

## Diab HA2 Work in partnership with individuals to sustain care plans to manage their diabetes

### OVERVIEW

This standard covers supporting individuals as they undertake care plans to manage their diabetes. The activities described in this standard will take place in between the regular reviews of an individual's health and the agreement of care plans. The activities described in this standard may accompany specific interventions, including:- assisting individuals to sustain courses of medication- helping individuals with Type 2 diabetes to continue insulin therapy. Users of this standard will need to ensure that practice reflects up to date information and policies. Version No 1

### KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

- 1.the NSF for diabetes
- 2.the NICE guidelines on diabetes monitoring, management and education
- 3.causes of diabetes
- 4.signs and symptoms of diabetes
- 5.normal and abnormal blood glucose and HbA1c values
- 6.how to monitor glucose levels, HbA1c, blood pressure
- 7.typical progressive patterns of diabetes
- 8.the importance and effects of patient education and self management
- 9.the psychological impact of diabetes, at diagnosis and in the long term
- 10.how to gather information from patients about their health
- 11.how to work in partnership with patients and carers
- 12.the social, cultural and economic background of the patient/carer group
- 13.the impact of nutrition and physical exercise
- 14.the effects of smoking, alcohol and illicit drugs
- 15.the effects of, and how to manage, intercurrent illness
- 16.how to manage hypoglycaemia
- 17.the medications used to manage diabetes
- 18.the long term complications of diabetes and when they are likely to occur
- 19.how to examine feet and assess risk status
- 20.how to monitor cardiovascular risk
- 21.how to monitor for renal disease
- 22.how to monitor for diabetic retinopathy
- 23.the law and good practice guidelines on consent

- 24.the staff member's role in the healthcare team and the role of others
- 25.local guidelines on diabetes healthcare
- 26.local referral pathways
- 27.local systems for recording patient information
- 28.quality assurance systems
- 29.the process of notification for legal and insurance purposes
- 30.sources of practitioner and patient information on diabetes
- 31.contact details of local and national support groups
- 32.how individuals can access facilities for exercise and physical activity, education and community activities

## PERFORMANCE CRITERIA

You must be able to do the following:

- 1.discuss the care plan with individuals and their carers in a way that encourages them to reflect and to express their views and concerns
- 2.provide the interventions that you have agreed to undertake in the care plan
- 3.confirm that any interventions by other members of the healthcare team have been carried out as planned, and agree action with the individual and with colleagues where problems have arisen
- 4.support individuals in carrying out the care plan, responding promptly to requests for help, while encouraging them to reflect on the issues that arise and to solve their problems for themselves
- 5.provide information that is relevant to the individual at appropriate times to support the individual's and carer's understanding of the individual's diabetes, and how they can manage it
- 6.liaise with other members of the care team and incorporate their feedback into discussions with individuals and carers so that modifications to the care plan can be considered
- 7.monitor progress with the care plan at agreed intervals appropriate to the individual's needs and the risks to be managed
- 8.jointly identify and acknowledge the individual's achievements where they have been successful in managing their diabetes, and provide positive support and reinforcement when they have not been able to reach their goals
- 9.discuss with the individual and carer any problems or difficulties in following the plan, and explore how they may be addressed
- 10.refer the individual, with their informed consent, for further examinations by another member of the healthcare team if you find new concerns about the individual's condition which are beyond the scope of the care plan
- 11.discuss potential adjustments to the care plan with individuals and carers in a way that enables them to understand benefits and limitations and to make an informed choice
- 12.record progress with the plan and any agreed changes to it in a form that can be followed by other members of the care team, the individual and carer

## ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health. This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004): Dimension: HWB7 Interventions and treatments