifted skin fold, where necessary.– Site rotation.– Storage of insulin.– Single use of needles.● Examine injection sites at least annually for detection of lipohypertrophy.● Identify correct reporting system for injectable therapy errors.● Complete the "Safe use of insulin" e-learning module (NHS Diabetes, 2010).● Describe circumstances in which insulin use might be initiated or altered and make appropriate referral.● Report concerns related to blood glucose or HbA_{1c} results in a timely and appropriate fashion.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none">● Demonstrate a broad knowledge of different insulin types (i.e. action, use in regimens).● Demonstrate a broad knowledge of GLP-1 receptor agonists (e.g. drug type, action, side-effects).● Assess individual patients' self-management and educational needs and meet these needs or make appropriate referral.● Support and encourage self-management wherever appropriate.● Initiate insulin or GLP-1 receptor agonist therapy where clinically appropriate.● Recognise when injection therapy needs to be adjusted.● Recognise the potential psychological impact of insulin or GLP-1 receptor agonist therapies and offer support to the person with diabetes or their carer.● Recognise signs of needle fear/needle phobia and offer strategies to help manage this.

Competency statements

5.8. INJECTABLE THERAPIES *continued*

For the safe administration and use of insulin and GLP-1 receptor agonists you should be able to:

4. Senior practitioner or expert nurse

As 3, and:

- Demonstrate expert knowledge of insulin and GLP-1 receptor agonist therapies and act as a resource for people with diabetes, their carer and HCPs.
- Initiate insulin pump therapy where appropriate.
- Where individually acceptable, deliver structured group education to people with diabetes, their carers and HCPs.
- Empower and support a person with diabetes to achieve an individualised level of self-management and an agreed glycaemic target.
- Maintain active knowledge of current practice and new developments.
- Establish local guidelines or policies according to local needs.
- Investigate all incidents and report to the relevant agencies, develop an action plan to prevent recurrence.
- If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice according to legislation and local guidelines.
- Adjust insulin treatment according to age, diagnosis and individual circumstances as appropriate, following local policies or individual clinical management plans.

5. Consultant nurse

As 4, and:

- Work with stakeholders to develop and implement local guidelines, promoting evidence-based practice and cost-effectiveness for the use of injectable therapies.
- Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes nurses involvement in prescribing and use of injectable therapies, including contributing to national data collections and audits.
- Initiate and lead research in diabetes prescribing and use of injectable therapies through leadership and consultancy.
- Identify service shortfalls in the provision and effective use of injectable therapies and develop strategies with the local commissioning bodies to address them.
- Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients, the diabetes population as a whole and the diabetes service.
- Influence national policy regarding use of injectable therapies for diabetes.
- Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HA11, HA12 and HD3 (refers to type 2 diabetes only).

See: *The First UK Injection Technique Recommendations* (www.trend-uk.org)

See: NHS diabetes e-learning module “Safe use of insulin” (www.diabetes.nhs.uk/safe_use_of_insulin)

Competency statements

5.9. HYPOGLYCAEMIA

For the identification and treatment of hypoglycaemia you should be able to:

1. Unregistered practitioner

- State the normal blood glucose range.
- Describe the signs and symptoms of hypoglycaemia, including both mild and severe.
- Recognise that older people may not demonstrate clear signs and symptoms of hypoglycaemia.
- Demonstrate competent use of blood glucose monitoring equipment to confirm hypoglycaemia.
- Offer appropriate treatment as per local guidelines.
- Know where treatment for hypoglycaemia is stored.
- Give reassurance and comfort to the person with diabetes or their carer.
- Document and report the hypoglycaemic event to a registered nurse.
- If the person with diabetes is unresponsive, ensure their airway is clear and call emergency services.

2. Competent nurse

- As 1, and:
- Actively seek and participate in peer review of one's own practice.
 - Recognise and provide appropriate treatment for the different levels of hypoglycaemia.
 - List possible causes of hypoglycaemia, including alcohol consumption and physical activity.
 - Make appropriate referral.
 - If using insulin therapy, check injection technique and injection sites.
 - Describe methods of hypoglycaemia avoidance.
 - Identify medications most likely to cause hypoglycaemia.
 - Describe what should be done if hypoglycaemia is not resolved and blood glucose levels remain low.
 - Demonstrate a knowledge of driving regulations and how they relate to hypoglycaemia.
 - Ensure appropriate hypoglycaemia treatments are available and in date.

3. Experienced or proficient nurse

- As 2, and:
- Identify people with diabetes at high risk of hypoglycaemia and advise and adjust therapy accordingly.
 - Give advice regarding driving regulations and hypoglycaemia.
 - Discuss hypoglycaemia (including hypoglycaemic unawareness and frequent hypoglycaemia), and its possible causes, with the person with diabetes or their carer.
 - Work with people with diabetes to prevent recurrent hypoglycaemia.
 - Participate in educating other HCPs and carers of people with diabetes in the identification, treatment and prevention of hypoglycaemia.
 - Interpret blood glucose levels and HbA_{1c} results in relation to unrecognised hypoglycaemia.

Competency statements

5.9. HYPOGLYCAEMIA *continued*

For the identification and treatment of hypoglycaemia you should be able to:

4. Senior practitioner or expert nurse

As 3, and:

- Educate people with diabetes, their carers and HCPs on the impact that hypoglycaemia has on the individual (e.g. in relation to their occupation, safety to drive, as a barrier to intensification of treatment, psychological impact, and effect on cognitive development in the under-5-year-olds).
- Provide expert advice on complex cases.
- Identify and teach appropriate strategies for prevention of hypoglycaemia during and after exercise.
- Act as an expert resource for information on hypoglycaemia for other HCPs.
- Encourage close liaison with A&E or the ambulance team to identify people with diabetes frequently presenting with severe hypoglycaemia.

5. Consultant nurse

As 4, and:

- Work with stakeholders to develop and implement local guidelines for the avoidance and management of hypoglycaemia, promoting evidence-based practice and cost-effectiveness.
- Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the incidence and outcomes of hypoglycaemia episodes, including contributing to national data collections and audits.
- Initiate and lead research in effectiveness of diabetes nursing and hypoglycaemia through leadership and consultancy.
- Identify service shortfalls in prevention and management of hypoglycaemia and develop strategies with the local commissioning bodies to address them.
- Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of hypoglycaemia, the diabetes population as a whole and the diabetes service.
- Lead on liaising with local and national emergency networks and diabetes teams in the development of diabetes integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries.
- Influence national policy regarding prevention and management of hypoglycaemia.
- Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competency HD4.

See: *The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus* (www.diabetes.nhs.uk)

Competency statements

5.10. HYPERGLYCAEMIA

For the identification and treatment of hyperglycaemia you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● State the normal blood glucose range. ● Describe signs and symptoms of hyperglycaemia. ● Recognise that older people may be asymptomatic of hyperglycaemia. ● Perform blood or urine ketones tests according to local guidelines. ● Correctly document results and report those out of the accepted range.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Recognise and provide appropriate treatment for the different levels of hyperglycaemia, including those in type 1 and type 2 diabetes. ● List possible causes of hyperglycaemia, including non-adherence with current medication and intercurrent illness or addition of steroid therapy. ● Make appropriate referral. ● Support self-management where possible. ● Administer or advise on treatment to resolve hyperglycaemia in accordance with local policies or individual clinical management plans. ● Demonstrate knowledge of the long-term impact of hyperglycaemia.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Determine the possible cause of hyperglycaemia, such as unrecognised infection. ● Work in partnership with the person with diabetes or their carer to agree treatment goals. ● Participate in educating people with diabetes, their carers and other HCPs in the identification, treatment and prevention of hyperglycaemia.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Provide expertise in the development of management plans for people with complex hyperglycaemia. ● Educate people with diabetes on drug interactions that can cause hyperglycaemia (e.g. steroids). ● Liaise with A&E and ambulance teams to identify people frequently presenting with episodes of diabetic ketoacidosis or in a hyperosmolar hyperglycaemic state. ● Act as a resource for information on hyperglycaemia for other HCPs.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for the prevention and management of hyperglycaemia, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the incidence and outcomes of hyperglycaemia, including contributing to national data collections and audits. ● Initiate and lead research in the effectiveness of diabetes nursing in prevention and management of hyperglycaemia through leadership and consultancy. ● Identify service shortfalls in the prevention and management of hyperglycaemia and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of hyperglycaemia, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national emergency networks and diabetes teams in the development of diabetes integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding prevention and management of hyperglycaemia. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

See: *Joint British Diabetes Societies Inpatient Care Group: The Management of Diabetic Ketoacidosis in Adults* (www.diabetes.nhs.uk)

Competency statements

5.11. INTERCURRENT ILLNESS

To manage intercurrent illness you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Identify common signs of intercurrent illness and report to a registered nurse. ● Be aware of the impact of intercurrent illness on glycaemic control. ● Document and report any clinical findings outside the expected ranges.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Take a comprehensive assessment and patient history. ● Initiate appropriate preliminary investigations. ● Make appropriate referrals. ● Administer baseline treatment. ● Give advice regarding continuation of treatment for diabetes during intercurrent illness. ● Encourage self-management as soon as is possible, e.g. self-injecting and self-monitoring. ● Ensure the person with diabetes is aware of when to seek medical advice.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Interpret test results and initiate appropriate action. ● Support the person with diabetes or their carer in managing diabetes during intercurrent illness. ● Adjust individual clinical management plan with person with diabetes or their carer. ● Give advice about sick-day diabetes management, including ketone testing, where appropriate, according to local policy. ● Educate people with diabetes, their carer and HCPs about sick-day diabetes management. ● Recognise when treatment may need adjusting, according to local and national guidelines or policies.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Provide expert advice on complex cases and multiple pathologies. ● Advise on treatment adjustments according to individual circumstances, following local policies or individual clinical management plans. ● Contribute to the evidence base and implement evidence-based practice in relation to the management of intercurrent illness in people with diabetes. ● Educate other HCPs on the effects and consequences of intercurrent illness on people with diabetes. ● Participate in the development of guidelines.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines in the management of diabetes and intercurrent illness, promoting evidence-based practice and cost-effectiveness. ● Initiate and lead research in diabetes nursing contribution to management of diabetes and intercurrent illness through leadership and consultancy. ● Identify service shortfalls in effective management of diabetes and intercurrent illness and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of complications from intercurrent illness, the diabetes population as a whole and the diabetes service. ● Influence national policy regarding the management of diabetes and intercurrent illness. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.12. MANAGING DIABETES IN HOSPITAL

5.12.1. GENERAL ADMISSION

To manage diabetes during a hospital admission you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none">● Carry out duties delegated by a registered nurse for the care of a person with diabetes.● Perform blood glucose and urine monitoring tests within local guidelines.● Inform a registered nurse of any observed change in the condition of a person with diabetes.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none">● Actively seek and participate in peer review of one's own practice.● Care for a person with diabetes in hospital in relation to general care and comfort, pressure relief, appropriate nutrition and fluids, monitoring of glycaemic control, and ensure administration of appropriate medication.● Follow local policies and guidelines in relation to inpatient care.● Know the appropriate referral system to the diabetes specialist team, and use where appropriate.● Be familiar with the person with diabetes' treatment regimen and device or delivery systems.● Establish, maintain and discontinue variable-rate insulin infusion regimens according to local policy and individual need.● Recognise diabetes-related emergencies (e.g. DKA, hypoglycaemia) and treat according to local guidelines (refer to competency pages 18–20).● Be aware of DKA and appropriate treatment in line with trust guidelines and make appropriate referral.● Enable a safe and effective discharge plan for the person with diabetes following liaison with relevant agencies.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none">● Explain and advise on care relating to hospital procedures and investigations for the person with diabetes.● Assess and, where appropriate, enable a person with diabetes to self-management their diabetes during an inpatient stay, according to local policy.● Demonstrate knowledge of all current diabetes treatments.● Deliver regular diabetes training for ward staff.● If ward link nurse, enhance knowledge by continuing professional development and disseminate knowledge to other HCPs.● Demonstrate knowledge of national guidelines for the care of people with diabetes admitted to hospital (e.g. <i>National Service Framework for Diabetes: Delivery Strategy</i> [DH, 2003]; <i>Position Statement: Improving Inpatient Diabetes Care</i> [Diabetes UK, 2009]).● Participate in the development or maintenance of local guidance for the care of people with diabetes in hospital.

Competency statements

5.12.1. GENERAL ADMISSION *continued*

To manage diabetes during a hospital admission you should be able to:

4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none">● Provide expert advice on the care of people with complex diabetes or unusual regimens.● Support the person with diabetes to maintain and re-establish diabetes self-management.● Participate in research relating to the care of people with diabetes in hospital.● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice.● Participate in informing national initiatives in the improvement of diabetes inpatient care.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none">● Work with stakeholders to develop and implement local guidelines in the management of diabetes during a hospital admission, promoting evidence-based practice and cost-effectiveness.● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care during a hospital admission, including contributing to national data collections and audits.● Initiate and lead research in management of diabetes during a hospital admission through leadership and consultancy.● Identify service shortfalls in effective management of diabetes during a hospital admission and develop strategies with the local commissioning bodies to address them.● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients during a hospital admission, the diabetes population as a whole and the diabetes service.● Lead on liaising with local and national secondary care networks and diabetes teams in the development of joint diabetes and medical and surgical integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries.● Influence national policy regarding cost-effective management of diabetes during a hospital admission.● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HD6 and HD7.

Competency statements

5.12. MANAGING DIABETES IN HOSPITAL *continued*

5.12.2. SURGERY

To manage diabetes before and after surgery, in addition to the competencies outlined for general hospital admission, you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Be aware of policies relating to fasting in people with diabetes undergoing surgical or investigative procedures.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Take a patient history and discuss adherence with treatment and glycaemic control. ● Advise on diabetes care surrounding pre- and perioperative procedures. ● Identify current medication (both oral and injectable) and develop an individualised care plan, taking into account fasting requirements. ● Follow guidelines regarding appropriate nutrition, monitoring of glycaemic control and administration of diabetes medication according to local guidelines. ● Provide information to relatives and carers of people with diabetes. ● Be aware of national recommendations and standards for the care of people with diabetes undergoing surgery or investigation.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Assess and, where appropriate, enable a person with diabetes to self-management their diabetes during an inpatient stay, according to local policy. ● Assess and respond to problems relating to the care of people with diabetes undergoing surgery. ● Participate in the development or maintenance of local guidance for the care of people with diabetes undergoing surgical procedures. ● Educate all HCPs in the care of people with diabetes undergoing surgery.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Provide expert advice for people with diabetes with complex management problems or unusual regimens following surgery or investigation. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Participate in research or audit relating to the care of the person with diabetes undergoing surgery. ● Participate in national initiatives in the improvement of inpatient care for people with diabetes undergoing surgical procedures or investigations.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for management of diabetes before, during and after surgical procedures and investigations, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care associated with surgical procedures and investigations, including contributing to national data collections and audits. ● Initiate and lead research for management of diabetes before, during and after surgical procedures through leadership and consultancy. ● Identify service shortfalls in cost-effective management of diabetes before, during and after surgical procedures and investigations and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients having surgical procedures or investigations, the diabetes population as a whole and the diabetes service. ● Influence national policy regarding management of diabetes before, during and after surgical procedures and investigations. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.13. PREGNANCY

5.13.1. PRE-CONCEPTION CARE

To support a woman with diabetes preparing for pregnancy you should be able to:	
1. Unregistered practitioner	<ul style="list-style-type: none"> ● Demonstrate awareness of the need for pre-conception care. ● Signpost women to local information and group sessions if available.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Demonstrate an understanding of the need for pre-conception care and follow local guidelines. ● Explain to the person with diabetes or their carer the need for pre-conception care. ● Identify medicines contraindicated in pregnancy and make appropriate referral. ● Know how to recognise and treat hypoglycaemia appropriately. ● Demonstrate knowledge of the appropriate referral system, including to the specialist diabetes team.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Demonstrate knowledge of care recommendations for the pre-conception management of diabetes. ● Provide education and support to achieve pre-conception diabetes targets. ● Participate in audit of healthcare outcomes. ● Act as a named contact person for women with diabetes contemplating pregnancy.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Demonstrate in-depth knowledge of pathophysiology of diabetes complications in pregnancy. ● Develop and implement treatment plans. ● Have an in-depth knowledge of national and local guidelines relating to diabetes pre-pregnancy care. ● Plan, implement and deliver education programmes around diabetes pregnancy care for other HCPs. ● Participate in the development of guidelines and protocols.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for pre-conception care, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of pre-conception care, including contributing to national data collections and audits. ● Initiate and lead research in diabetes nursing contribution to pre-conception care through leadership and consultancy. ● Identify service shortfalls in the management of pre-conception care and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of women planning a pregnancy, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national obstetric networks and diabetes teams in the development of joint diabetes and obstetric integrated pre-conception care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding pre-conception care. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.13. PREGNANCY *continued*

5.13.2. ANTENATAL AND POSTNATAL CARE

To support a woman with IGT, gestational diabetes and pre-existing diabetes during and after pregnancy you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Carry out duties designated by a registered nurse for the care of a pregnant women with diabetes, including routine screening and accurate documentation of results.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Demonstrate awareness of the issues involved in a pregnancy complicated by diabetes. ● Identify pregnant women with diabetes and make immediate referral to specialist team. ● Demonstrate an understanding of, and be involved in, the implementation of individual management plans and care targets. ● Identify medicines contraindicated in pregnancy and make appropriate referrals. ● Use protocols, specifically those relating to the care of women who develop diabetes during pregnancy. ● Demonstrate an awareness of the importance of communication with the wider specialist team across primary and secondary care. ● Demonstrate an awareness of the importance of having a 6-week postnatal blood glucose test (and thereafter according to local policy) post-pregnancy if gestational diabetes or IGT diagnosed during pregnancy.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Demonstrate an awareness of psychosocial impact of diabetes in pregnancy. ● Provide emotional support and motivational strategies. ● Demonstrate knowledge of care recommendations for the management of diabetes in pregnancy, including the pathway for fetal monitoring. ● Demonstrate an understanding of the complications of pregnancy in women with diabetes. ● Provide appropriate education about gestational diabetes. ● Be a named patient contact for the pregnant woman, or new mother, with diabetes.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Demonstrate an in-depth knowledge and understanding of diabetes during pregnancy. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Develop and implement individual treatment plans. ● Participate in the development of management protocols. ● Advise on diabetes medications, dosage and regimens during and after pregnancy. ● Plan, implement and deliver education programmes around diabetes pregnancy care for all HCPs. ● Participate in research and audit.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for the management of pregnancy, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes pregnancy care, including contributing to national data collections and audits. ● Initiate and lead research in management of pregnancy in impaired glucose states and diabetes through leadership and consultancy. ● Identify service shortfalls in the management of pregnancy in women with IGT, gestational and existing diabetes, and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of women during pregnancy, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national obstetric networks and diabetes teams in the development of joint diabetes and obstetric integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding management of pregnancy in women with IGT, gestational and existing diabetes. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.14. HYPERTENSION AND CORONARY HEART DISEASE

To care for people with hypertension and CHD you should be able to:

<p>1. Unregistered practitioner</p>	<ul style="list-style-type: none"> ● Undertake monitoring and assessment as requested. ● Maintain equipment in line with manufacturer's instructions. ● Care for people with diabetes undergoing cardiovascular investigations. ● Perform BP measurement according to the British Hypertension Society guidelines (Williams et al, 2004). ● Demonstrate awareness of the normal parameters for BP measurements. ● Take blood tests and specimens as requested by a registered nurse or doctor. ● Communicate test results to a registered nurse or doctor. ● Demonstrate awareness of CHD risk factors. ● Encourage people with diabetes to bring their prescriptions to each consultation. ● Observe people with diabetes for signs of fear or anxiety.
<p>2. Competent nurse</p>	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Identify people with diabetes at risk of hypertension and CHD. ● Refer people with diabetes for appropriate specialist intervention for hypertension or CHD. ● Demonstrate teaching skills. ● Interpret test results for non-specialist investigations. ● Demonstrate knowledge of self-management techniques. ● Ensure people with diabetes understand how to take medications, its side-effects and when to report them.
<p>3. Experienced or proficient nurse</p>	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Order tests and specialist investigations. ● Calculate UKPDS (Stevens et al, 2001) and Framingham Heart Study (2010) risk scores. ● Act on interpretation of results using risk assessment history. ● Initiate and develop personalised care plans and set goals with the person with diabetes. ● Influence therapeutic decisions. ● Act as a named contact person for people with diabetes and hypertension or CHD. ● Participate in the development of guidelines or protocols. ● Show proficiency in developing and delivering education. ● Manage and coordinate individual patient care and education programmes. ● Provide or refer for psychological support as required. ● Participate in service development.

Competency statements

5.14. HYPERTENSION AND CORONARY HEART DISEASE

continued

To care for people with hypertension and CHD you should be able to:

4. Senior practitioner or expert nurse

As 3, and:

- Lead service development.
- Identify links between diabetes and CHD registers (DH, 2003).
- Use evidence to develop practice and develop guidelines and protocols.
- Coordinate services across organisational and professional boundaries.
- Demonstrate knowledge and skills to facilitate behaviour modification.
- If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice.
- Develop integrated care pathways with MDTs and liaise with MDT members, including hypertension and cardiac nurse specialists.

5. Consultant nurse

As 4, and:

- Work with stakeholders to develop and implement local guidelines in the screening, prevention and management of CHD, promoting evidence-based practice and cost-effectiveness.
- Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care and prevention and management of CHD, including contributing to national data collections and audits.
- Initiate and lead research in diabetes nursing contribution to prevention and management of CHD through leadership and consultancy.
- Identify service shortfalls in the prevention and management of CHD and develop strategies with the local commissioning bodies to address them.
- Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of and with CHD, the diabetes population as a whole and the diabetes service.
- Lead on liaising with local and national cardiac networks and cardiac rehabilitation and diabetes teams in the development of joint diabetes and cardiac integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries.
- Influence national policy regarding prevention and management of hypertension and CHD.
- Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.15. NEUROPATHY

To care for people with, or at risk of, neuropathy, you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Demonstrate awareness that all people with diabetes are at risk of neuropathy, including sexual dysfunction. ● Know which people with diabetes in your care have neuropathy. ● Provide basic foot care under guidance from a registered nurse. ● Report changes in pain, sensitivity, skin integrity, colour or temperature to a registered nurse or doctor. ● Measure standing and lying BP using appropriate devices.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Recognise the need for, and carrying out, annual foot screening for people with diabetes. ● Demonstrate awareness of complications and prevention of neuropathy. ● Describe measures to prevent tissue damage in people with diabetes. ● Give foot care advice to people with diabetes, their carer and HCPs. ● Be aware of erectile and sexual dysfunction as a neuropathic process, and refer where appropriate. ● Identify possible neuropathy and make appropriate referral to confirm diagnosis.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Screen for neuropathy, including sexual dysfunction in both men and women, according to local guidelines. ● Identify risk factors in the development of neuropathy. ● Identify factors that may affect neuropathy (e.g. poor glycaemic control). ● Refer appropriately within the MDT for identified neuropathy issues. ● Ensure people with diabetes can access appropriate care.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Demonstrate detailed knowledge of the management and treatment of neuropathy. ● Conduct a holistic assessment of the person with diabetes for neuropathic risk and ability to self-care. ● Assess knowledge of people with diabetes of neuropathy risk. ● Advise and support people with diabetes and their carer about neuropathy and its management. ● Provide or refer for psychological support as required. ● Demonstrate knowledge of treatments for neuropathy and the associated diabetes management. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Educate HCPs on the prevention, progression and screening for neuropathy. ● Integrate management of diabetes with other contributing conditions. ● Participate in protocol development, implementation and monitoring. ● Participate in research and disseminate evidence-based practice. ● Support or contribute to specialist diabetes clinics (e.g. pain management, erectile dysfunction). ● Monitor and adjust treatment in line with local guidelines or refer appropriately.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for the prevention and management of neuropathic conditions, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care for preventing and managing neuropathy, including contributing to national data collections and audits. ● Initiate and lead research in diabetes nursing and neuropathy through leadership and consultancy. ● Identify service shortfalls in the prevention and management of neuropathy and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk or with neuropathic conditions, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national podiatry, sexual dysfunction and other relevant networks and podiatry, diabetes, pain management teams in the development of diabetes integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding the prevention and management of neuropathic conditions. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↘ This competency links with the Skills for Health (2009) competencies HA3 and HA4.

Competency statements

5.16. NEPHROPATHY

To care for people with, or at risk of, nephropathy, you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Demonstrate an awareness that all people with diabetes are at risk of nephropathy. ● Perform monitoring as directed. ● Know which people with diabetes in your care have nephropathy.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Demonstrate awareness of complications and prevention. ● Demonstrate awareness of annual screening tests to detect nephropathy. ● Organise or perform microalbuminuria screening, BP measurement and blood tests according to local and national protocols and guidelines. ● Demonstrate awareness of the five different stages of chronic kidney disease. ● Demonstrate awareness of the impact steroid use impact on glycaemic control.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● If test results are outside the expect range, refer appropriately and plan follow-up. ● Educate people with diabetes or their carer in prevention and importance of screening for nephropathy. ● Demonstrate awareness of the impact that deteriorating renal function may have on glycaemic control. ● Demonstrate an awareness of diabetes medications contraindicated in renal disease. ● Demonstrate awareness of the impact that renal replacement therapy may have on glycaemic control, including the additional risk of hypoglycaemia and potential need for reductions in diabetes medication. ● Participate in guideline development. ● Participate in education programmes for HCPs. ● Participate in multidisciplinary liaison.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Participate in research or audit and disseminate evidence-based practice. ● Participate in the development of protocols or guidelines in line with national recommendations. ● Educate HCPs regarding prevention, progress and screening for nephropathy. ● Review medication and ensure appropriate changes are made. ● Demonstrate a broad knowledge of renal treatments, including renal replacement therapy and transplantation. ● Demonstrate knowledge of how immunosuppressant treatment may impact on glycaemic control. ● Demonstrate a broad knowledge of renal treatments and their impact on glycaemic control. ● If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. ● Provide or refer for psychological support as required. ● Participate in the development and monitoring of the integrated care pathways.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for the prevention and management of nephropathy, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care and prevention and management of nephropathy, including contributing to national data collections and audits. ● Initiate and lead research in diabetes nursing contribution to the prevention and management of diabetes and renal disease through leadership and consultancy. ● Identify service shortfalls in the prevention and management of diabetes-related renal disease and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of or with diabetes-related renal disease, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national renal networks and diabetes and renal teams in the development of joint diabetes and renal integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding prevention and management of diabetes-related renal disease. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.17. RETINOPATHY

To care for people with, or at risk of, retinopathy, you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Demonstrate awareness that all people with diabetes are at risk of retinopathy. ● Support people with diabetes with impaired vision. ● Encourage people with diabetes to attend annual retinal screening appointments.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Recognise the need for regular retinal screening. ● Demonstrate awareness of retinopathy complications and prevention. ● Participate in retinal screening or laser clinics.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Educate the person with diabetes and their carer about the prevention of, and the importance of screening for, retinopathy. ● Participate in education programmes for HCPs. ● Refer people with diabetes with poor or reduced vision to eye clinic liaison officers for access to vision aids. ● Recognise the importance of good glycaemic, BP and cholesterol control in preventing and/or progressing diabetic retinopathy. ● Ensure 3-monthly retinopathy screening is performed in pregnant women.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Participate in research and disseminate evidence-based practice. ● Write and review local protocols and guidelines in line with national guidelines. ● Review medication and ensure appropriate changes are made. ● Provide or refer for psychological support as required. ● Plan, implement and deliver education programmes for HCPs. ● Participate in the development and monitoring of integrated care pathways.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for the screening and management of retinopathy, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care and retinopathy, including contributing to national data collections and audits. ● Initiate and lead research in diabetes nursing contribution to the identification, prevention and management of retinopathy through leadership and consultancy. ● Identify service shortfalls in the screening, prevention and management of diabetic retinopathy and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at risk of or with retinopathy, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national retinopathy screening and ophthalmology networks and diabetes teams in the development of joint diabetes and retinopathy integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding diabetic retinopathy. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

↪ This competency links with the Skills for Health (2009) competencies HC2 and HC3.

Competency statements

5.18. PRISON AND YOUNG OFFENDER UNITS

To support someone with diabetes residing in a prison or young offender unit you should be able to:

<p>1. Unregistered practitioner</p>	<ul style="list-style-type: none"> ● Demonstrate an understanding of specific issues relating to the care of people with diabetes in prison or institutionalised care, such as: <ul style="list-style-type: none"> – Understand the need for access to, and appropriate timing of, meals in relation to diabetes medication. – Perform blood glucose monitoring and urine testing according to manufacturers’ instructions. – Understand the normal glycaemic range and report readings outside this range to the appropriate person. – Demonstrate knowledge of signs of, and appropriate treatment for, hypoglycaemia. – Recognise and follow local policy regarding sharps disposal. – Know how to recognise depression, anxiety and other mental illness in inmates with diabetes.
<p>2. Competent nurse</p>	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one’s own practice. ● Demonstrate an awareness of how lifestyle issues impact on the prevention and/or progression of diabetes. ● Have a broad understanding of diabetes medications and their side-effects. ● Have a good knowledge of policies and procedures relating to the management of diabetes within the custodial environment. ● Have an in-depth knowledge of prison/care-home policies relating to the use of prescription medications and sharps disposal. ● Demonstrate knowledge of the impact of substance abuse on glycaemic control and the increased risk of hypoglycaemia. ● Know when to refer for medical assessment or specialist care. ● Have a working knowledge of other agencies (e.g. community health staff, dietetic and podiatry services), and how to refer to them. ● Assess someone on arrival to prison in terms of their previous knowledge of diabetes, previous access to diabetes care, and their understanding of their treatment goals. ● Identify inmates with diabetes who are at a high risk of poor glycaemic, lipid and BP control. ● Demonstrate knowledge on how “lock-down” may affect the timing of medicines and access to food, ensuring that inmates’ specific diabetes needs are met.
<p>3. Experienced or proficient nurse</p>	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Follow local policy and in-house guidance regarding care of inmates with diabetes in young offender units or prisons. ● Be aware of the need for cardiovascular and retinopathy screening in inmates with diabetes. ● Work with inmates with diabetes who have difficulty with medications adherence and encourage self-management. ● Ensure inmates understand how to take their medication, are aware of side-effects and know how to report them. ● Ensure the principles of active decision-making and a care-planning approach is available to inmates with diabetes. ● Manage and coordinate individual diabetes patient care and education programmes. ● Have knowledge of how to monitor intercurrent illness and when to seek specialist advice. ● Plan for ongoing diabetes care following release.
<p>4. Senior practitioner or expert nurse</p>	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Demonstrate expert knowledge of diabetes medications and prescribe, if qualified as an independent non-medical prescriber, within one’s own scope of practice. ● Provide expert advice on the care of inmates with diabetes. ● Coordinate services across organisation and professional boundaries. ● Participate in guideline and/or protocol development. ● Initiate and/or participate in audit and research. ● Work with prison healthcare staff to raise awareness of diabetes and its short- and long-term complications across prison staff groups.
<p>5. Consultant nurse</p>	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for care of people with diabetes in prison and young offenders units, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care in prison and young offenders units, including contributing to national data collections and audits. ● Initiate and lead research on diabetes management in prison and young offender units through leadership and consultancy. ● Identify service shortfalls in care of people with diabetes in prisons and young offender units and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of people with diabetes in prisons and young offender units, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national prison networks and staff and diabetes teams in the development of diabetes integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding management of diabetes in prisons and young offenders units. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.19. RESIDENTIAL AND NURSING HOMES

To care for someone with diabetes living in a residential or nursing home you should be able to:

<p>1. Unregistered practitioner</p>	<ul style="list-style-type: none"> ● Demonstrate an understanding of specific issues relating to the care of people with diabetes in residential or nursing homes, such as: <ul style="list-style-type: none"> – Access and timing of meals in relation to diabetes medication. – Understand course of action if food is refused. – Recognise the risk of, as well as the signs, symptoms and treatment for, hypoglycaemia. – Perform blood glucose monitoring and urine testing according to manufacturers' instructions. – Recognise and follow local policy around the disposal of sharps. – Understand the normal glycaemic range and report readings outside this range to the appropriate person. – Demonstrate knowledge of how to perform a basic foot examination and report adverse findings. – If appropriately trained, demonstrate how to perform the basic components of an annual review and report abnormal findings.
<p>2. Competent nurse</p>	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Identify and review the specifics of diabetes management in each individual's care plan. ● Demonstrate an awareness of how lifestyle can impact on the prevention and progression of diabetes. ● Have a broad understanding of diabetes medications and timings in relation to meals and side-effects. ● Have a good knowledge of policies and procedures relating to the management of diabetes and older people. ● Know when to refer for GP assessment or specialist care. ● Understand the requirement for influenza vaccination. ● Organise access to retinopathy screening. ● Organise access to podiatry, as required. ● Have a working knowledge of other agencies (e.g. community health staff, dietetic and podiatry services, social services and voluntary agencies), and how to refer to them. ● Follow local policy and guidance regarding care of people with diabetes in residential or care homes (Diabetes UK, 2010).
<p>3. Experienced or proficient nurse</p>	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Identify people with diabetes who are at a high risk of poor glycaemic, lipid and BP control. ● Ensure residents understand how to take their medication, are aware of side-effects and know how to report these. ● Manage and coordinate individual patient care and deliver education programmes. ● Have knowledge of how to monitor intercurrent illness in relation to glycaemic control, and when to seek specialist advice. ● Report regular hypo- and hyperglycaemic episodes to the GP for a joint review of management plan and medication.
<p>4. Senior practitioner or expert nurse</p>	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Demonstrate expert knowledge of diabetes medications and prescribe, if qualified as an independent non-medical prescriber, within one's own scope of practice. ● Provide expert advice on the care of people with diabetes in residential and nursing homes. ● Coordinate services across organisation and professional boundaries. ● Participate in guideline and or protocol development. ● Initiate and/or participate in audit and research. ● Develop appropriate education programmes in collaboration with care home staff.
<p>5. Consultant nurse</p>	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for care of people with diabetes living in residential and nursing homes, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care in residential and nursing homes, including contributing to national data collections and audits. ● Initiate and lead research on diabetes and residential and nursing homes through leadership and consultancy. ● Identify service shortfalls in the care of people with diabetes living in residential and nursing homes and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients living in residential and nursing homes, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national networks, diabetes teams and staff in residential and nursing homes in the development of diabetes integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy regarding the care of people with diabetes living in residential and nursing homes. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

Competency statements

5.20. END-OF-LIFE CARE

To care for someone with diabetes at end of life you should be able to:

1. Unregistered practitioner	<ul style="list-style-type: none"> ● Undertake blood glucose monitoring and care as requested by registered nurse. ● Document and report blood glucose monitoring results according to local guidelines and protocols. ● Be aware of policies relating to end-of-life care and diabetes. ● Be aware of signs and symptoms that may indicate hypoglycaemia or hyperglycaemia.
2. Competent nurse	<p>As 1, and:</p> <ul style="list-style-type: none"> ● Actively seek and participate in peer review of one's own practice. ● Assess the person's needs and ensure they are pain free, adequately hydrated and symptom free from their diabetes. ● Be aware that palliative care may vary in time, and diabetes control needs to be assessed on an individual and a daily basis. ● Be aware that glucocorticoid steroids may cause diabetes, which may require insulin treatment. Steroids can also worsen glycaemic control with pre-existing diabetes. ● Be aware that the aim of diabetes treatment in the last few days of life is to prevent discomfort from hypoglycaemia, hyperglycaemia, or DKA in people with type 1 diabetes, with minimum intervention. ● Recognise that people with type 2 diabetes may not need treatment for diabetes in the last few days of life. ● Recognise that people with type 1 diabetes may need a change in insulin, i.e. to a once-daily basal insulin, depending on that individual's eating pattern.
3. Experienced or proficient nurse	<p>As 2, and:</p> <ul style="list-style-type: none"> ● Initiate and develop personalised care plans in collaboration with the person with diabetes and their carers/family. ● Describe indications for the initiation or discontinuation of blood glucose-lowering agents in agreement with the person with diabetes and their carers. ● Give advice on blood glucose monitoring and, if required, the appropriate frequency of monitoring in agreement with the person and carers. ● Recognise when treatment needs to be adjusted.
4. Senior practitioner or expert nurse	<p>As 3, and:</p> <ul style="list-style-type: none"> ● Plan, implement and deliver education programmes around diabetes and palliative care for other HCPs. ● If a registered non-medical prescriber, adjust and prescribe medication related to diabetes, as required, within own competencies and scope of practice. ● Participate in the development of guidelines and protocols related to diabetes and palliative care.
5. Consultant nurse	<p>As 4, and:</p> <ul style="list-style-type: none"> ● Work with stakeholders to develop and implement local guidelines for appropriate diabetes management at end of life, promoting evidence-based practice and cost-effectiveness. ● Lead on developing, auditing and reporting on patient-related experience and patient-related outcome measures, and be able to produce information on the outcomes of diabetes care at end of life, including contributing to national data collections and audits. ● Initiate and lead research in diabetes management at end of life through leadership and consultancy. ● Identify service shortfalls in appropriate management of diabetes at end of life and develop strategies with the local commissioning bodies to address them. ● Identify the need for change, proactively generate practice innovations and lead new practice and service redesign solutions to better meet the needs of patients at end of life, the diabetes population as a whole and the diabetes service. ● Lead on liaising with local and national end-of-life networks and diabetes teams in the development of diabetes and end of life integrated care pathways, including the development of integrated IT solutions and systems for diabetes that record individual needs to support MDT care across service boundaries. ● Influence national policy concerning appropriate management of someone with diabetes at end of life. ● Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

- Castledine G (1991) The role of the diabetes specialist nurse: Nursing Forum presentation. In: Diabetes Specialist Nursing Working Party (eds). *Royal College of Nursing Forum Presentation and Diabetes Specialist Nursing Working Party Report*. RCN, London
- Castledine G (2002) Recognizing and valuing higher level practice. *Br J Nurs* 11: 143
- CMA Medical Data (2009) *The Directory of Diabetes Care*. CMA Medical Data, Loughborough
- Davies M, Dixon S, Currie CJ et al (2001) Evaluation of a hospital diabetes specialist nursing service: a randomised controlled trial. *Diabet Med* 18: 301–7
- Department of Health (1998) *Nurse Consultants Health Service Circular (HSC 1998/161)*. DH, London
- Department of Health (1999) *Agenda for Change: Modernising the NHS Pay System*. DH, London
- Department of Health (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*. DH, London
- Department of Health (2003) *National Service Framework for Diabetes: Delivery Strategy*. DH, London
- Department of Health (2005) *Agenda for Change: National Job Profiles*. DH, London
- Department of Health (2006) *Modernising Nursing Careers: Setting the Direction*. DH, London
- Department of Health (2007a) *Towards a Framework for Post Registration Nursing Careers*. DH, London
- Department of Health (2007b) *Making Every Young Person with Diabetes Matter: Report of the Children and Young People with Diabetes Working Group*. DH, London
- Department of Health (2010) *Commissioning*. DH, London
- Department of Health (2011) *Health and Social Care Bill*. DH, London
- Diabetes Nursing Strategy Group (2005) *An Integrated Career and Competency Framework for Diabetes Nursing*. SB Communications Group, London
- Diabetes UK (2009) *Position Statement: Improving Inpatient Diabetes Care*. Diabetes UK, London
- Diabetes UK (2010) *Commissioning Specialist Diabetes Services for Adults with Diabetes: A Diabetes UK Task and Finish Group Report*. Diabetes UK, London
- Framingham Heart Study (2010) *Risk Score Profiles*. Available at: tinyurl.com/yj4jjjo (accessed 05.02.10)
- International Society for Pediatric and Adolescent Diabetes (2009) *ISPAD Clinical Practice Consensus Guidelines 2009*. ISPAD, Berlin, Germany
- James J, Gosden C, Winocour P et al (2009) Diabetes specialist nurses and role evolution: a survey by Diabetes UK and ABCD of specialist diabetes services 2007. *Diabet Med* 26: 560–5
- Manley K (2001) Consultant Nurse: Concept, Processes, Outcome [unpublished PhD thesis]. University of Manchester, Manchester and RCN Institute, London
- Manley K, Garbett R (2000) Paying Peter and Paul: reconciling concepts of expertise with competency for a clinical career structure. *J Clin Nurs* 9: 347–59
- NHS Diabetes (2010) Safe use of insulin. NHS Diabetes. Available at: <http://bit.ly/hYLi> (accessed 25.01.11)
- NHS Employers (2004) *Knowledge and Skills Framework*. NHS Employers, London. Available from: tinyurl.com/ydtu3x5 (accessed 02.02.10)
- Roach MS (1992) *The Human Act of Caring: A Blueprint for the Health Professions*. 2nd edn. Canadian Hospital Association Press, Ottawa
- Royal College of Nursing (2004) *Services for Children and Young People: Preparing Nurses for Future Roles*. RCN, London
- Skills for Health (2009) *Skills for Health Competencies*. Skills for Health, Bristol. Available at: tinyurl.com/ydenbwj (accessed 02.02.10)
- Stevens RJ, Kothari V, Adler AI et al (2001) The UKPDS risk engine: a model for the risk of coronary heart disease in type II diabetes (UKPDS 56). *Clin Sci (Lond)* 101: 671–9
- TREND-UK (2010) *An Integrated Career and Competency Framework for Diabetes Nursing*. 2nd edn. SB Communications Group, London
- Williams B, Poulter NR, Brown MJ et al (2004) British Hypertension Society guidelines for hypertension management 2004 (BHS-IV): summary. *BMJ* 328: 634–40

Glossary

A&E – Accident and emergency department
BMI – Body mass index
BP – Blood pressure
CHD – Coronary heart disease
DH – Department of Health
DKA – Diabetic ketoacidosis
DSN – Diabetes specialist nurse

GLP-1 – Glucagon-like peptide-1
HbA_{1c} – Glycosylated haemoglobin
HCP – Healthcare professional
IFG – Impaired fasting glucose
IGT – Impaired glucose tolerance
ISPAD – International Society for Pediatric and Adolescent Diabetes
MDT – Multidisciplinary team
NICE – National Institute for Health and Clinical Excellence
UKPDS – United Kingdom Prospective Diabetes Study

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