SFHDiabHA2
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:

1. assisting individuals to sustain courses of medication
2. 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.

SFHDiabHA2

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Performance criteria

You must be able to:

- P1 discuss the care plan with individuals and their carers in a way that encourages them to reflect and to express their views and concerns
- P2 provide the interventions that you have agreed to undertake in the care plan
- P3 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
- P4 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
- P5 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
- P6 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
- P7 monitor progress with the care plan at agreed intervals appropriate to the individual's needs and the risks to be managed
- P8 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
- P9 discuss with the individual and carer any problems or difficulties in following the plan, and explore how they may be addressed
- P10 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
- P11 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
- P12 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

SFHDiabHA2

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Knowledge and understanding

You need to know and understand:

K1 the NSF for diabetes
K2 NICE guidelines on diabetes monitoring, management and education
K3 causes of diabetes
K4 signs and symptoms of diabetes
K5 normal and abnormal blood glucose and HbA1c values
K6 how to monitor glucose levels, HbA1c, blood pressure
K7 typical progressive patterns of diabetes
K8 the importance and effects of patient education and self management
K9 the psychological impact of diabetes, at diagnosis and in the long term
K10 how to gather information from patients about their health
K11 how to work in partnership with patients and carers
K12 the social, cultural and economic background of the patient/carer group
K13 the impact of nutrition and physical exercise
K14 the effects of smoking, alcohol and illicit drugs
K15 the effects of, and how to manage, intercurrent illness
K16 how to manage hypoglycaemia
K17 the medications used to manage diabetes
K18 the long term complications of diabetes and when they are likely to occur
K19 how to examine feet and assess risk status
K20 how to monitor cardiovascular risk
K21 how to monitor for renal disease
K22 2 how to monitor for diabetic retinopathy
K23 the law and good practice guidelines on consent
K24 the staff member's role in the healthcare team and the role of others
K25 local guidelines on diabetes healthcare
K26 local referral pathways
K27 local systems for recording patient information
K28 2 quality assurance systems
K29 the process of notification for legal and insurance purposes
K30 sources of practitioner and patient information on diabetes
K31 contact details of local and national support groups
K32 how individuals can access facilities for exercise and physical activity, education and community activities

SFHDiabHA2

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Additional Information

External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB7 Interventions and treatments

SFHDiabHA2

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