



## **DIABETES COMPETENCES FOR COMMUNITY NURSES**

This document has been developed in conjunction with the Diabetes Link Nurses and Diabetes Nurse Specialists working in, and for, Lothian Health Board. These competences were derived from existing competences and have been integrated into one document for ease of access and use. The document should be utilised in conjunction with the excel spreadsheet attached. The excel spreadsheet can be used to provide the evidence of how you as a Community Nurse meet these competences.

These competences are designed to reflect what you are doing in your current practice and to help you identify any learning needs you may have.

Competence can be defined as " the state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of ones professional responsibility" <sup>1</sup>

These competences require to be completed on a bi-annual basis and will form part of your professional development plans.

Suggested areas for further learning are:

1. PAN Lothian Diabetes Education
2. Situational learning/ shadowing
3. Management of Diabetes Module (QMU)
4. Insulin Resource pack
5. E Learning "Safe use of Insulin" module  
[http://www.diabetes.nhs.uk/safety/safe\\_use\\_of\\_insulin\\_elearning\\_module/elearning\\_course/](http://www.diabetes.nhs.uk/safety/safe_use_of_insulin_elearning_module/elearning_course/)

If further assistance for completion is required please contact your locality Diabetes Link Nurse or Diabetes Specialist Nurse

## **Tips and evidence required for completing**

Where possible base responses on patients on your caseload

Evidence can be:

- bullet pointed as much as possible
- examples of paperwork (care plans, insulin adjustment sheets etc)
- references to guidelines, websites, resources
- discussion with caseload holder

## **COMPETENCE 1**

### **Personal role in diabetes care as a member of the MDT**

TIP: Think of a patient in your care who has required or may require MDT approach

EVIDENCE: Provide example of when patient might need MDT approach

Care plan you have completed which details your role

### **Personal accountability and that of other members of MDT**

TIP: Think about how you keep up your knowledge and skills in diabetes care

EVIDENCE: Diabetes study days attended/ completion of resource pack

Examples of areas for development and actions taken

### **Communication systems and methods of record keeping**

TIP: Think about how diabetes care is recorded. How would you seek specialist advice?

EVIDENCE: Examples of paperwork you have completed and discuss how it is used

Provide evidence of how to contact Diabetes Specialist Services and examples of when this might be required

### **Information Technology systems**

TIP: What IT systems do you use to record contacts and results for patients with diabetes?

EVIDENCE: Provide details

## **COMPETENCE 2**

### **Knowledge of specific tests used in diabetes care**

TIP: Think about annual and routine reviews required for people with diabetes. Where would you access information about what is required for these reviews?

EVIDENCE: Reference: GP practice local guidelines, SIGN 116 <sup>2</sup>, Lothian diabetes handbook <sup>3</sup>

### **Interpretation, recording and reporting of results**

TIP: When performing annual/routine reviews how do you identify if these are within target?

EVIDENCE: VISION, TRAK or similar or as above

### **Importance of risk assessment and management in diabetes care**

TIP: Think about patients of concern who have required referral to MDT team / specialist services

EVIDENCE: Provide an example of when this may be necessary and how referral made

## **COMPETENCE 3**

### **Pharmaceutical interventions in diabetes**

TIP: Think about diabetes drugs used commonly by patients on your caseload and the action, timing and side effects of these

EVIDENCE: Provide examples of above  
Reference Balance guide <sup>4</sup>

### **Influence of diet and nutrition**

TIP: Think about what advice you would give to a patient with diabetes regards food and nutrition

EVIDENCE: Examples of diet leaflets used  
Balance of good health model  
Example of when to refer to the dietician

### **Influence of physical activity on diabetes**

TIP: Think about the benefits of exercise and how to avoid hypoglycaemia

EVIDENCE: List benefits and any advice required to avoid adverse effects

### **Recognition of signs and symptoms of complications**

TIP: Think about patients you see with diabetes who have related complications

EVIDENCE: Provide example of patient on caseload with complications/risk factors  
Care plan

### **Prevention of complications through health promotion**

TIP: Think about what education or health promotion your patients with diabetes need

EVIDENCE: Care plan, diabetes specific health promotion material e.g. NHS Lothian, Diabetes UK

## **COMPETENCE 4**

### **Lifestyle factors**

TIP: Think about how life style can affect diabetes

EVIDENCE: Bullet point your role

### **The importance of informed consent**

TIP: Think about NMC Code of Professional Conduct <sup>5</sup>

EVIDENCE: Care plan completed where patient involved

## **COMPETENCE 5**

### **Perform blood glucose test**

EVIDENCE: What meter should be should be used, when  
Ability to perform BG test and QC meter  
Obtaining supplies

### **Interpreting results**

TIP: Think about individual patients blood glucose targets

EVIDENCE: Completed Resource pack training  
Titration sheet in use  
Care plan  
Discussion

**Teach blood glucose monitoring patients**

EVIDENCE: Bullet points/discuss aims of education and any possible difficulties

**Identify situations where testing for ketones appropriate**

TIP: Think about which patients might need ketone testing and why. Specialist services would be best placed to give advice

EVIDENCE: Describe what you would do  
Contact details for Specialist Services

**Support with diabetes to interpret results**

EVIDENCE: Promotion of self care

**COMPETENCE 6****Demonstrate basic knowledge of insulins**

TIP: Think about insulins used commonly by patients on your caseload and the action, timing and side effects of these

EVIDENCE: Provide examples of above  
Reference Balance guide<sup>4</sup>

**Demonstrate knowledge of insulin administration and devices used**

TIP: Think about community nurse guidance on use of insulin pens, advance preparation of insulin. Who would you contact if you felt a patient wasn't managing their insulin device?

EVIDENCE: Bullet point your role with patients using insulin pen devices, and appropriate advance preparation of insulin  
Reference RCN document – 'Advance preparation of Insulin syringes for patients to administer at home' <sup>6</sup>

**Teach basic method of insulin administration**

TIP: Think about correct injection technique and needle choices

**12.7mm needles SHOULD NOT BE USED**

EVIDENCE: Bullet point /Discuss steps required  
Reference BD Logo and BD Microfine insert resource pack

**Assess individual patient educational needs**

EVIDENCE: When would it be appropriate to provide education or refer onto specialist services?

**Recognise when treatment needs adjusted**

TIP: Think about titration of insulin – what resources could you use?

EVIDENCE: Completion of insulin resource pack, appropriate use of titration sheets, and or individual discussion

**Recognise potential psychological impact of insulin**

TIP: think of barriers which may occur when a patient requires long term insulin and or barriers affecting a patient's ability to self care

EVIDENCE: Discuss psychological impact of diabetes  
Care plan

## REFERENCE LIST

1. Roache MS The human act of caring a blue print for the health professions 2<sup>nd</sup> Edition (1992) Canadian Hospitals Associate Press Ottawa
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5. Nursing and Midwifery Council (NMC) NMC Code of Professional Conduct Nursing and Midwifery Council (2010) London
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