Diabetes Competence Assessment Tool for **General Practice Nurses**

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 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 (appendix 1) determined the competencies required by General Practice Nurses (GPNs), 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

The DoH Diabetes Strategic Framework[3] highlights the need for all staff who are not specialists in diabetes to have the skills to support people living with diabetes. With the emphasis on care closer to home and increasing prevalence of diabetes, it is vital that GPNs who have direct contact with patients living with diabetes and actively advise them, have the necessary knowledge and skills to effectively support them to manage their condition well and maximise outcomes. GPNs' have a role in diabetes care, as a member of the multidisciplinary team, and their contribution to improving outcomes should be maximised. Diabetes UK recommends the 15 Healthcare Essentials as an essential guide for practice.[4] (Appendix 2).

The Nursing and Midwifery Code (2015)[5] also requires that 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.

[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.health-ni.gov.uk/sites/default/files/publications/health/diabetes-framework-november-2016.pdf

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

[5] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Purpose of Competency Framework

The purpose of this framework 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 GPNs

3. Provide a reference for commissioning and planning education 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 (NMC) revalidation and Knowledge and Skills Framework (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 General Practice Nurses have been adapted with permission from Trend-UK [6] (2015); mainly from the Competent Nurse and Experienced/Proficient Nurse levels in the Trend-UK Framework http://trend-uk.org/. It is assumed that General Practice Nurses will already have the competences identified by Trend-UK as relevant for Practitioners below Competent Nurse and Experienced/Proficient Nurse levels.

[6] 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 at risk of type 2 diabetes (e.g. long-term use of steroid, antipsychotic medication, previous gestational diabetes and family history) and initiate appropriate screening/diagnostic tests. Maximise opportunistic screening opportunities, e.g. obesity, CHD or Hypertension clinics.			
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.			
Provide advice and refer people; • to programmes that address the role of lifestyle intervention in the prevention or delay in progression to type 2 diabetes, e.g. exercise and smoking cessation; • to a peer-reviewed structured education programme for newly diagnosed type 2 diabetes.			

Promoting self-care

To support the person to self-care for their diabetes you should be able to:	LD	SD	WD
Assess the person with diabetes and their carer and support optimisation of self-care skills using structured motivational interviewing techniques. Promote informed decision-making about • lifestyle choices, i.e. diet, exercise, smoking, drugs & alcohol; • monitoring control; • choice of treatment and follow-up; • risk reduction; and • complications.			
Identify psychosocial barriers to self-care and refer on where 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
Demonstrate knowledge of the psychological impact of diabetes and facilitate appropriate referral if necessary.			
Demonstrate a basic understanding of the mental health issue 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).			
Be aware of how antipsychotic medication impacts on the risk of developing type 2 diabetes, their diabetes management, and refer as appropriate.			
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
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.			
Refer the patient with diabetes to a dietician as appropriate.			

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
Demonstrate an awareness of when further diagnostic and surveillance tests such as HbA1c, random blood glucose, or renal function would be indicated.			
Instigate further tests such as HbA1c and random blood glucose.			

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
Interpret results and assess other parameters, take appropriate action including referral, as well as initiating further tests, such as HbA1c.			
Teach people with diabetes or their carer to interpret test results and take appropriate action, incorporating the preferences of the person with diabetes.			
Demonstrate use of Blood Glucose and Ketone monitors including the quality control procedure.			
Demonstrate awareness of regional guideline on the choice of blood glucose meters and test strips for type 2 diabetes.			

Oral Therapies

For the safe administration and use of oral antihyperglycaemic medication you should be able to:	LD	SD	WD
Demonstrate a knowledge 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.			
Audit outcomes of care against accepted national and/or local standards			

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 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 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 and be able to teach the correct method of GLP-1 receptor agonist or insulin self-administration, including: • Correct choice of needle type; • Appropriate use of a lifted skin fold, where necessary; • Correct site selection and rotation; • Storage of GLP-1 and insulin; • Single use of needles and safe sharps disposal (according to local policy); and • 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 needs to be 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.			
Demonstrate knowledge of blood glucose levels and HbA1c results within the context of the clinical presentation to identify unrecognised hypoglycaemia.			
Recognise appropriate glycaemic treatment targets for at risk groups (e.g. pregnant women, older people, those with significant comorbidities, the frail, those in end-of-life care and vulnerable adults).			
Provide advice regarding driving regulations and hypoglycaemia (i.e. according to current Driver and Vehicle Licensing Agency (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.			
Recognise the need to 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, their carers and HCPs about sick-day diabetes management, including ketone testing, where appropriate, according to local policy, and provide written information.			

Pregnancy

To support a women with diabetes preparing for pregnancy you should be able to:	**LD**	**SD**	**WD**
Be aware of the latest national guidelines.			
Demonstrate an understanding of the need for pre-conception care, provide explanation to the woman with diabetes or her carer, and refer to preconception clinic.			
Identify if a woman is on any medication and refer to the appropriate medical practitioner for advice.			
Be aware of the need for a higher dose of folic acid.			
Demonstrate knowledge of the appropriate referral system, including to the specialist diabetes team.			

Cardiovascular Disease (CVD)

To care for people with established CVD and associated risk factors (including hypertension and dyslipidaemia) you should be able to:	**LD**	**SD**	**WD**
Demonstrate knowledge of appropriate blood tests, initiate and interpret results.			
Be aware of when patients may need referral for specialist investigations.			
Educate patients and/or carers about lifestyle measures, e.g. diet, exercise and smoking, and their impact in terms of reducing CVD risk.			
Support people with diabetes to understand how their CV medications work, how to take them, to recognise potential side effects and know when and how to report them.			
Manage and coordinate a personalised co-produced plan of care.			

Neuropathy

To care for people with, or at risk of, neuropathy, you should be able to:	LD	SD	WD
Recognise the need for and carry out annual foot screening for people with diabetes, and allocate risk status.			
Demonstrate awareness of factors that may affect neuropathy (e.g. poor glycaemic control), complications and prevention of neuropathy.			
Describe measures to prevent tissue damage in people with diabetes.			
Provide foot care advice to people with diabetes and/or carers and HCPs.			
Be aware of erectile and sexual dysfunction as a neuropathic process, and refer where appropriate.			
Refer appropriately for identified neuropathy issues.			

Nephropathy

To care for people with, or at risk of, nephropathy, you should be able to:	LD	SD	WD
Demonstrate awareness of when test results are outside the expected range, and refer appropriately.			
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 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.			
Be aware of fluid restrictions required in people with advanced kidney disease.			

Retinopathy

To care for people with, or at risk of, retinopathy, you should be able to:	LD	SD	WD
Educate the person with diabetes and their carer about the prevention of, and the importance of screening for retinopathy.			
Recognise the importance of good glycaemic, BP and cholesterol control in preventing and/or progressing diabetic retinopathy.			

Palliative and End of Life Care

To care for someone with diabetes at end of life you should be able to:	LD	SD	WD
Be aware that diabetes control needs to be assessed on an individual basis during palliative and end of life care.			
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.			

Appendix 1: Membership of Diabetes General Practice Nurse task and finish group

Name	Title
Rose McHugh (Chair)	PHA Nurse Consultant
Eileen Breslin	BHSCT Diabetes Specialist Nurse
Florence Findlay White	Diabetes UK
Dr Bernard McCoy	GP and ICP diabetes lead
Donna Hanlon	General Practice Nurse
Heather Finlay	Department of Health Nursing Officer
Diane McFarland	General Practice Nurse
Rosemarie Papachristopolous	General Practice Nurse
Evelyn Walton	CEC Nurse Education Consultant
Linzi McIlroy	RCN Senior Professional Development Officer
Sophia Polatol	General Practice Nurse
Heather McClure	General Practice Nurse
Ber Harty	General Practice Nurse

Appendix 2 – 15 Healthcare Essentials for everyone with diabetes[7]

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.

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