Diabetes Competence Assessment Tool for **District Nursing**

Final version 26 July 2017

In 2016, the Department of Health (DoH) Diabetes Nurse Education Group was established. A key objective was to determine the learning and development needs in relation to knowledge and skills of primary care and community nurses, necessary for the effective management of diabetes.

A task and finish group of the Regional District Nursing Diabetes sub group (appendix 1) determined the competencies required by District Nursing, using the Trend Framework for Diabetes Nursing (2014)[1].

The rating scale used was developed by Northern Ireland Practice and Education Council (NIPEC) '[2].

Introduction

Health and Wellbeing 2026: Delivering Together vision is to move to a new model of person centred care focused on prevention, early intervention, supporting independence and wellbeing. To aspire to this;

- People are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing.
- When they need care people have access to safe high quality care.
- Staff are empowered and supported to deliver high quality care

District Nursing is well placed to support people living with diabetes. Additionally, evidence suggests that adopting a *Making Every Contact Count*[3] approach could potentially have a significant impact on the health of our population.

The DoH Diabetes Strategic Framework[4] highlights the need for staff who are not specialist in diabetes to have the skills to support people living with diabetes. With the emphasis on care closer to home and growing prevalence of Type 2 diabetes and older people requiring insulin therapy, it is increasingly important that nurses working in primary and community care have the necessary knowledge and skills to effectively support people living with diabetes (and their carers), to self-manage their condition well and improve outcomes. District Nursing has a role in diabetes care, as a member of the multi-disciplinary team, particularly for frail elderly who are housebound, and their contribution to improving outcomes should be maximised.

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[1] The Core Specific Competence Areas have been adapted and developed with permission from Trend- UK (2015) *An Integrated Career and Competency Framework for Diabetes Nursing* 4th edition, Version 9. London: SB Communications Group.

[2] https://nipecportfolio.hscni.net/compro/compSelect.asp

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515949/Making_Every_Contact_Count_Consensus_Statement.pdf

[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/diabetes-framework-november-2016.pdf

Diabetes UK recommends the 15 Healthcare Essentials for everyone with diabetes as an essential guide for practice[5] (appendix 2).

A PHA scoping exercise carried out for a one month period (July 2016) indicated that there were 530 people living with diabetes in NI who require the District Nursing service to administer insulin, and 63% required twice daily administration. In addition to patients who are primarily housebound other patient groups that required the District Nursing service included physical disability, sensory disability, dementia, learning disability and mental ill health.

The Nursing and Midwifery Code (2015)[6] also requires registered Nurses are accountable for their practice and must provide care on the basis of the best available evidence and best practice, and maintain the knowledge and skill necessary for safe effective practice. Registered Nurses must advise on and prescribe medicines within the limits of their training, competence, legislation, regulatory guidance and other relevant policies, guidance and regulations.

Digital technology is already and will undoubtedly further transform the design and delivery of care to people with diabetes in the future. District Nursing must ask how can:

- We work in partnership with patients and their carers to consider the use of technology to enable their care?
- Digital technologies help us organise our work so that we make the most of our expertise and time?
- We generate more effective methods of feedback on our services so that we continually improve and achieve better quality, safety and experience for patients, their carers and the service
- We ensure sustainable development of eHealth skills and professional development in the nursing workforce?

[5] https://www.diabetes.org.uk/Guide-to-diabetes/Managing-your-diabetes/15-healthcare-essentials/
[6] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Purpose of Competency Assessment Tool

The purpose of this assessment tool is to:

1. Assist individuals in assessing their learning and development needs in relation to diabetes care and management.

2. Help organisations to build the capability and capacity of District Nursing.

3. Provide a reference for commissioning and planning educational programmes.

When individuals are undertaking a self-assessment, the diabetes competence assessment tool can help identify the knowledge, skills and attitudes required for the role. Following self-assessment this should be discussed with the line manager, as part of the annual appraisal and/or personal development plan, in order to agree an action plan addressing identified learning and development needs. This will support individuals meet revalidation and KSF requirements.

Assessing yourself

The rating scale below should be used to assess learning and development needs against each of the statements

LD = I need a lot of development

SD = I need some development

WD = I feel I am well developed.

The specific diabetes competencies for District Nursing have been adapted with permission from Trend-UK [7] (2015); mainly from the Competent Nurse and Experienced/Proficient Nurse levels in the Trend-UK Framework http://trend-uk.org/. It is assumed that District Nursing will already have the competences identified by Trend-UK as relevant for Practitioners below Competent Nurse and Experienced/ Proficient Nurse levels.

[7] Trend- UK (2015) *An Integrated Career and Competency Framework for Diabetes Nursing* 4th edition, Version 9. London: SB Communications Group.

Screening, prevention and early detection of type 2 diabetes

For the prevention and early detection of type 2 diabetes you should be able to:	LD	SD	WD
Demonstrate knowledge of the pathophysiology of the types of diabetes.			
Identify individuals in at risk groups, the available tests for diagnosis and appropriate action required.			
Be aware of the lifestyle behaviours and the complications associated with type 2 diabetes e.g. Cardiovascular Disease, Neuropathy, Nephropathy, Retinopathy.			
Sign-post people to information and support to encourage lifestyle changes to prevent or delay progression to type 2 diabetes.			

Promoting self-care

To support the person to self-care for their diabetes you should be able to:	LD	SD	WD
Sign-post people to information and support to encourage informed decision-making about living with diabetes and managing life events.			
Assess the person with diabetes and their carer and support optimisation of self-care skills using motivational interviewing and promote informed decision-making about • lifestyle choices; • monitoring control; • choice of treatment and follow-up; • risk reduction; and • complications.			
Identify psychosocial barriers to self-care and refer on if necessary.			
Support people to continue with their personalised co-produced plan of care.			

Mental Health

To care for someone with diabetes and poor mental health you should be able to:	LD	SD	WD
Perform a holistic assessment using Northern Ireland Single Assessment Tool (NISAT) to inform coproduced plan of care.			
Demonstrate awareness that some mental health medications can have a detrimental effect on glycaemic and lipid control.			
Support the person with diabetes, who has poor mental health, in obtaining the appropriate diabetes investigations in a timely manner.			
Provide advice to people with diabetes who have mental health problems on the importance of how to take their diabetes medication, recognise common side-effects and how to report them.			
Recognise the implications of poor mental health on lifestyle choices/addiction problems and support the person with small, achievable changes, in line with their personalised coproduced plan of care.			

Nutrition

To meet the person's individual nutritional needs you should be able to:	LD	SD	WD
Perform a MUST assessment if triggered by the NISAT (Domain 1), and refer to the patient with diabetes to a dietician as appropriate			
Know how to calculate and interpret BMI against the healthy range.			
Work in partnership with the individual with diabetes to identify realistic, achievable dietary changes to manage their glucose levels in the short and long term.			
Know the dietary factors that affect Blood Pressure and lipid control.			
Be aware of local policy on the care of people undergoing enteral feeding, and for patients living with diabetes know how different feeding regimens impact on blood glucose levels.			

Urine Glucose and Ketone Monitoring

For the safe use of urine glucose or ketone monitoring and associated equipment you should be able to:	LD	SD	WD
Identify and demonstrate an understanding of when testing for ketones is appropriate, and when to refer on for further investigation and/or treatment.			
Provide advice to patients of the appropriate action to take if ketones are moderate/high.			
Provide advice to patients of the appropriate action to take if vomiting occurs.			

Blood Glucose and Ketone Monitoring

For the safe use of blood glucose and ketone monitoring and associated equipment you should be able to:	LD	SD	WD
Identify and demonstrate an understanding of when testing for ketones is appropriate.			
Demonstrate use of Blood Glucose and Ketone monitors including the quality control procedure as per Trust policy.			
Demonstrate awareness of regional guideline on the choice of blood glucose meters and test strips for type 2 diabetes.			
Interpret results, assess other parameters, take appropriate action, and refer if necessary. Have an awareness of further tests that may be required, such as HbA1c, Random Blood Glucose (RBG) and renal function.			
Teach people with diabetes and/or their carer to interpret test results and take appropriate action, incorporating the preferences of the person with diabetes.			

Oral Therapies

For the safe administration and use of oral antihyperglycaemic medication you should be able to:	LD	SD	WD
Demonstrate awareness of oral antihyperglycaemic agents, including: • Regional formulary guidance for diabetes; • rationale for initiation; • therapeutic doses, frequency and efficacy; • risks and benefits of medication including impact of co morbidities; • monitoring and control e.g. self-monitoring of blood glucose or by HbA1c); and • those that carry a higher risk of hypoglycaemia.			
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.			

Injectable Therapies

For the safe administration and use of insulin and GLP-1 receptor agonists you should be able to:	LD	SD	WD
Demonstrate knowledge of different insulin types, including • Regional formulary guidance for diabetes; • profile (including timing of insulin injection), dose(s), frequency and efficacy; • risks and benefits of medication; • monitoring and control e.g. self-monitoring of blood glucose or by HbA1c); and • Risk of hypoglycaemia.			
Demonstrate knowledge of different GLP-1 receptor agonists, including • Regional formulary guidance for diabetes; • therapeutic doses, frequency and efficacy; • risks and benefits of medication; • monitoring and control e.g. self-monitoring of blood glucose or by HbA1c); and • Risk of hypoglycaemia.			
Demonstrate and be able to teach the correct method of insulin or GLP-1 receptor agonist self-administration, including: • Correct choice of needle type; • Appropriate use of a lifted skin fold, where necessary; • Correct site selection and rotation; • Storage of insulin and GLP-1; • Single use of needles and safe sharps disposal (according to local policy); • Assessment of injection technique and site, at least annually, to detect and avoid lipohypertrophy.			
Be aware of common insulin and management errors and identify correct reporting system.			
Demonstrate understanding of when injection therapy may need initiated, adjusted or changed, take appropriate action including referral.			
Recognise the potential psychological impact of injectable therapies, and support the person with diabetes and/or their carer to achieve an individualised level of self-management and an agreed glycaemic target.			
Recognise signs of needle fear/needle phobia and the strategies to help manage this.			

Hypoglycaemia

For the identification and treatment of hypoglycaemia you should be able to:	LD	SD	WD
Demonstrate knowledge of hypoglycaemia (including hypoglycaemic unawareness and frequent hypoglycaemia), at risk groups, its possible causes and how to prevent recurrent hypoglycaemia,			
Recognise appropriate glycaemic treatment targets for at risk groups (e.g. vulnerable people, older people, those with significant comorbidities, learning disabilities, the frail and those in end-of-life care).			
Provide advice regarding driving regulations and hypoglycaemia (i.e. according to current DVLA guidelines).			

Hyperglycaemia

For the identification and treatment of hyperglycaemia you should be able to:	LD	SD	WD
Demonstrate knowledge of management of 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 personalised coproduced plan of care.			
Recognise appropriate glycaemic treatment targets for at risk groups (e.g. vulnerable people, older people, those with significant comorbidities, learning disabilities, the frail and those in end-of-life care).			
Demonstrate knowledge of the possible cause of hyperglycaemia, such as unrecognised infection, drug interactions (glucocorticosteroids).			
Work in partnership with the person with diabetes and/or their carer to agree treatment goals.			
Educate people with diabetes, their carers and other HCPs in the identification, treatment and prevention of hyperglycaemia.			

Intercurrent illness

To manage intercurrent illness you should be able to:	LD	SD	WD
Recognise when to seek urgent medical advice and treatment (e.g. dehydration and vomiting).			
Provide advice to the person with diabetes and/or carer regarding when to seek medical advice.			
Support the person with diabetes and/or carer in managing their diabetes during intercurrent illness, and encourage self-management as soon as possible where appropriate.			
Educate people with diabetes and/or their carers about sick-day diabetes management, including ketone testing, where appropriate, according to local policy, and provide written information.			

Palliative and End of Life Care

To care for someone with diabetes at end of life you should be able to:	LD	SD	WD
Recognise that people with type 1 diabetes must remain on insulin therapy during the last days of life, but may need a change in insulin/insulin regime.			
Recognise that people with type 2 diabetes may not need treatment for diabetes in the last few days of life.			
Initiate and develop personalised coproduced care plans to support the person with diabetes to be pain free, adequately hydrated and symptom free from their diabetes.			
Recognise indications for the initiation, adjustment or discontinuation of blood glucose-lowering agents in agreement with the person with diabetes and/or their carers, and the prescriber.			
Provide advice on blood glucose monitoring and, if required, the appropriate frequency of monitoring in agreement with the person and/or carers, and the prescriber.			

Appendix 1: Membership of Diabetes District Nurse and Community Nurse task and finish group

Name	Title
Rose McHugh (Chair)	PHA Nurse Consultant
Kim Archibald	PHA Planning and Projects Manager
Cathy McCusker	NIPEC Senior Professional Officer
Eileen Breslin	BHSCT DSN
Florence Findlay White	Diabetes UK National Care Adviser
Fiona McGuigan	Acting ASM BHSCT
Helen McGrath	District Nurse WHSCT
Evelyn Walton	CEC Nurse Education Consultant
Hilary Caskey	WHSCT DSN
Deirdre Cunningham	CEC Senior Education Manager
Ciara Cunningham	SHSCT DSN
Margaret Diamond	NHSCT Interim Professional Lead for Community Nursing

Appendix 2 – 15 Healthcare Essentials for everyone with diabetes[8]

1. Get your blood glucose levels measured at least once a year.
2. Have your blood pressure measured and recorded at least once a year
3. Have your blood fats measured every year.
4. Have your eyes screened for signs of retinopathy every year by your local diabetic eye screening service
5. Have your feet and legs checked at least once a year, normally by your GP or practice nurse, but also if problems arise or on admission to hospital.
6. Have your kidney function monitored annually.
7. Get individual, ongoing dietary advice from a healthcare professional with appropriate expertise in nutrition, and be referred to a dietitian for tailored advice if necessary. You should have the opportunity to check your weight and get the support and information you need to manage your weight.
8. Get emotional and psychological support.
9. Be offered a group education course in your local area.
10. See specialist diabetes healthcare professionals to help you manage your diabetes. Diabetes affects different parts of the body and you should be referred to specialist professionals when needed, such as a diabetes specialist nurse, dietitian, ophthalmologist, pharmacist or podiatrist
11. Get a free flu vaccination every year from your GP.
12. Receive high-quality care if admitted to hospital.
13. Have the opportunity to talk about any sexual problems you might be experiencing.
14. If you smoke, get support and advice on how to quit.
15. Get information and specialist care if you are planning to have a baby.

[8] https://www.diabetes.org.uk/Guide-to-diabetes/Managing-your-diabetes/15-healthcare-essentials/