An Integrated Career and Competency Framework for Diabetes Nursing

trend UK
TRAINING, RESEARCH AND EDUCATION FOR NURSES IN DIABETES

4th Edition

Contents

1 Foreword

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 National Diabetes Inpatient Specialist Nurse Group and the Practice Nursing Forum, as well as Diabetes UK, and people living with diabetes.

Representatives from these groups have reviewed and further developed the framework, building on the third edition published in 2010. This fourth edition of the framework was necessary to keep the document up to date. The development of the framework was funded by an unrestricted educational grant from members of the pharmaceutical industry. I would like to take this opportunity to thank those industry members for investing in diabetes nursing for the future through this important project. Thanks also to SB Communications Group for their administrative support.

I would also like to acknowledge the hard work and commitment of my TREND-UK Co-Chairs, Jill Hill and June James, and our TREND-UK Associates, Jane Diggle and Su Down. 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

Acknowledgements

Many thanks to all the people and organisations listed below who reviewed, updated and further developed the document contents: Kit McAuley, DSN, Barnet, Enfield and Haringey Mental Health Trust; Lesley Mills, Nurse Consultant–Diabetes, Warrington Hospital Trust; Rachel Berrington, Senior DSN and Diabetic Foot Lead, University Hospitals of Leicester NHS Trust; Rebecca Saker, Diabetes Renal Dietitian, University Hospitals of Leicester NHS Trust; and Sabera Khan, Opthalmic Lead DSN, University Hospitals of Leicester NHS Trust.

Many thanks also to the following pharmaceutical companies for their generous support of this project: BD Medical - Diabetes; and Sanofi.

Comment

“The nursing community provides a valuable and vital contribution to the care of people at risk of type 2 diabetes and living with type 1 and type 2 diabetes – providing the support, education and advice that people need to manage their own health on a day-to-day basis. As members of the multidisciplinary diabetes team, they are often responsible for the coordination of care between different parts of the healthcare system, which can be complicated to navigate. This framework provides practice nurses, diabetes specialist nurses, healthcare assistants, facilitators and nurse consultants with clear guidance on the competencies needed to meet professional standards of practice.

Work is needed to embed these competencies into practice, with commissioners and hospital, general practice and community teams working together to put in place the appraisal, learning opportunities and support to enable nurses to keep up to date, develop their skills and deliver the care that people with diabetes expect – no matter where they live.”

Bridget Turner
Head of Policy, Care and Improvement
Diabetes UK

A GLOSSARY OF TERMS CAN BE FOUND ON PAGE 35.

Introduction

2

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 fourth edition of *An Integrated Career and Competency Framework for Diabetes Nursing*, addresses a number of political and professional issues, including:

- 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 establishing professional standards for HCPs.
- An increased focus on work-based, life-long learning and supervision.
- The focus on professional, rather than academic, accreditation for HCPs.
- The need for cost-effectiveness within the economic constraints of the NHS.
- The impact of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust (Francis, 2013).
- The Vision for Nursing and the 6 "C"s (Cummings and Bennett, 2012).
- *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* (NMC, 2015).
- The NMC's introduction of revalidation for nurses (see: www.nmc.org.uk/standards/revalidation).

While we know that multidisciplinary working underpins all diabetes care, this framework focuses specifically on nurses and unregistered practitioners providing diabetes care, but it can be used together with other frameworks that highlight core nursing skills and competencies.

Since the launch of the Department of Health's (DH, 2005) *Agenda for Change*, 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 assists 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).

Nurses and commissioning

Diabetes is a common and complex condition affecting all aspects of the individual's life, with potentially costly and life-changing 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 high-quality, safe and affordable diabetes care to the population for which they are responsible, with the emphasis on the achievement of measurable outcomes (DH, 2010). To achieve this, they need: an awareness of the healthcare needs of that population and the priority of those needs; recognition of the skills required to deliver a service to meet 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 both 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 requiring insulin therapy, or leading a team of nurses delivering a comprehensive number of services, including pump therapy, inpatient care and antenatal care.

Nurses are key to 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 services to support self-management 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, either as Clinical Commissioning Groups in England or those working with other health delivery systems in the UK, 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 and 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 a vital element 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. ■

3 Development of the framework

The first edition of *An Integrated Career and Competency Framework for Diabetes Nursing* was developed in 2005 by more than 40 generalist and specialist nurses, as well as people with diabetes, with feedback provided by over 250 people involved in diabetes care. The result was a competency framework for adult diabetes nursing developed by nurses, for nurses. However, diabetes nursing and the context in which it is practised has evolved since then, and the document has been revised several times to reflect this.

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 and leadership; Manley and Garbett, 2000).

Every nurse has a number of common competencies at the core of their practice (Manley, 2001). *An Integrated Career and Competency Framework for Diabetes Nursing* lists 20 clinical areas, each of which 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 following the introduction of the *Agenda for Change* (DH, 2005), the role of team manager has emerged. This post spans some elements of the senior nurse and nurse consultant competencies and encompasses 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.

Diabetes nursing and beyond

Since the 1970s, the DSN role has become increasingly common. The dramatic increase in the numbers of people with diabetes has increased the need for DSNs, with the role becoming very diverse, with a variety of titles, reflecting the diversity of working environment and complexity of treatments and technologies used in diabetes care.

DSNs work wholly in diabetes care; they may be employed in primary, community or secondary care or across two or more areas. 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 medical consultants providing expert clinical support, as recommended in the RCN report defining such roles (Castledine, 1991). This diversity is a challenge for diabetes nursing as, firstly, the professional group is becoming more fragmented as DSNs are employed by various non-NHS healthcare providers (James et al, 2009). Secondly, 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 still no single recognised qualification for the DSN role. The *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 to be working towards, a master's 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.

Following the inquiry into increased death rates and poor quality of care at Mid Staffordshire NHS Foundation Trust (Francis, 2013), nine recommendations directly concerning nurses were included in the 290 recommendations in the inquiry report. A process of revalidation every 3 years for all nurses was one of these. In January 2015, the revised "Code" for nurses and midwives was published by the NMC, listing 25 standards of care, categorised into four areas:

- Prioritise people.
- Practise effectively.
- Preserve safety.
- Promote professionalism and trust.

Development of the framework

The revalidation process is based on the Code standards, with evidence required to demonstrate that the Code is embedded in the daily work of every practising nurse and midwife. Evidence demonstrating competency is included. In previous editions of the *Competency Framework*, each competency topic for the competent nurse level and above included the line "Actively seek and participate in peer review of one's own practice". The revalidation process formalises this as a requirement to be able to continue practising as a registered nurse.

DSNs influence care indirectly through education of HCPs 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 though 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.

Increasingly, diabetes care is being carried out in primary care by practice nurses. All practice nurses are registered nurses, but few are employed under the terms and conditions of the *Agenda for Change* (DH, 2005). Their involvement in diabetes care can vary from delivering the components of the annual diabetes review as part of a general long-term conditions management role, to working full-time in diabetes care, providing a high level of service including initiation and management of injection therapies. Practice nurses also have a significant role in diabetes prevention and the early diagnosis of diabetes.

Like DSNs, 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. However, achievement of at least 35 hours of relevant CPD will be required for successful revalidation every 3 years. ■

4 How to use the framework

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.

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 to plan a career pathway if a nurse wishes to specialise in diabetes care. The framework should be used alongside the *Knowledge and Skills Framework* (NHS Employers, 2004). The revalidation process recommends that every nurse should maintain a portfolio of evidence that demonstrates competency and keeping updated. Examples of evidence that can be used to demonstrate competency are included in the competency assessment tool included in this document.

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, 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
NHSIQ e-learning modules www.nhsiq.nhs.uk/news-events/news/ext-0114-insulin-modules.aspx
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
Six Steps to Insulin Safety www.cpd.diabetesonthenet.com

Some guidance on how to assess competency

5

Assessing and assuring competence in healthcare is essential with the increasing complexity of treatments and interventions available, prevention and management of risk, the increasing cost of litigation, planning and developing new services to meet evolving need, measuring the efficacy of training and identifying gaps in knowledge to inform training and personal development. There are an increasing number of alternative providers of healthcare, and the comparison of provider performance (ability to deliver as well as cost) may lead to rejection of one provider for another. The financial constraints of the NHS in an environment of increasing demand emphasises the need to avoid waste through inefficiencies or litigation when mistakes are made, for example when providers are not delivering a competent service. It is also a core requirement for delivering quality care to patients.

Why do diabetes nurses need to assess competence?

All nurses will need to provide evidence that they are safe and competent to practice. It is a requirement of the *Knowledge and Skills Framework* and to successfully pass through the relevant gateways identified in the *Agenda for Change*. It is also a requirement for the 3-yearly revalidation process for nurses to continue to be registered and practise. The diversity of career pathways and the lack of a standard recognised diabetes specialist nursing qualification makes the demonstration of competence essential to ensure high-quality care and public confidence in the role.

Who should assess competence?

Someone who has the knowledge and skills *and experience* of completing the task to be assessed, someone who is expert, is appropriate to assess the competence of another. This may not necessarily be another nurse and it does not have to be someone senior to the person who is being assessed. When delegating a task (e.g. a district nurse delegating an aspect of care to a healthcare assistant), it is the responsibility of the delegator to ensure that the person is competent to complete the task.

When should competence be assessed?

Competence should be checked before someone takes on a new task or care. Unfortunately, internal factors, such as inertia or health issues, and external factors, such as inadequate staffing levels or lack of equipment or support, can all affect competency. Therefore, competency should be reviewed annually, with evidence collected in a portfolio for appraisal meetings and revalidation. There may be guidance provided by the employing Trust or organisation policies. It may be necessary to review competency earlier if there are concerns about the ability of an individual or as part of a serious event review.

Where?

This is usually undertaken in the place of work, during a placement or secondment, or in a college or place of training.

How to assess competence

Identify the topics that are relevant to the person's role and the level appropriate to their expected competency. An accurate description of the task is required, related to national guidelines, local policies or manufacturers' guidelines. Competency can be measured in a number of ways, such as by a quiz, questionnaire or verbal questioning to assess knowledge and understanding, observation of a task being completed, review of care plans, record keeping and other documents. The following table gives some examples related to descriptive words used in the *Integrated Career and Competency Framework for Diabetes Nursing*.

The outcome of the assessment should be a written account of those competencies which have been performed to the acceptable level expected of the individual according to their job role and responsibilities, as well as those competencies which have not been achieved. An action plan should be agreed by the assessor and the assessee as to how the failed competency can be met, then reassessed at an appropriate time in the future. ■

Assessments of competence	
Interpret	• Ask the person to examine and identify patterns or problems from a given range of results, for example, a blood glucose profile.
Lead on	• Ask for evidence of organising and chairing meetings, developing guidelines or disseminating knowledge to groups of others.
Demonstrate/ perform	• Someone who is experienced and acknowledged as competent should observe the task being performed and assess if it has been completed properly (e.g. the correct use of a blood glucose meter as per the manufacturer's guidelines, as well as in compliance with local policy about safe disposal of sharps, infection control, etc.). • Ask the person to describe what they would do in a particular situation or clinical scenario (e.g. how they would identify and treat hypoglycaemia).
Initiate	• Example of prescribing new treatment, referral or intervention in the context of a case scenario.
Provide expert advice	• Example of an insulin management plan developed by a DSN for district nurses to follow. • Example of a letter to a GP explaining the rationale for a prescribing decision and the ongoing care required. • Publication of articles or national guidance, or delivering presentations locally or nationally.
Teach	• Observation of delivering a structured education or one-to-one session. • Evaluation or post-training knowledge survey from a teaching session.
Explain, describe, state, list, understand, know, identify	• Verbal questioning or written test.

6 Competency statements

6.1. 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	• Describe the risk factors for developing 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	As 1, and: • Make a comprehensive assessment of an individual's risk of type 2 diabetes utilising a valid diabetes risk assessment tool. • Sign-post 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. • Keep a register and ensure appropriate follow-up/system of recall is in place for those at risk to identify the progression to 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 and diabetes prevention.
3. Experienced or proficient nurse	As 2, and: • Interpret test results and, if diagnostic, make appropriate referral. • Educate other HCPs and care workers 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). • Be aware of the need to refer people with newly diagnosed diabetes to a peer-reviewed structured education programme.
4. Senior practitioner or expert nurse	As 3, and: • Provide expert advice on the benefits of screening programmes/procedures for high-risk groups to HCPs and care workers, 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	As 4, and: • Work with stakeholders to develop and implement local guidelines for early identification and management of non-diabetic hyperglycaemia (NDH), 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 NDH and outcomes of interventions, including contributing to national data collections and audits. • Initiate and lead research in identification and management of NDH through leadership and consultancy. • Identify service shortfalls in screening for, and management of, people with NDH 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 NDH integrated care pathways or the National Diabetes Prevention Programme (NDPP), including the development of integrated IT solutions and systems for NDH 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.

See: NICE Guideline PH35 (NICE, 2011a).

6.2. PROMOTING SELF-CARE

To support the person to self-care for their diabetes you should be able to:	
1. Unregistered practitioner	• 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 individualised and agreed care plans.
2. Competent nurse	As 1, and: • Assess the ability of the person with diabetes to self-care and work with them or their carer to optimise self-care skills. • Sign-post people to information and support to encourage informed decision-making about living with diabetes and managing life events (e.g. peer-reviewed structured education programmes). • Support the person with diabetes in setting realistic goals and in the achievement of those goals.
3. Experienced or proficient nurse	As 2, and: • 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 individualised and agreed care plan.
4. Senior practitioner or expert nurse	As 3, and: • Demonstrate knowledge of theoretical frameworks and educational philosophies underpinning behaviour change. • Demonstrate knowledge and understanding of bio-physical and psychosocial factors affecting self-management of long-term conditions. • 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 and care workers in diabetes self-care skills.
5. Consultant nurse	As 4, and: • 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.

6.3. MENTAL HEALTH

To care for someone with diabetes and poor mental health you should be able to:	
1. Unregistered practitioner	• Have an awareness of how poor mental health, such as depression, anxiety and schizophrenia, affects 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	As 1, and: • Raise the issue of current mental health/addiction problems sensitively during individual consultations. • Conduct a mental health assessment using a recognised depression tool. • Demonstrate awareness that some mental health medications can have a detrimental affect on glycaemic and lipid control. • Support the person with diabetes and poor mental health in obtaining the appropriate investigations in a timely manner. • Ensure people with diabetes and mental health problems understand the importance of how to take the diabetes medication, recognise common side-effects and how to report them.
3. Experienced or proficient nurse	As 2, and: • Assess those people with mental health problems and how antipsychotic medication impact on the risk of developing type 2 diabetes and their 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 and the medications used 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 poor mental health. • Manage and coordinate individual patient care and education programmes. • Recognise the implications of poor 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	As 3, and: • 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 poor mental health. • Have an in-depth understanding of additional complex issues of poor 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 glycaemic control; the high prevalence of smoking in mental health sufferers and the impact this has on the CHD risk factors).
5. Consultant nurse	As 4, and: • Work with stakeholders to develop and implement local guidelines for management of diabetes in those with poor mental health, 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 poor mental health, including contributing to national data collections and audits. • Initiate and lead research in the management of diabetes in those with poor mental health through leadership and consultancy. • Identify service shortfalls in the care of people with diabetes and poor mental health 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 poor mental health, 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 poor mental health. • Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

6.4. NUTRITION

To meet the person's individual nutritional needs you should be able to:	
1. Unregistered practitioner	• Follow the individual nutritional plan and report any related problems. • Recognise foods and drinks high in carbohydrate and refined sugar. • Measure and record waist circumference, height and weight accurately. • Understand the importance of regular meals, avoiding long periods without food. • Report if meals are not eaten, especially carbohydrates, if the patient is taking insulin or sulphonylureas.
2. Competent nurse	As 1, and: • List the principles of a healthy, balanced diet, including low sugar, high fibre, low salt and low fat elements. • Calculate and interpret BMI against the healthy range. • 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	As 2, and: • Work in partnership with the individual and/or group with diabetes to identify realistic and achievable dietary changes to help individuals to manage their glucose levels 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 and how different feeding regimens impact on blood glucose levels.
4. Senior practitioner or expert nurse	As 3, and: • Perform an assessment of how lifestyle (i.e. diet and physical activity) and pharmacological agents impact on glycaemic control. • Support the person with diabetes to make informed decisions about appropriate nutritional choices. • Teach the person with diabetes and/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	As 4, and: • 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.

6.5. URINE GLUCOSE AND KETONE MONITORING

For the safe use of urine glucose or ketone monitoring and associated equipment you should be able to:	
1. Unregistered practitioner	• 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	As 1, and: • 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	As 2, and: • If ketones are present in moderate or large amounts, refer on for further investigation and/or treatment. • Ensure patients are aware of appropriate action to take if ketones are moderate/high. • Ensure patients know what to do if vomiting should occur. • 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	As 3, and: • Demonstrate an awareness of when further diagnostic and surveillance tests, such as HbA_{1c}, random blood glucose, eGFR or blood gases, would be indicated. • 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	As 4, and: • 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.

6.6. BLOOD GLUCOSE AND KETONE MONITORING

For the safe use of blood glucose and ketone monitoring and associated equipment you should be able to:	
1. Unregistered practitioner	• Perform the test according to manufacturers' instructions and local guidelines if trained and competent to do so. • Perform the test unsupervised, if trained and competent to do so, at the request of a registered nurse. • Document and report the result according to local guidelines. • Follow local policy for safe disposal of sharps. • Recognise and follow local quality assurance procedures. • 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	As 1, and: • 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 and demonstrate an understanding of when testing for ketones is appropriate.
3. Experienced or proficient nurse	As 2, and: • Interpret results and assess other parameters and take appropriate action, including initiating further tests, such as HbA_{1c}. • Teach people with diabetes or their carer to interpret test results and take appropriate action. • Interpret blood ketone results, assess other parameters and take appropriate, timely action.
4. Senior practitioner or expert nurse	As 3, and: • Use results to optimise treatment interventions according to evidence-based practice, while incorporating the preferences of the person with diabetes. • Initiate continuous blood glucose monitoring, if appropriate or available locally, 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.
5. Consultant nurse	As 4, and: • 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.

See: ***Blood Glucose Monitoring Guidelines: Consensus Document*** **(www.trend-uk.org/resources.php)**

6.7. ORAL THERAPIES

For the safe administration and use of oral antihyperglycaemic medication you should be able to:	
1. Unregistered practitioner	• Describe the effect of common oral antihyperglycaemic agents on blood glucose levels. • Demonstrate an understanding of the progressive nature of type 2 diabetes and the need for treatment intensification over time. • Describe common side-effects of antihyperglycaemic agents. • Recognise the signs of hypoglycaemia and administer the appropriate treatment (see Hypoglycamia competency, section 6.9). • Know when to refer to or seek guidance from a colleague.
2. Competent nurse	As 1, and: • Assess suitability of drugs depending on current eGFR level and specific contraindications. • Demonstrate knowledge of the range of oral antihyperglycaemic agents currently available and their mode of action. • Demonstrate knowledge of therapeutic doses and recommended timing of doses. • Administer or supervise the administration of prescribed medication. • Assess and convey to the patient the risks and benefits of taking, or not taking, a medicine. • Be aware which oral antihyperglycaemic agents carry a higher risk of hypoglycaemia. • Complete documentation accurately. • Demonstrate knowledge of which oral agents may be safely and effectively combined. • Demonstrate an understanding of how the efficacy of various agents are most appropriately measured (e.g. through self-monitoring of blood glucose or by HbA_{1c}).
3. Experienced or proficient nurse	As 2, and: • Describe indications for the initiation of oral antihyperglycaemic agents. • Demonstrate understanding of the various factors that impact on the pharmacodynamics and pharmokinetics of antihyperglycaemic agents. • Assess the impact of multiple pathologies, comorbidities, existing medications and contraindications on management options. • Demonstrate awareness of issues related to polypharmacy and drug interactions (e.g. use of steroids). • Demonstrate knowledge of how to detect and report adverse drug reactions. • Demonstrate understanding around the potential for adverse effects and how to avoid, minimise, recognise and manage them. • Apply the principles of evidence-based practice including clinical and cost-effectiveness. • Demonstrate knowledge of, and work within, national and local guidelines (e.g. upcoming NICE guidance on type 2 diabetes; see: www.nice.org.uk). • Evaluate treatment outcomes in a timely and appropriate fashion, making changes as required.
4. Senior practitioner or expert nurse	As 3, and: • Explain the rationale behind and the potential risks and benefits of different therapies. • Demonstrate awareness of the need to optimise or add in other glucose-lowering therapies, including insulin, in a timely manner. • 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 that informs practice. • If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice, ensuring that the appropriate level of supervision and support is in place to fulfil this role safely and effectively. • Adjust oral treatment according to individual circumstances, following local policies or individual clinical management plans. • Audit outcomes of care against accepted national and/or local standards (e.g. NICE, 2011b).
5. Consultant nurse	As 4, and: • 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.

6.8. INJECTABLE THERAPIES

For the safe administration and use of insulin and GLP-1 receptor agonists you should be able to:	
1. Unregistered practitioner	• Describe the effect of insulin on blood glucose levels. • Describe the effect of GLP-1 receptor agonists on blood glucose levels. • Show an understanding of the ongoing nature of the therapy. • Administer insulin injections competently using a safety-engineered device, where supported by local policy. • Administer GLP-1 receptor agonist injections competently using a safety-engineered device, where supported by local policy. • Report identified problems appropriately. • Be aware of the local Sharps Disposal Policy. • Be aware of the European Directive on prevention from sharp injuries in the hospital and healthcare sector (available at: http://bit.ly/1aWrPmX).
2. Competent nurse	As 1, and: • 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: – Correct choice of needle type and length for the individual. – Appropriate use of a lifted skin fold, where necessary. – Correct method for site rotation. – Storage of insulin. – Single use of needles and safe sharps disposal (according to local policy). • Examine injection procedure and injection sites at least annually for detection of lipohypertrophy, and be able to give appropriate advice for resolving poor injection sites. • Be aware of common insulin and management errors. • Identify correct reporting system for injectable therapy errors. • Provide evidence of insulin safety training. • Describe circumstances in which insulin use might be initiated or altered and make appropriate referral.
3. Experienced or proficient nurse	As 2, and: • Demonstrate a broad knowledge of different insulin types (i.e. action, use in regimens). • Demonstrate a broad knowledge of different GLP-1 receptor agonists (e.g. drug type, action, side-effects). • Be proficient in providing necessary education relating to commencement of injection therapy. • Initiate insulin or GLP-1 receptor agonist therapy where clinically appropriate. • Assess individual patients' self-management and ongoing educational needs and meet these needs or make appropriate referral. • Support and encourage self-management wherever appropriate. • Recognise when injection therapy needs to be adjusted or changed. • 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.

6.8. 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 if trained and competent and in line with local and national policy. • 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. • Be aware of emerging research relating to injection technique and be competent to implement outcomes into daily practice.
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.

See: NICE Guideline NG17 (NICE, 2015a)

See: Upcoming NICE guidance on type 2 diabetes (www.nice.org.uk)

See: *The UK Injection Technique Recommendations*, 3rd edition (http://fit4diabetes.com)

See: *The Six Steps to Insulin Safety* CPD module (www.cpd.diabetesonthenet.com)

See: NHSIQ e-learning modules (www.nhsiq.nhs.uk/news-events/news/ext-0114-insulin-modules.aspx)

See: Education for Health *Diabetes Injection Technique and Safety* modules (www.ditaslearning.org)

6.9. HYPOGLYCAEMIA

For the identification and treatment of hypoglycaemia you should be able to:	
1. Unregistered practitioner	• State the normal blood glucose range and describe the level at which it would be appropriate to treat as hypoglycaemia. • Describe the signs and symptoms of hypoglycaemia, including both mild and severe. • Recognise that some people may not demonstrate or recognise clear signs and symptoms of hypoglycaemia (e.g. older people, those with longer duration of diabetes and those who have experienced recurrent episodes of hypoglycaemia). • Demonstrate competent use of blood glucose monitoring equipment to confirm hypoglycaemia. • Know how to access and administer appropriate treatment for hypoglycaemia as per local guidelines. • Give reassurance and comfort to the person with diabetes or their carer. • Document and report the hypoglycaemic event to a registered HCP. • If the person with diabetes is unresponsive, ensure their airway is clear and call emergency services.
2. Competent nurse	As 1, and: • Recognise and provide appropriate treatment for the different levels of hypoglycaemia. • Describe the possible causes of hypoglycaemia and any factors that can increase risk (e.g. alcohol consumption, physical activity and poor injecton sites). • Ensure episodes of hypoglycaemia are followed up appropriately and according to local policies. • If using insulin therapy, check injection technique and injection sites according to recommended correct practice (refer to the *The UK Injection Technique Recommendations*, 3rd edition). • Describe methods of hypoglycaemia avoidance and explain how these will be implemented to minimise future risk. • Identify medications most likely to cause hypoglycaemia and explain how the risks may be minimised. • Describe what should be done if hypoglycaemia is not resolved and blood glucose levels remain low. • Demonstrate a knowledge of current driving regulations and how they relate to hypoglycaemia (see DVLA, 2015). • Ensure appropriate hypoglycaemia treatments are accessible to patients and in date. • Be aware of appropriate and recommended blood glucose targets for type 1 and type 2 diabetes and in pregnancy. • Be aware when tight glycaemic control is not recommended (e.g. in the frail or older person or those in end-of-life care).
3. Experienced or proficient nurse	As 2, and: • Identify people with diabetes at high risk of hypoglycaemia, advise and adjust therapy accordingly. • Give advice regarding driving regulations and hypoglycaemia (i.e. according to current DVLA guidelines and with reference to DVLA, 2015). • 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 within the context of the clinical presentation to identify unrecognised hypoglycaemia.

6.9. 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 and psychological impact). • Provide expert advice on complex cases. • Identify and teach appropriate strategies for prevention of hypoglycaemia during and after exercise and under special circumstances (e.g. during Ramadan or periods of fasting). • Act as an expert resource for information on hypoglycaemia for other HCPs. • Work in collaboration 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.

See: *Recognition, Treatment and Prevention of Hypoglycaemia in the Community* (www.trend-uk.org/resources.php)

See: *The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus* (www.diabetologists-abcd.org.uk)

See: *The UK Injection Technique Recommendations*, 3rd edition, 2015 (http://fit4diabetes.com)

See: *Diabetes: Safe Driving and the DVLA* (www.trend-uk.org/resources.php)

See: *Diabetes: Why do I sometimes feel shaky, dizzy and sweaty?* (www.trend-uk.org/resources.php)

6.10. HYPERGLYCAEMIA

For the identification and treatment of hyperglycaemia you should be able to:	
1. Unregistered practitioner	• State the normal blood glucose range. • Describe signs and symptoms of hyperglycaemia. • Recognise that older people may be asymptomatic of hyperglycaemia. • Perform blood glucose and blood/urine ketone tests according to local guidelines. • Correctly document results and report those out of the accepted range.
2. Competent nurse	As 1, and: • 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. • Recognise the impact that glucocorticosteroids have on blood glucose levels and trends. • Make appropriate referral for advice. • Support self-management where possible. • Know how to manage hyperglycaemia and/or ketonuria to minimise the risk of progression to diabetic ketoacidosis (DKA) or hyperosmolar hyperglycaemic state (HHS) in accordance with national or local policies or individual clinical management plans.
3. Experienced or proficient nurse	As 2, and: • Recognise appropriate glycaemic treatment targets for special patient groups (e.g pregnant women, older people, those with significant comorbidities, the frail and those in end-of-life care). • 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	As 3, and: • 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 DKA or HHS. • Act as a resource for information on hyperglycaemia for other HCPs.
5. Consultant nurse	As 4, and: • 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: ***The Management of Diabetic Ketoacidosis in Adults*** **(www.diabetes.org.uk)**

See: ***The Management of the Hyperosmolar Hyperglycaemic State (HHS) in Adults with Diabetes*** **(www.diabetes.org.uk)**

See: ***Diabetes: What to Do When You Are Ill*** **(http://www.trend-uk.org/resources.php)**

See: ***Type 2 Diabetes and Steroid Tablets*** **(www.trend-uk.org/resources.php)**

6.11. INTERCURRENT ILLNESS

To manage intercurrent illness you should be able to:	
1. Unregistered practitioner	• 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	As 1, and: • Take a comprehensive assessment and patient history. • Initiate appropriate preliminary investigations (e.g blood glucose and ketone measurements). • Recognise when to seek urgent medical advice and/or when to admit to hospital (e.g ketonuria in pregnancy, children, dehydration and vomiting). • Make appropriate referrals. • Administer baseline treatment. • Give advice regarding continuation of treatment for diabetes during intercurrent illness and provide written information. • 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	As 2, and: • 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, and provide written information. • Educate people with diabetes, their carers and HCPs about sick-day diabetes management. • Provide appropriate literature for the learning needs of people with diabetes, their carers and HCPs. • Recognise when treatment may need adjusting, according to local and national guidelines or policies.
4. Senior practitioner or expert nurse	As 3, and: • 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	As 4, and: • 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.

See: ***Diabetes: What to Do When You Are Ill*** **(http://www.trend-uk.org/resources.php)**

6.12. MANAGING DIABETES IN HOSPITAL

6.12.1. GENERAL ADMISSION

To manage diabetes during a hospital admission you should be able to:	
1. Unregistered practitioner	• Carry out duties delegated by a registered nurse for the care of a person with diabetes. • Ensure ward blood glucose meters are quality-controlled according to hospital policy. • Perform blood glucose and blood/urine ketone tests within local guidelines. • Inform a registered nurse of any observed change in the condition of a person with diabetes.
2. Competent nurse	As 1, and: • Care for a person with diabetes in hospital in relation to general care and comfort, pressure relief, appropriate nutrition (JBDS, 2012) and fluids, monitoring of glycaemic control, and ensure administration of appropriate medication. • Be aware of national and local guidance and training requirement on insulin safety. • Demonstrate awareness of the importance of daily foot checks in those with poor mobility, the frail and the bedbound. • 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. • Recognise the impact that glucocorticosteroids have on blood glucose levels and trends. • Be aware of different non-insulin or insulin therapies and regimens. • Establish, maintain and discontinue insulin infusion regimens according to local policy and individual need. • Recognise the different indications for use of a variable-rate or fixed-rate insulin infusion. • Recognise diabetes-related emergencies (e.g. DKA, HHS, hypoglycaemia) and treat according to local guidelines. • Make appropriate referrals to the diabetes specialist team. • Enable a safe and effective discharge plan for the person with diabetes following liaison with relevant agencies.
3. Experienced or proficient nurse	As 2, and: • Recognise appropriate glycaemic treatment targets for special patient groups (e.g. older people, those with significant comorbidities, the frail and those in end-of-life care; see: www.diabetes.org.uk/end-of-life-care). • Have an understanding of treatment pathways to manage steroid-induced hyperglycaemia (JBDS, 2014). • Be aware of the impact of enteral feeding of food supplements on blood glucose. • Demonstrate knowledge of the management of diabetes medications prior to investigations and procedures. • 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-manage 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. JBDS guidelines; see below). • Participate in the development or maintenance of local guidance for the care of people with diabetes in hospital.

6.12. MANAGING DIABETES IN HOSPITAL

6.12.1. GENERAL ADMISSION *continued*

To manage diabetes during a hospital admission you should be able to:	
4. Senior practitioner or expert nurse	As 3, and: • 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	As 4, and: • 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.

See: Joint British Diabetes Societies for Inpatient Care guidance (www.diabetologists-abcd.org.uk/JBDS/JBDS.htm)

See: *Discharge Planning for People with Diabetes* (www.diabetologists-abcd.org.uk/JBDS/JBDS.htm)

6.12. MANAGING DIABETES IN HOSPITAL *continued*

6.12.2. 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	• Be aware of policies relating to fasting in people with diabetes undergoing surgical or investigative procedures.
2. Competent nurse	As 1, and: • Take a patient history and discuss adherence with treatment and glycaemic control. • Advise on diabetes care surrounding pre- and perioperative procedures. • Demonstrate knowledge of the indications for use of a variable-rate insulin infusion. • Be able to demonstrate competence when setting up, managing and discontinuing a variable-rate insulin infusion. • 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. • Know when to refer to dietetics for nutritional review. • Provide information to relatives and carers of people with diabetes. • Be aware of national recommendations, standards and guidelines for the care of people with diabetes undergoing surgery or investigation (e.g. JBDS; see below).
3. Experienced or proficient nurse	As 2, and: • Assess and, where appropriate, enable a person with diabetes to self-manage 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	As 3, and: • 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	As 4, and: • 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.

See: ***Management of Adults with Diabetes Undergoing Surgery and Elective Procedures: Improving Standards*** **(www.diabetologists-abcd.org.uk)**

6.13. PREGNANCY

6.13.1. PRE-CONCEPTION CARE

To support a woman with diabetes preparing for pregnancy you should be able to:	
1. Unregistered practitioner	• Demonstrate awareness of the need for pre-conception care. • Sign-post women to local information and group sessions if available.
2. Competent nurse/midwife	As 1, and: • Be aware of the latest national guidelines. • Demonstrate an understanding of the need for pre-conception care and follow local guidelines. • Explain to the woman with diabetes or her carer the need for pre-conception care. • Identify medicines contraindicated in pregnancy and make appropriate referral. • Be aware of the need for the higher dose of folic acid. • 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/midwife	As 2, and: • Demonstrate knowledge of latest 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/midwife	As 3, and: • 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 management 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/midwife	As 4, and: • 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.

See: NICE Guideline NG3 (NICE, 2015b)

6.13. PREGNANCY *continued*

6.13.2. 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	• 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/midwife	As 1, and: • Be aware of the latest national guidelines. • 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/midwife	As 2, and: • 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 foetal monitoring. • Demonstrate an understanding of the complications of pregnancy in women with pre-existing or gestational diabetes. • Provide appropriate education about gestational diabetes and its management to women diagnosed with the condition. • Be a named patient contact for the pregnant woman, or new mother, with diabetes.
4. Senior practitioner or expert nurse/midwife	As 3, and: • Recognise the situations that would lead to urgent referral and need for admission during pregnancy (e.g. symptoms of pre-eclampsia, euglycaemic DKA, severe hypoglycaemia). • Demonstrate an in-depth knowledge and understanding of both pre-existing and gestational diabetes during pregnancy. • If a registered non-medical prescriber, prescribe medications, as required, within own competencies and scope of practice. • Develop and implement individual management 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. • Advise on management of diabetes if steroid use is necessary during pregnancy. • Ensure effective communication systems are in place to inform general practice of the diagnosis of gestational diabetes in their patients.
5. Consultant nurse/midwife	As 4, and: • 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.

See: NICE Guideline NG3 (NICE, 2015b)

6.14. CARDIOVASCULAR DISEASE (CVD)

To care for people with established CVD or associated risk factors (including hypertension and dyslipidaemia) you should be able to:	
1. Unregistered practitioner	• 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 in accordance with hypertension guideline published in collaboration between the British Hypertension Society and NICE (NICE, 2011d). • Demonstrate awareness of the normal parameters for BP measurements. • Take blood tests and specimens as requested by a registered nurse or doctor. • Demonstrate awareness of the risk factors for CVD. • Recognise and describe the impact of fear and anxiety on BP readings. • Be capable of discussing lifestyle measures, such as diet, exercise and smoking cessation, and their impact in terms of reducing CV risk.
2. Competent nurse	As 1, and: • Identify people with diabetes at risk of CVD. • Be capable of undertaking a comprehensive CVD risk assessment using an accepted risk calculation tool (e.g. QRisk2; available at: www.qrisk.org). • Refer people with diabetes for appropriate specialist intervention. • Interpret and act on test results appropriately. • Support people with diabetes to better understand how their medications work, how to take them, to recognise potential side-effects and know when and how to report them.
3. Experienced or proficient nurse	As 2, and: • Order appropriate blood tests and specialist investigations. • Initiate and develop personalised care plans and set goals with the person with diabetes to reduce CV risk. • Show proficiency in developing and delivering education. • Manage and coordinate individual patient care and education programmes. • Be aware of policies relating to the prevention and management of CVD and participate in the development of local guidelines and protocols.
4. Senior practitioner or expert nurse	As 3, and: • Lead service development. • Use evidence to develop practice and develop guidelines and protocols. • Coordinate services across organisational and professional boundaries. • Recognise and describe the link between diabetes and CVD. • Provide an organised programme of care designed to manage established CVD according to local and national guidelines . • Demonstrate knowledge and skills that support behaviour change. • 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 CVD, 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 CVD, including contributing to national data collections and audits. • Initiate and lead research in diabetes nursing contribution to prevention and management of CVD through leadership and consultancy. • Identify service shortfalls in the prevention and management of CVD 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 CVD, 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 diabetes and CVD. • Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

See: NICE Clinical Guideline CG127 (NICE, 2011d).

See: NICE Clinical Guideline CG172 (NICE, 2013).

See: NICE Clinical Guideline CG181 (NICE, 2014a).

6.15. NEUROPATHY

To care for people with, or at risk of, neuropathy, you should be able to:	
1. Unregistered practitioner	• 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. • Demonstrate the procedure of basic diabetes foot screening in line with national guidance and/or local protocols, and record screening results in the patient record. • Identify possible neuropathy and make appropriate referral to confirm diagnosis.
2. Competent nurse	As 1, and: • Recognise the need for and carry out annual foot screening for people with diabetes, and allocate risk status. • 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.
3. Experienced or proficient nurse	As 2, and: • 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	As 3, and: • 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. • Carry out an in-depth neurovascular assessment. • 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	As 4, and: • 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.

See: NICE Guideline NG19 (NICE, 2015c).

6.16. NEPHROPATHY

To care for people with, or at risk of, nephropathy, you should be able to:	
1. Unregistered practitioner	• Demonstrate an awareness that all people with diabetes are at risk of nephropathy. • Perform blood glucose monitoring and other blood/urine tests as directed. • Know which people with diabetes in your care have nephropathy. • Be able to undertake diabetic foot screening and record results on the patient notes. • Report any abnormal finding to a registered nurse.
2. Competent nurse	As 1, and: • Demonstrate awareness of complications and prevention. • Demonstrate awareness of annual screening tests to detect nephropathy. • Organise or perform albumin/creatinine screening, blood pressure measurement and blood tests according to local and national protocols and guidelines. • Demonstrate awareness of the five different stages of chronic kidney disease.
3. Experienced or proficient nurse	As 2, and: • 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 moderate or severe 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. • Be aware of the impact chronic kidney disease has on the excretion of some diabetes medications, including sulphonylureas and insulin therapies. • Know when to refer to dietetics for advice on diabetes and renal diets. • Participate in guideline development. • Be aware of fluid restrictions required in people with advanced kidney disease. • Participate in education programmes for HCPs. • Participate in multidisciplinary liaison.
4. Senior practitioner or expert nurse	As 3, and: • Be aware of relevant national polices (e.g. NICE, 2014b) • 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, including steroids, may affect 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. • Know when to refer to specialist renal or diabetes teams. • Provide or refer for psychological support as required. • Participate in the development and monitoring of the integrated care pathways.
5. Consultant nurse	As 4, and: • 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.

See: NICE Clinical Guideline CG182 (NICE, 2014b).

6.17. RETINOPATHY

To care for people with, or at risk of, retinopathy, you should be able to:	
1. Unregistered practitioner	• 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 all retinal screening appointments.
2. Competent nurse	As 1, and: • 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	As 2, and: • 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	As 3, and: • 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 and new retinal screeners. • Participate in the development and monitoring of integrated care pathways. • Keep updated with new therapies available for patients with diabetic macular oedema.
5. Consultant nurse	As 4, and: • 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.

6.18. PRISON AND YOUNG OFFENDER UNITS

To support someone with diabetes residing in a prison or young offender unit you should be able to:	
1. Unregistered practitioner	• Demonstrate an understanding of specific issues relating to the care of people with diabetes in prison or a secured unit, such as: – 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 for the individual and report readings outside this range to the appropriate person. – Demonstrate knowledge of the signs of, and appropriate treatment for hypoglycaemia and hyperglycaemia. – Recognise and follow local policy regarding sharps disposal. – Know how to recognise depression, anxiety and other mental illness in people with diabetes.
2. Competent nurse	As 1, and: • 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. • Be able to state action identified within the local policy for treating hypoglycaemia and follow local protocols. • Be able to state action identified within the local policy for treating hyperglycaemia and intercurrent illness, and follow local protocols. • 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 and alcohol misuse 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, ophthalmology 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 individual treatment goals. • Identify offenders with diabetes who are at a high risk of poor glycaemic, lipid and BP control, and develop appropriate action plan. • Identify offenders who are at high risk of hypoglycaemia or lack hypoglycaemia awareness, and ensure that safeguarding is in place. • Demonstrate knowledge of implications that "not-in-possession medications" may have on glycaemic control.
3. Experienced or proficient nurse	As 2, and: • Follow local policy and in-house guidance regarding care of offenders with diabetes in secured units. • Be aware of the need for regular cardiovascular, neuropathy and retinopathy screening in offenders with diabetes. • Work with offenders with diabetes who have difficulty with medications adherence and encourage self-management with an agreed care plan if appropriate. • Ensure offenders 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 all people 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.

6.18. PRISON AND YOUNG OFFENDER UNITS *continued*

To support someone with diabetes residing in a prison or young offender unit you should be able to:	
4. Senior practitioner or expert nurse	As 3, and: • 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 offenders with diabetes. • Coordinate services across organisational 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.
5. Consultant nurse	As 4, and: • 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 offender units. • Work in collaboration with higher educational institutions and other education providers to meet educational needs of other HCPs.

6.19. RESIDENTIAL AND NURSING HOMES

To care for someone with diabetes living in a residential or nursing home you should be able to:	
1. Unregistered practitioner	• Demonstrate an understanding of specific issues relating to the care of people with diabetes in residential or nursing homes, such as: – 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 if trained and competent to do so. – 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.
2. Competent nurse	As 1, and: • Identify and review the specifics of diabetes management in each person's individualised care plan. • Demonstrate an awareness of how lifestyle changes 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, and be aware of current national reports and guidance.
3. Experienced or proficient nurse	As 2, and: • 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 HCP education programmes depending on the needs of residential staff. • 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.
4. Senior practitioner or expert nurse	As 3, and: • 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.
5. Consultant nurse	As 4, and: • 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.

6.20. END-OF-LIFE CARE

To care for someone with diabetes at end of life you should be able to:	
1. Unregistered practitioner	• 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	As 1, and: • 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. • Demonstrate knowledge of appropriate blood glucose targets (e.g. 6–15 mmol/L) to avoid hypoglycaemia and hyperglycaemia. • 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 and DKA or HHS. • Be aware that people with type 1 diabetes must remain on insulin therapy during the last days of life. • 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. • Be aware that, where possible, diabetes treatment plans and medication changes must be discussed with the patient, relatives or carers.
3. Experienced or proficient nurse	As 2, and: • 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	As 3, and: • 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	As 4, and: • 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.

See: ***End of Life Diabetes Care: Clinical Care Recommendations*** **(www.diabetes.org.uk)**

7 References

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

Cummings J, Bennett V (2012) *Compassion in Practice: Nursing Midwifery and Care Staff. Our Vision and Strategy*. NHS England, London. Available at: http://bit.ly/1g6ZNmT (accessed 27.07.15)

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 (2010) *Commissioning*. DH, London

Diabetes UK (2010) *Commissioning Specialist Diabetes Services for Adults with Diabetes: A Diabetes UK Task and Finish Group Report*. Diabetes UK, London

DVLA (2015) Current medical guidelines: DVLA guidance for professionals. DVLA, Swansea. Available at: www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals (accessed 28.07.15)

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationary Office, London. Available at: http://bit.ly/1LSaha9 (accessed 27.07.15)

James J, Gosden C, Winocour P et al (2009) Diabetes specialist nurses and role evolvement: a survey by Diabetes UK and ABCD of specialist diabetes services 2007. *Diabet Med* **26**: 560–5

Joint British Diabetes Societies (2012) *Glycaemic Management During the Inpatient Enteral Feeding of Stroke Patients with Diabetes*. JBDS, Leicester. Available at: http://bit.ly/1LVcSi5 (accessed 08.09.15)

Joint British Diabetes Societies (2014) *Management of Hyperglycaemia and Steroid (Glucocorticoid) Therapy*. JBDS, Leicester. Available at: http://bit.ly/1UyudoF (accessed 08.09.15)

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 Employers (2004) *Knowledge and Skills Framework*. NHS Employers, London. Available at: http://bit.ly/1F9N55R (accessed 14.08.15)

NICE (2011a) Preventing Type 2 Diabetes: Population and Community-Level Interventions (PH35). NICE, London. Available at: www.nice.org.uk/guidance/ph35 (accessed 14.08.15)

NICE (2011b) *Diabetes in Adults Quality Standard* (QS6). NICE, London. Available at: www.nice.org.uk/guidance/qs6 (accessed 14.08.15)

NICE (2011c) *Management of Stable Angina* (CG126). NICE, London. Available at: www.nice.org.uk/guidance/cg126 (accessed 14.08.15)

NICE (2011d) *Hypertension: Clinical Management of Primary Hypertension in Adults* (CG127). NICE, London. Available at: www.nice.org.uk/guidance/cg127 (accessed 14.08.15)

NICE (2013) *MI – Secondary Prevention: Secondary Prevention in Primary and Secondary Care for Patients Following a Myocardial Infarction* (CG172). NICE, London. Available at: www.nice.org.uk/guidance/cg172 (accessed 14.08.15)

NICE (2014a) *Lipid Modification: Cardiovascular Risk Assessment and the Modification of Blood Lipids for the Primary and Secondary Prevention of Cardiovascular Disease* (CG181). NICE, London. Available at: www.nice.org.uk/guidance/cg181 (accessed 14.08.15)

NICE (2014b) *Chronic Kidney Disease: Early Identification and Management of Chronic Kidney Disease in Adults in Primary and Secondary Care* (CG182). Available at: www.nice.org.uk/guidance/cg182 (accessed 14.08.15)

NICE (2015a) *Type 1 Diabetes in Adults: Diagnosis and Management* (NG17). Available at: www.nice.org.uk/guidance/ng17 (accessed 06.09.15)

NICE (2015b) *Diabetes in Pregnancy: Management of Diabetes and its Complications from Preconception to the Postnatal Period* (NG3). Available at: www.nice.org.uk/guidance/ng3 (accessed 14.08.15)

NICE (2015c) *Diabetic Foot Problems: Prevention and Management* (NG19). Available at: www.nice.org.uk/guidance/ng19 (accessed 28.09.15)

NMC (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. NMC, London. Available at: http://bit.ly/1bZNQBi (accessed 27.07.15)

Roach MS (1992) *The Human Act of Caring: A Blueprint for the Health Professions*. 2nd edn. Canadian Hospital Association Press, Ottawa

Glossary

A&E – Accident and emergency department
BMI – Body mass index
BP – Blood pressure
CVD – Cardiovascular disease
DH – Department of Health
DKA – Diabetic ketoacidosis
DSN – Diabetes specialist nurse
DVLA – Driver and Vehicle Licensing Agency
GLP-1 – Glucagon-like peptide-1
HbA_{1c} – Glycated haemoglobin
HCP – Healthcare professional
MDT – Multidisciplinary team
NICE – National Institute for Health and Care Excellence
NMC – Nursing and Midwifery Council

October 2015

Published by
SB Communications Group
A Schofield Media Group Company
1.01 Cargo Works, 1–2 Hatfields, London
SE1 9PG

An electronic version of *An Integrated Career and Competency Framework for Diabetes Nursing* (4th edition) is available to download from:

www.trend-uk.org

Tel. (0) 207 627 1510
Fax. (0) 207 627 1570

Competency framework tool coming soon