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Diab HA9 Help an individual with diabetes to improve blood glucose control

OVERVIEW

This standard describes helping an individual with diabetes to improve their blood glucose control. This may follow tests that show symptoms of diabetic complications which can be deferred by tighter blood glucose control, or may simply be a part of good practice in optimising control. The activities described in this standard may follow from the regular review of health and the agreement of an overall care plan. 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. national frameworks for service delivery for diabetes
2. national 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 on glycaemic control
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 effects of insulin on diabetes
19. types of insulin
20. how to obtain and store insulin
21. insulin delivery and blood testing systems
22. the range of delivery devices that are used in the UK
23. local sharps disposal procedure
24. the long term complications of diabetes and when they are likely to occur

25. how to examine feet and assess risk status
26. how to monitor cardiovascular risk
27. how to monitor for renal disease
28. how to monitor for diabetic retinopathy
29. the law and good practice guidelines on consent
30. the staff member's role in the healthcare team and the role of others
31. local guidelines on diabetes healthcare
32. local referral pathways
33. local systems for recording patient information
34. quality assurance systems
35. the process of notification for legal and insurance purposes
36. sources of practitioner and patient information on diabetes
37. contact details of local and national support groups
38. how individuals can access local facilities for exercise and physical activity, education and community activities

PERFORMANCE CRITERIA

You must be able to do the following:

1. accept the individual and carer as equal partners in the discussion and communicate with them in way that encourages them to express their interests and concerns
2. assess the individual's and carer's understanding of
    1. current and previous care plans
    2. the benefits of optimising glycaemic control
    3. the variety of factors that can affect glycaemic control
    4. home glucose monitoring and how it aids self-management
3. review the individual's history of glycaemic control and discuss any difficulties they are experiencing with current therapy
4. ensure the individual and carer understand the choices, issues and risks relating to optimising the individual's glycaemic control
5. identify through discussion options for improving the individual's blood glucose control, taking into account their
    1. age
    2. culture
    3. lifestyle
    4. family circumstances
6. assess the need for referring the individual to other members of the care team for expert help or advice, and where this is appropriate discuss and agree the referral with the individual
7. agree realistic individualised targets, plans and timescales for achieving improved glycaemic control, including the number of appointments that will be needed
8. assess and reinforce where necessary the individual's understanding of the effects on glycaemic control of lifestyle, eating patterns and atttitudes to food, and physical activity
9. provide or arrange for the provision of any new medications required by the plans, and ensure the individual and carer understand how to use them, when to take them, and

for what period of time

10. provide information at a suitable level and pace to help the individual consider how to manage the issues and risks of the new therapy, including understanding how to recognise and manage the risks of hypoglycaemia
11. identify and discuss the support network available to the individual and carer and
    1. ensure they have clear contact details
    2. refer them to other sources of support where this has been agreed
12. assess and reinforce where necessary the individual's understanding of sick day rules
13. provide copies of the agreed targets for the individual and carer, for their records
14. record the targets and strategies you have agreed in a form that can be followed by other members of the care team, the individual and carer
15. identify in partnership with the individual and carer progress with the strategy, including achievements, learning, awareness, coping skills, shortfalls and difficulties
16. encourage and reinforce the individual's achievements, and provide positive support where they have encountered difficulties
17. consider options for modifying the plan where it is not meeting the individual's needs, based on
    1. progress to date
    2. changes in the individual's condition
    3. changes in the individual's circumstances
18. negotiate changes to targets and plans, based on experience to date, to achieve a balance between
    1. achieving lower HbA1c
    2. the risk of hypoglycaemia
    3. the individual's lifestyle choices
19. provide copies of the revised plan for the individual and carer, for their records
20. record the outcomes of the review in a form that can be followed by other members of the care team, the individual and the 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: HWB6 Assessment and treatment planning