National Diabetes Nursing Knowledge and Skills Framework

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Aotearoa College of Diabetes Nurses
NZNO

New Zealand Society for the Study of Diabetes
NZSSD

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

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Foreword

Nurses across many practice settings are key providers of diabetes clinical care and education. It is imperative they are adequately prepared to ensure best possible outcomes. The National Diabetes Nursing Knowledge and Skills Framework (NDNKSF) was first published in 2009 to provide a platform for nurses to develop and then evidence their competence in diabetes nursing practice through the Professional Development and Recognition Portfolio (PDRP) process and ultimately via the diabetes specialty specific accreditation process offered by the Aotearoa College of Diabetes Nurses (ACDN) NZNO Tōpūtanga Tapuhi Kaitiaki o Aotearoa.

The NDNKSF articulates the knowledge and skill required for nurses at varying levels of practice depending on the complexity of the health needs of their population group. It is aligned to the Nursing Council of New Zealand (NCNZ) competencies for registration as a registered nurse (RN).

In particular it:

- Assists in the development of a range of transferable clinical skills which can be used in care delivery throughout the nurse's career
- Seeks to minimise risk by ensuring all staff know the standard of care required in the speciality and are competent to provide that care
- Provides guidance to employers about expectations of competency at different levels of nursing practice
- Has a system of levels to facilitate nurses learning in a systematic and targeted fashion
- Provides content for portfolio development for local PDRP and NCNZ's requirements for ongoing registration
- Links with the ACDN NZNO's National Accreditation Process for Nurses Specialising in Diabetes (2016)
- Informs curricula for undergraduate and postgraduate registered nursing programmes.

On behalf of the project team, I would also like to acknowledge and thank the clinical review team, multidisciplinary expert review group, all the other people who have provided expertise and constructive feedback, and the New Zealand Society for the Study of Diabetes (NZSSD), who generously provided funding to support the review process.

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Review of the National Diabetes Nursing Knowledge and Skills Framework

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1. National Diabetes Nursing Knowledge and Skills Framework

All nurses deliver care to people with diabetes. The NDNKSF has been developed to assist all RNs to evidence that **they are competent to provide the required care and education** for the person with diabetes and related co-morbidities, **regardless of their practice setting**. To promote best practice, the NDNKSF is linked to national and international guidelines, standards of practice and the **NCNZ's competency domains for the Registered Nurse scope of practice** (NCNZ, 2017: **1) Professional responsibility; 2) Management of nursing care; 3) Interpersonal relationships; and 4) Interprofessional health care and quality improvement,** http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse.

1.1 Rationale and Approach

Diabetes is an important health problem in Aotearoa New Zealand with an estimated prevalence of 241,463 as of December 31, 2016 excluding pre-diabetes and gestational diabetes (Ministry of Health [MoH] Virtual Diabetes Register, 2017). Diabetes is a major contribution to inequalities in life expectancy, cardiovascular outcomes and diabetes specific health outcomes for Māori, Pacific peoples and Asian populations and as a long-term condition it has prominence in the 2016 New Zealand Health Strategy: Future Directions (MoH, 2016), http://www.health.govt.nz/publication/new-zealand-health-strategy-2016, He Korowai Oranga, Māori Health Strategy (MoH, 2014) (http://www.health.govt.nz/publication/guide-he-korowai-oranga-maori-health-strategy), the 2016 workplan (http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga), and 'Ala Mo'ui Pathways to Pacific Health and Wellbeing (2014–2018, MoH 2014a) http://www.health.govt.nz/our-work/populations/pacific-health.

The Living Well with Diabetes Plan (2016) identifies a clear pathway and objectives to improve the health and wellbeing of people with diabetes in Aotearoa New Zealand (http://health.govt.nz/publication/living-well-diabetes). In addition, in 2014, the MoH published a set of Quality Standards for Diabetes Care (the Standards) (http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/quality-standards-diabetes-care) encompassing wide ranging aspects of diabetes care. The objective of the Standards is to guide district health board (DHB) planning and funding departments, managers, clinicians and consumers involved in the design and delivery of health services, on what and how services could be provided across the continuum of care (prevention, primary health and secondary care specialist services) and the full spectrum of diabetes (lifespan, pregnancy, complications and other vulnerable groups). The Standards Toolkit (MoH, 2014b) http://www.health.govt.nz/publication/quality-standards-diabetes-care-toolkit-2014 also provide guidance on the measurement of meaningful outcomes.

The size of the gap between the Standards and recommended best practice, and current practice in diabetes care in Aotearoa New Zealand is currently unknown. However, current national patient clinical indicator data (Atlas of Healthcare Variation, Health, Quality and Safety Commission New Zealand, 2016) http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/diabetes/ demonstrate that diabetes care could be significantly improved. Nurses are the largest health workforce and play an important role in diabetes care and education. Patients' knowledge of diabetes and its management depends, to a large extent, on the adequacy and effectiveness of the diabetes-related care and education they receive. A major prerequisite for nurses to provide up-to-date diabetes care and education, wherever they practise, is a fundamental level of knowledge, competence and confidence. The application of this knowledge should promote the provision of consistent, evidenced-based practice, and contribute to improved health outcomes.

Nursing practice is centred on health, wellbeing, therapeutic partnership, autonomy and accountability, collaboration, co-ordination and continuity of care. The approach to a person's care is holistic, systematic and dynamically responsive to emerging health issues. As diabetes is a long-term condition, nurses will often be part of care delivery on a long-term basis with people with diabetes. The long-term nature of diabetes provides a unique opportunity for effective therapeutic relationships to grow over extended time periods. Learning and consequent self-care and self-management is constant and develops along a continuum parallel with the relationship the person with diabetes has with their health care team. Effective partnering with the person with diabetes (and their whānau, family as appropriate) and establishing agreed health goals together, could serve as an indicator of the importance of the interconnectedness of the education process, advancing health literacy and the nurse-patient relationship aka partnership (Personal communication, Baty, 2016).

1.2 National Diabetes Nursing Knowledge and Skills Framework – Introduction

New Zealand RNs are required to demonstrate their competence within the requirements of their annual practising certificate. While the NDNKSF is explicitly linked to the NCNZ competency domains for registration, local PDRPs and the ACDN national accreditation process, it does not cover all aspects of a nurse's practise. (http://www.nzno.org.nz/groups/colleges_sections/colleges/aotearoa_college_of_diabetes_nurses/accreditation)

This framework is explicitly focused on supporting nurses to deliver high-quality care to people with diabetes across the health care continuum. The NDNKSF is about identifying the diabetes specific knowledge and skills a RN requires to deliver and evaluate care to all people, including Māori and Pacific Peoples. In Aotearoa New Zealand RNs should incorporate the articles of te Tiriti o Waitangi in their practice and follow the principles of partnership, participation and protection, as outlined in the MoH He Korowai Oranga, Maori Health Strategy (2016 update). It is recognised within this framework that the tangata whenua of Aotearoa Māori, and have increased risks, disparities in all aspects of its care and its complications. The principle of protection aims to ensure that Māori have the right to good health that encompasses wellness in its fullest sense and includes the physical, spiritual and cultural wellbeing of Māori as individuals and collectively (Aparangi Tautoko Auahi Kore, 2003). In this regard, the nurse should practise to ensure equitable distribution of care, resources and management to achieve best health outcomes for Māori. Māori should also be given the opportunity to actively participate in planning of all aspects of diabetes care through active partnership, thereby people with diabetes and their whānau will be supported to meet their specific health needs and wellbeing through delivery of care that is both culturally appropriate and culturally responsive.

Diabetes is a complex disease of multi-pathology requiring a diverse array of interventions, consequently impacting on almost every facet of a person's life. Management of diabetes is relatively unique in that the majority of care is delivered by the person with diabetes through self-care. Adequate health literacy is important to support people living with long-term conditions to navigate the complexity of health care and to engage as actively as possible in self-care of their condition. As illustrated in Figure 1 below, their lives, and therefore their capability to actively engage in self-care activities, is influenced by many factors at the individual, social and wider community levels and by the broader determinants of health.

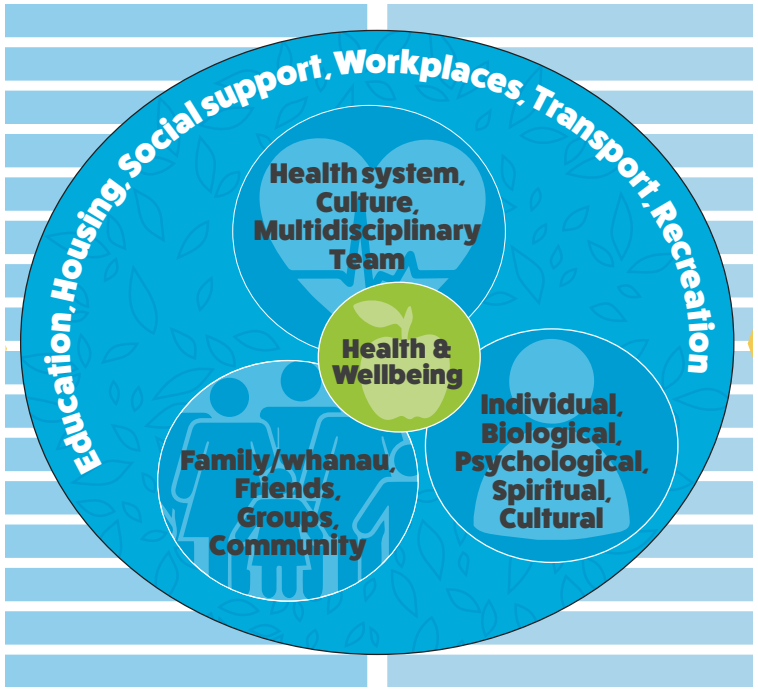

Figure 1. Multiple factors influencing the person with diabetes.

The nurse-patient relationship is central to patient experience and a major determinant of health outcomes. Nursing is committed to advancing the health of New Zealanders through nursing leadership, partnerships in health care delivery, the advancement of clinical expertise across **all aspects of diabetes care**, and achieving a high standard of **health outcomes** as illustrated in Figure 2.

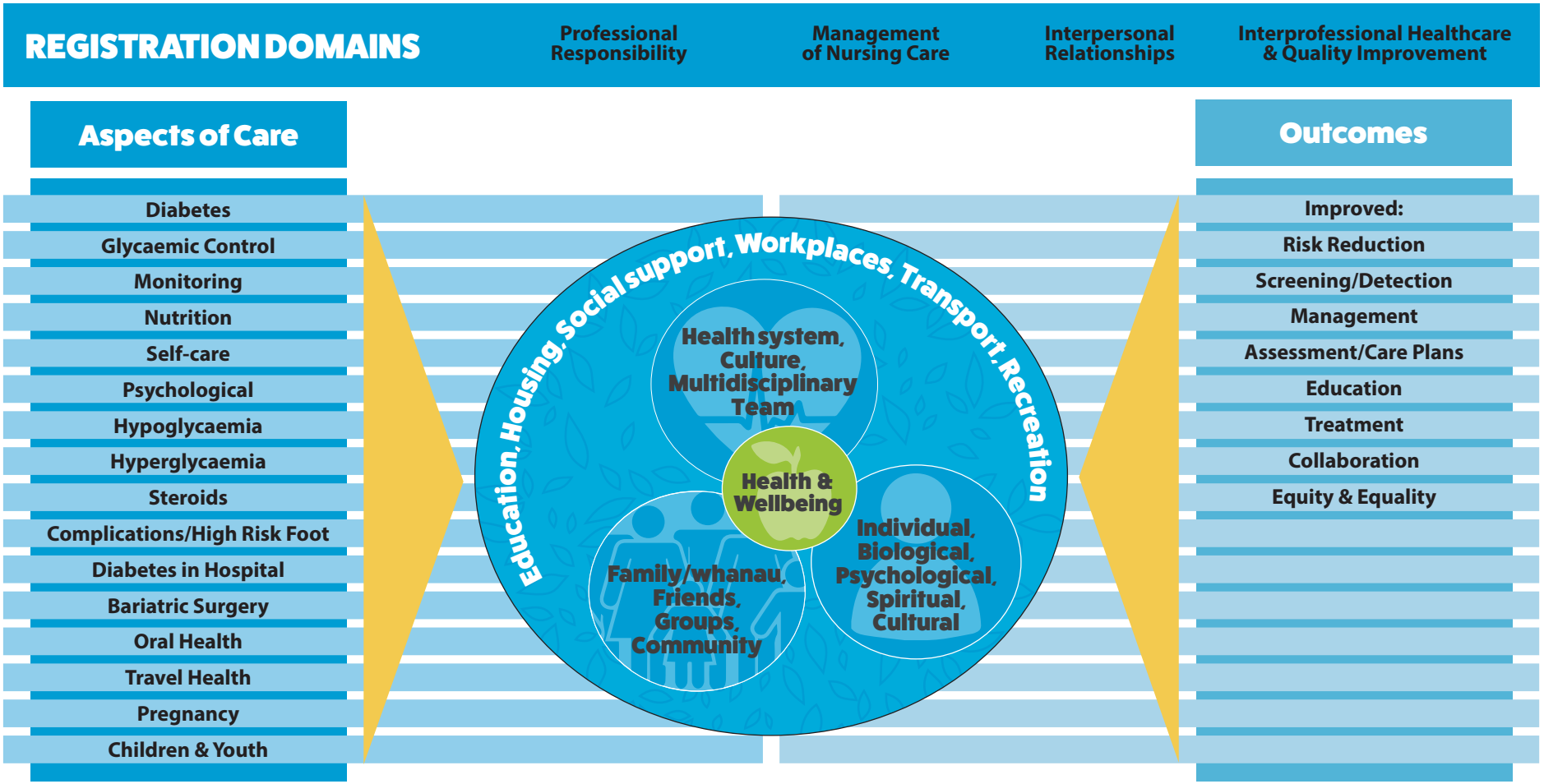

Figure 2. Aspects of diabetes care and outcome measurement.

1.3 National Diabetes Nursing Knowledge and Skills Framework – Levels of Practice

People with diabetes have differing health care needs relating to their diabetes: risk reduction, early identification and diagnosis of their diabetes; ongoing predictable health needs; being at high risk for disease progression and complication development; and experiencing highly complex problems. The NDNKSF contains **three levels** of registered nursing practice in diabetes care: **All Nurses, Proficient and Specialist.** These terms align with national PDRP titles but are specific to knowledge and skills within the specialty of diabetes. For example, it is possible to be a Level 4 Expert Nurse on a generic PDRP programme and meet 'All Nurses' knowledge and skills in the NDNKSF, if that aligns with the diabetes patient groups being cared for, such as risk reduction, early diagnosis and predictable diabetes related health needs.

Regardless of practice setting, nurses are required to work in partnership with the person with diabetes to address their health needs. At all stages of life, and at several points across the health continuum, people with diabetes will require services from nurses in generalist settings such as general practice, diagnostic services and general medical/surgical services. People with diabetes may also have co-morbidities requiring identification, treatment and monitoring. Nurses may participate either frequently, or for short intensive periods of time in the care of people with diabetes. These nurses may have expertise in other health conditions but require generalist diabetes knowledge and skills to support people with diabetes who have predictable health care needs.

All Nurses, regardless of their area of practice, are likely to have contact with people with diabetes and will therefore require baseline knowledge and skills for the safe care and management of risk reduction, early identification and diagnosis of pre-diabetes and diabetes, and supporting ongoing predictable health needs for people with diabetes. Therefore, **All Nurses** need to be capable of applying generic diabetes nursing knowledge and skills to meet the health needs of these individuals.

Nurses practising at a **proficient level** in diabetes care require speciality diabetes knowledge and skills to enable them to provide care for adults with diabetes who are at high risk for disease progression and complication development. It is expected that as their practice advances, proficient diabetes nurses will demonstrate more effective integration of theory, practice and experience along with increasing degrees of autonomy in their judgments and interventions for people with diabetes.

Nurses demonstrating diabetes knowledge and skills at a proficient level may apply to the ACDN for national accreditation as a Proficient Diabetes Nurse.
http://www.nzno.org.nz/groups/colleges_sections/colleges/aotearoa_college_of_diabetes_nurses/accreditation

Nurses practising at a **specialist** level in diabetes care require advanced knowledge and skills of diabetes, as their practice requires them to respond to children, youth, adolescents, pregnant women and adults with diabetes who have highly complex clinical health needs and require episodic care or longer-term oversight of their diabetes management. Nurses at a specialist level also provide clinical leadership and expert management of interpersonal relationships across disciplines and at a high organisational level. These nurses are typically clinical nurse specialists who have developed expert diabetes practice through additional experience and postgraduate education towards a Masters of Nursing. Specialist Diabetes Nurses incorporate nursing leadership and management of or within their respective Diabetes Specialist Services. In accordance with national guidance on advanced practice roles (NZNO and CNA(NZ), 2012), the Specialist Diabetes Nurse will demonstrate knowledge, skills, attitudes and behaviours required at expert level as demonstrated at PDRP Level 4.

Nurses demonstrating diabetes knowledge and skills at a specialist level may apply to the ACDN for national accreditation as a Specialist Diabetes Nurse.
http://www.nzno.org.nz/groups/colleges_sections/colleges/aotearoa_college_of_diabetes_nurses/accreditation

Nurse practitioner (NP) practice is an advanced scope of nursing practice. According to the NCNZs scope of practice description "Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practise beyond the level of a registered nurses. As clinical leaders they work across health care settings and influence health service delivery and the wider profession" (http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Nurse-practitioner, 2017). The NDNKSF is aligned to the **RN** scope of practice competency domains and provides nurses with identification of specialist level knowledge and skills that will support progression towards registration as a NP.

Nurse practitioners demonstrating diabetes knowledge and skills at a specialist level may apply to the ACDN for national accreditation as a Specialist Diabetes Nurse.

These areas of practice **do not represent a hierarchy of practice** but rather the **level of diabetes clinical knowledge and skill associated with the complexity of the health needs** of the groups the nurse serves, **regardless of practice settings.** This framework recognises the need for universal services for all people with diabetes. Many of these may be provided by nurses working in non-specialised services and augmented by the specialist services people with diabetes require at particular points of their life. Nurses require ongoing professional development opportunities to enable them to develop the level of knowledge and skills in diabetes care they require for the level of complexity their patients present with. The nature and scope of the learning experience each individual nurse requires will be determined by the level of diabetes specific knowledge and skill required.

The areas of practice in the NDNKSF are aligned with respective population groups, and post-registration education pathways as illustrated in Figure 3.

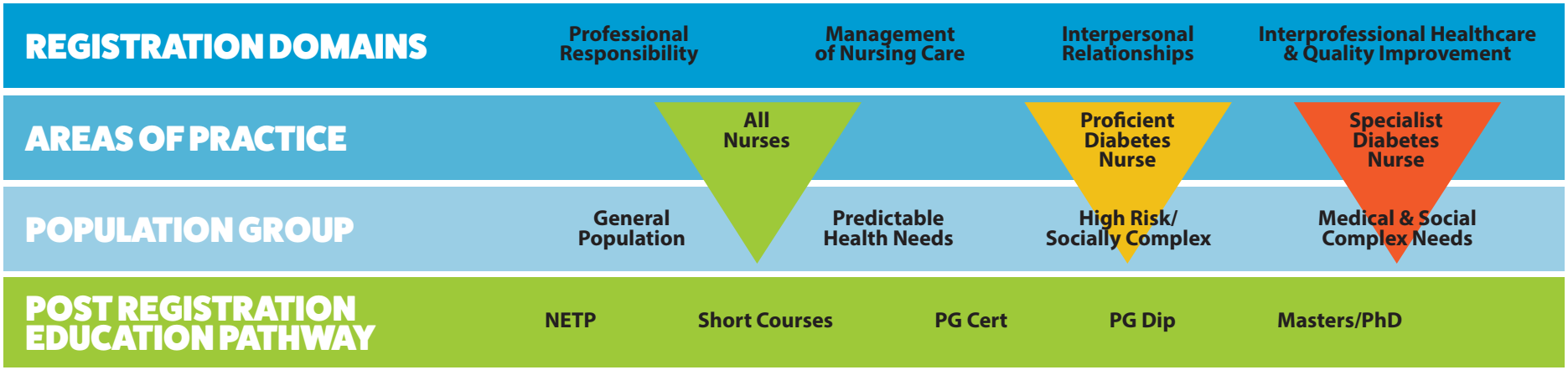

Figure 3. Alignment of areas of practice with respective population groups, and post-registration education pathways.

Alongside experiential, clinically-based learning and skill development, it is expected the nurse will be undertaking ongoing clinically relevant academic study, ranging from short courses to postgraduate certificates or diplomas, Masters Degree or PhD, dependent on the requirements of their role and their personal aspirations. In addition, clinically relevant professional development such as attendance at national scientific meetings (e.g. NZSSD Annual Scientific Meeting) and the ACDN NZNO study day, national symposia and prescribing meetings, will further provide focused learning and development opportunities. Regardless of educational level or practice role, all nurses are bound by standards of professional practice in nursing and are expected to work within existing decision making frameworks that guide their scope of practice.

To summarise, the model presented in Figure 4 below illustrates the nurse's varying contributions at all stages of the health care continuum, identifying the minimum diabetes knowledge and skills required associated with the complexity of the health needs of the groups the nurse serves, regardless of practice settings. It is cross referenced to the NCNZ's competency domains for the RN scope of practice, and the post-registration education pathway.

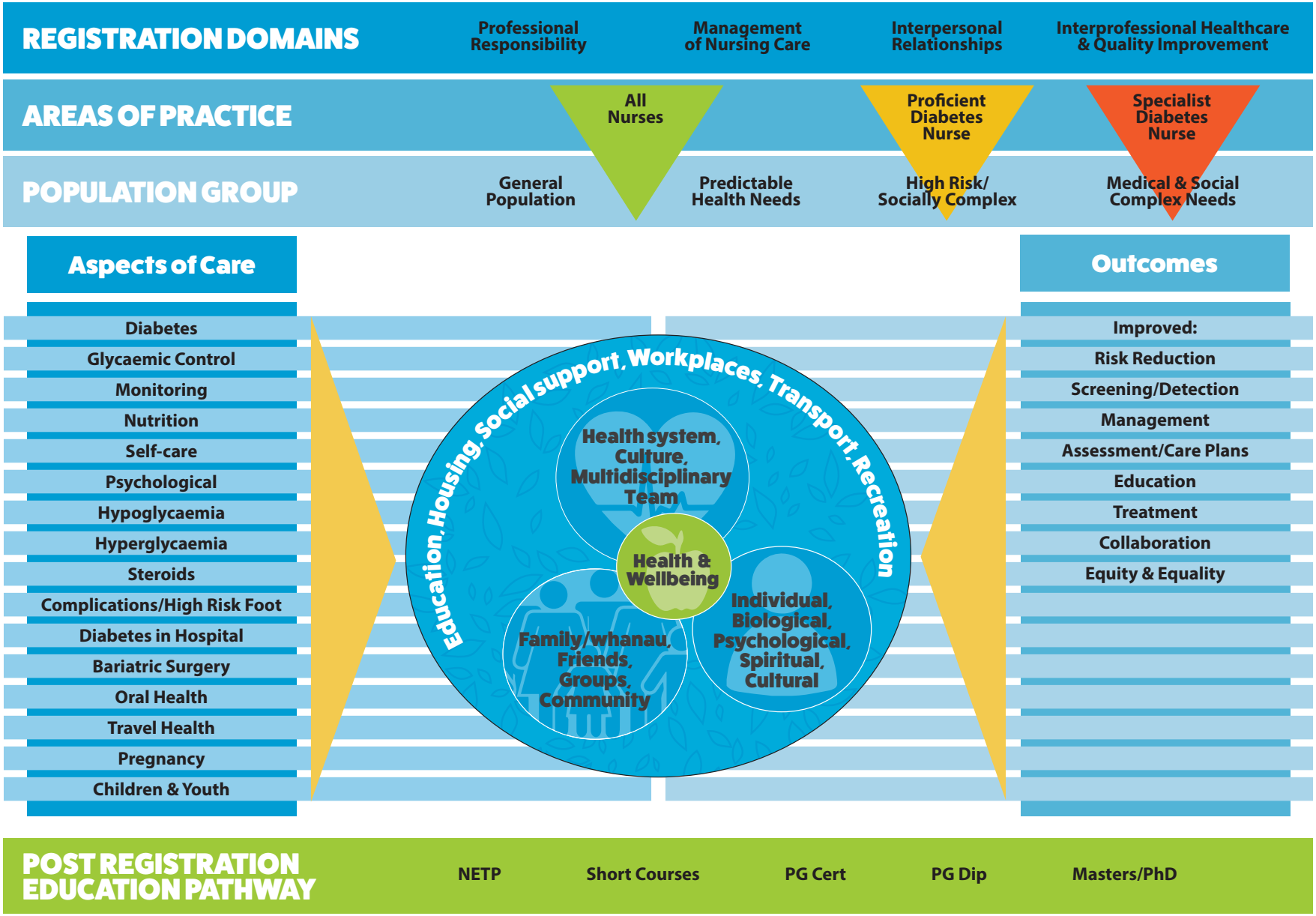

Figure 4: National Diabetes Nursing Knowledge and Skills Framework.

1.4 National Knowledge and Skills Framework and the Accreditation Process for Nurses Specialising in Diabetes

The ACDN fosters professional accountability for nurses working in the specialty of diabetes. An important component of accountability is the ongoing maintenance and development of professional knowledge and skills within the focus of practice. Nurses in Aotearoa New Zealand work in a multitude of practice settings across the health continuum and within a uniquely bicultural context. We are required to demonstrate our competence to practise. Knowledge and skills inform competence and there are a number of frameworks that exist by which competence can be evidenced, such as PDRP, performance review and/or accreditation or credentialing. Accreditation is one way by which registered nurses may receive professional recognition of their advancing knowledge and skills within this specialty area of nursing practice.

The development of an accreditation process for nurses specialising in diabetes began in 1994. The inaugural Accreditation Committee consulted with many health and education professionals (both in New Zealand and overseas), liaising with New NZNO and NZSSD, formulating standards and guidelines and regularly consulting with the members of the then Diabetes Nurse Specialist Section (DNSS) of NZNO regarding their ideas. DNSS (NZNO) members ratified the process and the first applications for accreditation were made in 1997. In 2013 the DNSS (NZNO) became the ACDN (NZNO).

The accreditation process has been reviewed several times, most recently in 2011, and changes made to align the process to the NDNKSF, to the NCNZ requirements for PDRPs, and to address some issues that have tested the accreditation process. The accreditation process for nurses specialising in diabetes continues to offer a unique opportunity for nurses to be recognised within the specialty. A pathway for NP accreditation was implemented in 2013. This framework provides the substance to underpin the accreditation process and guide the development of other resources including self-assessment tools, orientation programmes, job descriptions, and curriculum for education programmes.

In summary, the NDNKSF provides a robust and credible definition of the knowledge and skills nurses require to deliver care to people living with diabetes across the health continuum and spectrum of health care practice settings. It is envisaged that this framework will continue to provide a measurable means of informing the evaluation of practice, guiding the development of individual nurses and demonstrating capability via the ACDN accreditation process. Collectively, these improve the quality of nursing care and have a direct impact on positive health outcomes for people with diabetes (Rooderkerk, 2009).

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Coordinator
Accreditation Programme Aotearoa College of Diabetes Nurses (NZNO) 2012–2017

1.5 What the NDNKSF Is and What It Is Not – Standards, Competencies or Knowledge and Skills?

A standard:

- is an agreed, repeatable way of doing something
- helps to increase the reliability and the effectiveness of the work we do
- can be seen as a set of rules for ensuring quality.

Competencies are:

- observable behaviors that encompass the knowledge, skills, attitudes, values and abilities required effective work performance
- how knowledge and skills need to be applied to meet all of the competencies in that level.

Knowledge and Skills Framework:

- describes the knowledge and skills that health care staff need to apply in their practice in order to deliver quality services
- it is NOT a programme of learning – learning programmes will be required, informed by the knowledge and skills framework, that will contribute to the more specific competencies and indicators required
- can assist in making the links between how individuals apply their knowledge and skills to their patient groups and how this relates to the needs of the team and the organisation they work in.

This is a Knowledge and Skills Framework

Another way of understanding the utility of the NDNKSF is to consider it from an input/outcome process perspective (Figure 5 below, Wood & Snell, 2008). The NDNKSF is one of the **inputs** towards the development of the **outcomes** of a RN with the required confidence and competence specific to diabetes care.

Inputs ⇨⇨⇨⇨⇨⇨⇨	Processes ⇨⇨⇨⇨⇨	Outputs ⇨⇨⇨⇨⇨⇨	Outcomes
Examples include: Guidelines Standards of care Protocols Patient Population Service infrastructure Library **Knowledge and skills framework**	**Examples include:** Service delivery Clinical practice Clinical mentorship Case review Self-directed learning, e.g. healthmentoronline Scientific meetings/Conferences Courses – Diabetes/LTC Postgraduate study Quality assurance Quality improvement **Assessment of competence** Assessments are practise and competence based, e.g.: • Demonstration of skills • Assessment and care planning • Case review • Exemplars • Reflection on practice.	**Examples include:** Service quality **Competence evidenced via:** Academic study Clinical practice assessment Portfolio: • PDRP • **ACDN Accreditation** Evaluation Peer review Performance review	Confidence Competence: *"The combination of skills, knowledge, attitudes, values and abilities underpinning effective performance." NC NZ(2017, p.14)*

Figure 5. NDNKSF contribution to outcome of competence and confidence.

As previously articulated, the NDNKSF is **not practice setting specific** so each level is relevant and directly applicable to nurses practising in primary health care, secondary and tertiary care services. The level of practice is not intended to be hierarchical, rather it relates to the level of knowledge and skill the nurse requires to competently attend to the diabetes-related health needs of the people s/he is providing care for. As clinical complexity increases, the requirement for more detailed and specialised knowledge and skill occurs.

1.6 How Can the NDNKSF Assist Nurses, Employers and People With Diabetes?

The NDNKSF:

- Assists in the development of a range of transferable clinical skills which can be used in care delivery throughout a nurse's career
- Seeks to minimise risk by ensuring all staff know the standard of care required within diabetes care and are capable to provide that care
- Provides guidance to employers about what to expect for different nursing position descriptions, e.g. long term condition nurse requires a minimum of a proficient level of diabetes care; clinical nurse specialist requires a minimum of specialist level knowledge and skills
- Helps to prepare nurses who wish to progress to advanced practice roles in care delivery and leadership
- Provides a reference point for planning educational programmes and clinical preparation for each area of nursing practice
- Provides a mechanism for nurses to measure health outcomes and the effectiveness of their practice
- Provides a mechanism for portfolio development for local PDRPs and NCNZ's requirements for ongoing registration
- Links with the Aotearoa College of Diabetes Nurses NZNO National Accreditation Process for Nurses Specialising in Diabetes (2013)
- Can inform curricula for undergraduate and postgraduate registered nursing programmes.

2. Components of the National Diabetes Nursing Knowledge and Skills Framework

The NDNKSF describes:

- Treatment and management guidelines
- Orientation and professional development principles
- Processes for completing the NDNKSF
- Rating scale for clinical competency evaluation
- Aspects of diabetes care with knowledge and skill requirements for level of practice
- Guidance in evaluation of practice and health outcomes.

3. Quality Monitoring Framework and Health Gains

The nurse-patient relationship is central to the patient experience and a major determinant of patient outcomes. Nursing is committed to advancing the health of all New Zealanders through nursing leadership, partnerships in health care delivery, and the advancement of clinical expertise. Quality care is the cumulative result of the interactions of people, individuals, teams, organisations and systems. Potential improved health outcomes for the person with diabetes that can be expected by nurses more actively engaging in outcome measurement are:

- A reduction in the risk of developing Type 2 diabetes (Type 1 not preventable)
- Improved screening, early detection and clinical management of their diabetes, particularly for those at most risk, i.e. Māori and Pacific Peoples
- Improved assessment, care planning and education
- Improved treatment of acute diabetes related emergencies
- Improved collaboration between health providers delivering their care.

Quality improvement needs to be embedded within all levels of the system and the interactions between systems. It ranges from the overall health system, through the organisations and teams and individuals within those organisations, to the people receiving and affected by the services delivered within systems.

Although most nurses providing care for the person with diabetes do so in the context of a multidisciplinary team, it is important that nurses take responsibility for monitoring outcomes relating to their own practice and practice environment. Nurses should determine locally relevant quality improvement, assurance and monitoring measures to demonstrate their contribution to improving diabetes standards of care, care processes and health outcomes. This is discussed further in Section 11.

4. Summary

This framework is an important step forward for diabetes nursing. It addresses a number of political and professional issues including ones that emerge from:

- Quality Standards for Diabetes Care (2014)
- Living well with diabetes strategy (2016)
- The New Zealand Health Strategy (2016)
- The Primary Health Care Strategy (2001)
- He Korowai Oranga: Māori Health Strategy (2016)
- 'Ala Mo'ui – Pathways to Pacific Health and Wellbeing (2014)
- Health of Older People Strategy update(2016)
- The need for leadership in diabetes nursing
- The increased focus on work-based and lifelong learning
- The need for a framework for career progression in diabetes
- The focus on both professional and academic qualifications
- The incorporation of outcome measurement into daily practice.

This framework provides nurses with the ability to plan their careers in a more structured way, and supports their continuing professional development by identifying individual development and training requirements. Lastly, incorporation of health and clinical outcome measurement into daily practice is of particular importance. This feedback loop will provide nurses with the tools to measure the impact and maintenance of change in practice, and their effectiveness in their daily practice.

Dr Helen Snell
Nurse Practitioner, PhD

Diabetes Nursing Knowledge and Skills Framework for Registered Nurses Providing Diabetes Care

- Treatment and management guidelines
- Responsibilities and activities according to area of practice
- Knowledge and skills for each area of practice
- Guidance in evaluation of practice and health outcomes

Aotearoa College of Diabetes Nurses
NZNO

5. Treatment and Management Guidelines

Diabetes	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Guidelines Group, New Zealand Primary Care Handbook (2012). Management of Type 2 Diabetes • Type 1 Diabetes Through the Lifespan: A Position Statement of the American Diabetes Association (2016) • National Institute for Health and Care Excellence (NICE): Type 1 Diabetes in Adults: Diagnosis and Management • NICE: Type 2 Diabetes in Adults: Management • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • American Diabetes Association Standards of Medical Care in Diabetes (2017) • Canadian Diabetes Association Clinical Practice Guidelines
Glycaemic control	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Guidelines Group, New Zealand Primary Care Handbook (2012). Management of Type 2 Diabetes • American Diabetes Association Standards of Medical Care in Diabetes (2017) • NICE: Type 2 Diabetes in Adults: Management • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • NICE: Continuous Subcutaneous Insulin Infusion for the Treatment of Diabetes Mellitus
Glycaemic control	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Guidelines Group, New Zealand Primary Care Handbook (2012). Management of Type 2 Diabetes
Nutritional plan and weight management	• Diabetes UK Evidence-based Nutrition Guidelines for the Prevention and Management of Diabetes • Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Guidelines Group, New Zealand Primary Care Handbook (2012). Management of Type 2 Diabetes • New Zealand Guidelines Group, Type 2 Diabetes (2011). Section 2: Lifestyle Management: Dietary intervention: pp. 9–15 • American Diabetes Association Standards of Medical Care in Diabetes (2017) • Guideline: Sugar Intake for Adults and Children. Geneva: World Health Organisation (2015)
Promoting self-management of diabetes and healthy lifestyle	• Ministry of Health Quality Standards for Diabetes Care (2014) • Dose Adjustment for Normal Eating (DAFNE) Programme for Type 1 Diabetes • Programme for Diabetes Education and Treatment for a Self Determined Living with Diabetes (PRIMAS) • Diabetes Education and Self Management for Ongoing and Newly Diagnosed Diabetes (DESMOND) • New Zealand Guidelines Group. New Zealand Primary Care Handbook (2012). General, Specific and Intensive Lifestyle Interventions • New Zealand Transport Agency (2009). Medical Aspects of Fitness to Drive: A Guide for Medical Practitioners • Identification of Common Mental Disorders and Management of Depression in Primary Care (New Zealand Guidelines Group, 2008) • Depression. Information for Primary Health Practitioners. (New Zealand Guidelines Group, 2008) • Beating the Blues® in New Zealand • New Zealand Guidelines Group, New Zealand Primary Care Handbook (2012). Smoking Cessation Interventions • American Diabetes Association Standards of Medical Care in Diabetes (2017)

Hypoglycaemia	• Ministry of Health Quality Standards for Diabetes Care (2014) • National Institute for Health and Care Excellence (NICE): Type 1 Diabetes in Adults: Diagnosis and Management • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • American Association of Diabetes Educators (AADE) Core Curriculum (2003). Diabetes Management Therapies • American Diabetes Association Standards of Medical Care (2017)
Hyperglycaemia	• Ministry of Health Quality Standards for Diabetes Care (2014) • National Institute for Health and Care Excellence (NICE): Type 1 Diabetes in Adults: Diagnosis and Management • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • American Diabetes Association Standards of Medical Care in Diabetes (2017) • AADE Core Curriculum (2003). Diabetes & Complications
Complications	• Ministry of Health Quality Standards for Diabetes Care (2014) • National Institute for Health and Care Excellence (NICE): Type 1 Diabetes in Adults: Diagnosis and Management • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • American Diabetes Association Standards of Medical Care in Diabetes (2017) • AADE Core Curriculum (2003). Diabetes & Complications
Hypertension/ cardiovascular disease	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Primary Care Handbook 2012 (updated 2013): Cardiovascular Disease Risk Assessment • Ministry of Health Quality Standards for Diabetes Care (2014)
Retinopathy	• Ministry of Health Quality Standards for Diabetes Care (2014) • Ministry of Health (2016). Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • American Diabetes Association Standards of Medical Care in Diabetes (2017)
High risk foot	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Society for the Study of Diabetes(2014). Foot screening & Risk Stratification Tool • New Zealand Society for the Study of Diabetes(2016). Podiatrists – Diabetes Foot Assessment & Treatment Form • American Diabetes Association Standards of Medical Care in Diabetes (2017) • SIGN Guideline 116 Management of Diabetes • NICE : Diabetic foot problems: Prevention and Management • National Evidence-Based Guideline: Prevention, Identification and Management of Foot Complications in Diabetes • IWGDF Guidance on the Management and Prevention of Foot Problems in Diabetes (2015)
Neuropathy	• Ministry of Health Quality Standards for Diabetes Care (2014) • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • New Zealand Guidelines Group (2003). Management of Type 2 Diabetes. Section 7. Diabetic Foot

Nephropathy	• Ministry of Health Quality Standards for Diabetes Care (2014) • New Zealand Guidelines Group (2011). Management of Type 2 Diabetes. Section 5. Diabetic Renal Disease • AADE Core Curriculum (2003). Diabetes & Complications • Ministry of Health (2015). Managing Chronic Kidney Disease in Primary Care, National Consensus Statement • Chronic Kidney Disease (CKD). Management in General Practice: Summary Guide. Kidney Health New Zealand (nd) • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes
Concurrent illness	• Ministry of Health Quality Standards for Diabetes Care (2014) • AADE Core Curriculum (2003). Diabetes Management Therapies
Managing diabetes in hospital	• Ministry of Health Quality Standards for Diabetes Care (2014) • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes • AADE Core Curriculum (2003). Diabetes Management Therapies • American Diabetes Association Standards of Medical Care in Diabetes (2017)
Bariatric surgery	• Treatment of Diabetes Prior to and After Bariatric Surgery. Journal of Diabetes Science Technology. 2012 • Holter, et al. (2017). Glucose Metabolism After Gastric Banding and Gastric Bypass in Individuals With Type 2 Diabetes: Weight Loss Effect. Diabetes Care, 40(1): 7–15. https://doi.org/10.2337/dc16-1376 • American Diabetes Association Standards of Medical Care in Diabetes (2017)
Travel health	• Medical Guidelines for Airline Travel, 2nd Edition. Aerospace Medical Association Medical Guidelines Task Force Alexandria, VA (2003)
Pregnancy – pre-conception care for women with pre-existing diabetes	• Ministry of Health Quality Standards for Diabetes Care (2014) • NICE: Diabetes in Pregnancy: Management From Preconception to the Postnatal Period • Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of Diabetes
Pregnancy – antenatal and postnatal	• Ministry of Health Quality Standards for Diabetes Care (2014): Ministry of Health (2014). Diabetes in Pregnancy. Quick Reference Guide for Health Professionals on the Screening, Diagnosis and Treatment of Gestational Diabetes in NZ • Ministry of Health Guidance for Health Weight Gain During Pregnancy
Children and youth	• Ministry of Health Quality Standards for Diabetes Care (2014) • Starship Clinical Guidelines • APEG National Evidence-Based Clinical Care Guidelines for Type 1 Diabetes in Children, Adolescents and Adults • ISPAD Clinical Practice Consensus Guidelines, 2014 (Type 1 and Type 2 Diabetes) • American Diabetes Association. Children and Adolescents. Diabetes Care 2016 Jan; 39 (Supplement 1)

6. Orientation and Professional Development: Principles

Recognition of Prior Learning (RPL)

It is the responsibility of the nurse to provide evidence of the depth and nature of prior learning and to identity how this relates to the knowledge and skills within the NDNKSF. Exemptions can be granted on the basis of recognition of prior learning, defined as a process of recognising learning outcomes achieved through formal study, work experiences and/or life experiences. Recognition or prior learning will be granted where a nurse can satisfactorily demonstrate their prior learning matches current knowledge and the standards required for the identified competencies. The nurse must demonstrate or provide evidence their experiences meet the performance criteria of the knowledge and skills identified within the NDNKSF.

The following may be used as the basis of evidence for the RPL process:

- Using the nurse's portfolio as a guide. The portfolio highlights the nurse's past educational experiences and accomplishments. It gives the learner the opportunity to provide evidence of knowledge and skills gained through prior learning and experiences
- Challenge testing, where knowledge and skills in an identified area are evaluated in a simulated setting by an assessor
- The interview assessment
- Attestation
- All applications for RPL should be made to the relevant body, who will seek further expert opinion if required.

Knowledge and Skill Development

The greatest emphasis is on **self-directed learning and clinical practice experiences.** There are a variety of teaching/learning strategies used, including clinical experts, self-directed learning, ward rounds, and case review. **Assessments are practice and competency based,** with direct relevance to the development of clinical knowledge, skills and attitudes.

7. Assessment

Assessment is part of the teaching/learning process, designed to assist the nurse to evaluate their own progress against the NDNKSF, facilitate feedback, assist with the identification of learning needs and establish that the nurse has achieved the required level of knowledge and skills. The process of assessment is a positive and open experience that assists the nurse to successfully complete their programme of learning. It requires active participation by the nurse, preceptor and nurse educator.

Assessment against the NDNKSF will be undertaken using the rating scale adapted from the LearningNurse.Com Rating Scale for Nursing Competency Self-assessment (2008–2016 Learning Nurse Resources Network/Steppingstones Partnership Inc. www.learningnurse.com).

A variety of methods will be utilised to assess learning outcomes and assist the nurse to reflect on practice, develop new knowledge and plan their further development including:

- Demonstration of clinical competencies
- Assessment and care planning
- Presentations in the form of case review
- Exemplars; and
- Reflection on practice.

7.1 Process for Completing Diabetes Nursing Knowledge and Skills Framework

- All areas are to be completed within the time specified by your preceptor/mentor/nurse leader.
- Summarise the evidence you obtained to assist you in meeting the identified knowledge and skill requirement.
- Complete a self-assessment using the rating scale below, then discuss/demonstrate with your mentor/preceptor and have them sign in the relevant sections.
- It is acknowledged that some aspects of care may not be relevant to a nurse's practice, for example if s/he is not involved in pregnancy care or children and youth with diabetes, then 'not applicable' may then apply in those circumstances. However, a demonstration of fundamental level knowledge in those areas may still be required.

7.2 Assessment Rating Scale

NA = Not applicable. The knowledge and skills within this aspect of care DO NOT apply to me in my current nursing practice.

DEV = Developmental. This knowledge and skill needs to be developed because I am NEW to this area of the speciality, or because I may wish to change or expand my professional role and responsibilities, or because I need to improve my knowledge, skills, attitudes and critical judgments.

COM = Competent. I have the knowledge, skills, attitudes and critical judgments to adequately meet all the requirements. I function independently, providing high quality nursing health services and patient/client care.

MET:RTE = Requirement to Enhance. Even though I am already competent, I would like to/need to further enhance my knowledge, skills, attitudes and critical judgments in this knowledge and skill area to become Excellent.

EXC = Excellent. I excel and have more than basic knowledge, skills, attitudes and critical judgments related to this area of knowledge and skill. I would be confident to mentor other nurses and nursing students in this knowledge and skill area.

When the assessment across all aspects of care is completed, the ratings can be summarised in the Aspects of Care section at the beginning of the relevant level of practice.

As an example:

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
DIABETES	**For the delivery of safe diabetes care you should be able to:**	1, 2		
	• Describe the two main types of diabetes mellitus • State normal blood glucose range • Describe pre-diabetes		COM COM COM	COM RTE COM
GLYCAEMIC CONTROL: ORAL THERAPY	**For the safe administration and appropriate use of oral diabetes therapy you should be able to:**	1, 2, & 3		
	• Describe the effect of oral hypoglycaemic agents on blood glucose levels and basic understanding of types of diabetes • Administer/supervise administration of prescribed medication • Report identified problems appropriately		DEV DEV COM	DEV DEV COM

8. All Diabetes Nurses: Nurses Who Provide Regular Care To People At Risk Of Or With Diabetes

Responsibilities and Activities	Met	Not Met
• Work as part of multidisciplinary health care team, and understand their role in diabetes care	☐	☐
• Practise nursing in a manner that the PWD determines as culturally appropriate and safe	☐	☐
• Role model the application of the te Tiriti o Waitangi articles in nursing practice	☐	☐
• Promote and strengthen the development of health literacy	☐	☐
• Assists individuals with (or at risk of developing) diabetes on accessing resources/information	☐	☐
• Is aware of local community support services to refer individuals to as appropriate	☐	☐
• Lead or assists community health professionals with prevention initiatives as appropriate	☐	☐
• Undertake health assessments and identify diabetes related health care and education needs and promotes self-management where possible	☐	☐
• Assess and interpret clinical indicators of general health status and metabolic control	☐	☐
• Provide diabetes care to the person with diabetes and their family, or their whānau in a manner that demonstrates an awareness of the individual's and their family, whānau's health beliefs	☐	☐
• Create a learning environment that promotes informed decision making	☐	☐
• Collaborate and consult with other health professionals as required	☐	☐
• Communicate clinical care provided and outcomes to relevant health professionals	☐	☐
• Evaluate treatment outcomes and refer to appropriate services when necessary	☐	☐
• Document assessment, care plan, continuing care and management plan, evaluation and referrals made	☐	☐
• Have an awareness of local, national and international guidelines and be able to access them	☐	☐
• Act as a resource for the unregistered health care provider and individuals with diabetes and their whānau, families	☐	☐
• Is engaged in quality activities	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

[1]It is expected all RNs in NZ have undergone te Tiriti o Waitangi and cultural safety training to meet the competencies of a RNs as set by the NCNZ.

Aspect of Care	NA	DEV	COM	MET:RTE	EXC
Diabetes	☐	☐	☐	☐	☐
Glycaemic control – tablets	☐	☐	☐	☐	☐
Glycaemic control – insulin therapy	☐	☐	☐	☐	☐
Monitoring glycaemic control	☐	☐	☐	☐	☐
Nutritional plan and weight management	☐	☐	☐	☐	☐
Promoting self-management	☐	☐	☐	☐	☐
Hypoglycaemia	☐	☐	☐	☐	☐
Hyperglycaemia	☐	☐	☐	☐	☐
Steroid induced hyperglycaemia	☐	☐	☐	☐	☐
Complications	☐	☐	☐	☐	☐
Hypertension/cardiovascular and peripheral vascular disease	☐	☐	☐	☐	☐
Retinopathy	☐	☐	☐	☐	☐
High risk foot	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐
Nephropathy	☐	☐	☐	☐	☐
Oral health	☐	☐	☐	☐	☐
Concurrent illness	☐	☐	☐	☐	☐
Managing diabetes in hospital	☐	☐	☐	☐	☐
Bariatric surgery	☐	☐	☐	☐	☐
Travel heath	☐	☐	☐	☐	☐
Pregnancy – preconception care	☐	☐	☐	☐	☐
Pregnancy – antenatal and postnatal care	☐	☐	☐	☐	☐
Children and Youth	☐	☐	☐	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
DIABETES	**For the delivery of safe diabetes care you should be able to:**	1, 2		
	• Demonstrate knowledge of the pathophysiology of Type 1 and 2 diabetes • Describe the difference between Type 1 and Type 2 diabetes • Describe the importance of insulin for glucose, lipid and protein metabolism • State the normal blood glucose range • Describe pre-diabetes • Demonstrate awareness of who should be screened for pre-diabetes/diabetes as per primary care guidelines • Demonstrate an understanding of the progressive nature of Type 2 diabetes • Demonstrate awareness of ketosis prone Type 2 diabetes			
GLYCAEMIC CONTROL: ORAL DIABETES THERAPY	**For the safe administration and appropriate use of oral diabetes therapy you should be able to:**	1, 2 & 3		
	• Demonstrate basic knowledge of types of diabetes tablets and their mode of action • Describe indications for initiation of diabetes tablets in people with pre-diabetes or Type 2 diabetes • Describe common side effects, especially hypoglycaemia and when to seek advice • Recognise abnormal results or problems and report appropriately • Adminster/supervise administration of prescribed medication • Report identified problems appropriately • Identify and address issues affecting adherence to prescribed oral diabetes therapy • Demonstrate ability to produce a basic diabetes management plan			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
GLYCAEMIC CONTROL: INSULIN THERAPY	**For the safe administration and appropriate use of insulin you should be able to:**	1, 2, 3		
	• Describe the effects of insulin on blood glucose levels • Assess an individual patient's educational needs relating to insulin therapy • Report identified problems appropriately and refer as required • Demonstrate a basic knowledge of insulin, e.g. action/type/side effects, especially hypoglycaemia • Demonstrate knowledge of indications for initiation of insulin therapy • Demonstrate knowledge of when insulin dose and/or type might need to be altered and consult as appropriate • Demonstrate competence in preparation and administration of insulin, including different mechanisms for administration, e.g. syringes and pen • Demonstrate knowledge of needle length guidelines, e.g. FITTER • Describe preferred sites for insulin injection and rationale for rotation of sites and how to avoid lipohypertrophy • Demonstrate basic knowledge of the timing of doses, especially in relation to meals and type of insulin • Demonstrate awareness of insulin pump therapy as a mode of insulin delivery • Recognise the potential psychological impact of insulin therapy and where appropriate offer support to person with diabetes (PWD) and significant others			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
MONITORING GLYCAEMIC CONTROL	**For the safe and appropriate use of blood glucose monitoring equipment, and monitoring of glycaemic control you should be able to:**	1, 2, & 4		
	• Perform blood glucose test according to manufacturer's instructions and local guidelines • Recognise abnormal results or problems and report appropriately • Teach blood glucose monitoring procedure to PWD/carer in the context of self-management, including frequency of testing, interpretation of results and required action • Demonstrate awareness of and follow local/workplace quality assurance procedures, including disposal of sharps. Inform PWD about safe disposal of sharps • Demonstrate awareness of need for individualised targets, e.g. older adult; previous myocardial infarction, wound healing • Demonstrate knowledge of blood glucose level testing times for different types of diabetes and treatment regimens • Demonstrate ability to interpret the result, treat if required and report to the appropriate person if outside the expected range • Demonstrate understanding of what ketones are and when to check for ketones • Demonstrate awareness of how to access blood glucose and ketone testing supplies			
NUTRITIONAL PLAN AND WEIGHT MANAGEMENT	**To meet the individual's nutritional needs you should be able to:**	1, 2, 3 & 4		
	• List the principles of a healthy diet for people with diabetes and the influence of diet and nutrition on glycaemic control • Demonstrate knowledge of foods high in free sugars and saturated fat • Identify significance of Body Mass Index (BMI) and waist circumference • State relationship between obesity and diabetes and the need to attain/maintain desirable body weight • Identify safe alcohol intake levels for PWD • Demonstrate awareness of when and how to refer to a dietitian • Demonstrate awareness of local and national nutritional guidelines			

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PROMOTING SELF MANAGEMENT OF DIABETES, HEALTHY LIFESTYLE AND WELLBEING	**To support individuals to self-manage their diabetes you should be able to:**	1, 2, 3 & 4		
Education & behaviour change	• Demonstrate knowledge of strategies to support the PWD to support empowerment and develop self-management skills • Provide health education in a manner that the PWD determines as culturally appropriate and safe • Provide health education in a manner that is accessible and meaningful and appropriate • Observe and document any barriers to self-care • Demonstrate ability to assess health literacy • Assess self-care ability and work with the PWD to optimise self-care skills • Describe current theoretical approaches to support self-care skills • Direct people towards information and support encouraging informed decision-making about living with diabetes • Demonstrate ability to develop a diabetes management plan with the PWD to maximise independence and self-care			
Physical activity	• Demonstrate knowledge of benefits of regular physical activity for PWD • Demonstrate knowledge of local agencies to support physical activity such as Green Prescription			
Smoking cessation	• Identify the relationship between smoking and long-term implications for PWD • Demonstrate capability to provide smoking cessation advice • Demonstrate ability to refer to smoking local cessation services			
Psychological	• Demonstrate awareness of psychological impact on PWD and their family/whānau of living with diabetes and associated complications • Describe appropriate screening/assessment tools for quality of life/diabetes distress and/or depression • Demonstrate ability to refer to specialist services as required			

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HYPOGLYCAEMIA	**For the appropriate prevention, identification and treatment of hypoglycaemia you should be able to:**	1, 2 & 3		
	• Identify the normal blood glucose range and define mild and severe hypoglycaemia • Identify those at risk of hypoglycaemia • Identify possible causes of hypoglycaemic episodes • Describe signs and symptoms of hypoglycaemia • Describe and implement treatment for hypoglycaemia, according to local guidelines and severity of hypoglycaemia • Demonstrate awareness of when and how to use Glucagon and precautions required • Identify when and how to refer to specialist services for assessment and medication review			
HYPERGLYCAEMIA	**For the appropriate identification and treatment of hyperglycaemia you should be able to:**	1, 2 & 3		
	• Identify the normal blood glucose range and define hyperglycaemia • Identify signs and symptoms of hyperglycaemia • Identify possible reasons for hyperglycaemia • Identify, perform and describe rationale for appropriate tests (e.g. blood and/or urine) in accordance with local guidelines • Demonstrate ability to interpret blood or urine ketones and action required • Describe a fundamental understanding of sick day management • Demonstrate basic knowledge of influence of hyperglycaemia on development of diabetes complications • Identify when to seek advice and refer to ED or Specialist Diabetes Team as appropriate/according to guidelines			

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STEROID INDUCED HYPERGLYCAEMIA	**For the appropriate identification and treatment of steroid induced (SIH) hyperglycaemia you should be able to:**			
	• Identify those individuals at increased risk of SIH • Provide a basic explanation to the PWD on the potential impact of steroid use on blood glucose levels and the need to monitor blood glucose levels • Initiate monitoring in those at increased risk of SIH • Advise person at risk of SIH how and when to seek further advice to manage blood glucose levels • Consult with local diabetes team for advice on management of SIH and/or refer as required			
COMPLICATIONS	**To care for people with microvascular or macrovascular complications you should be able to:**	1, 2 & 3		
	• Demonstrate basic knowledge of the pathophysiology of microvascular disease • Demonstrate basic knowledge of the pathophysiology of macrovascular disease • Demonstrate awareness of complications and prevention strategies • Demonstrate awareness of available guidelines in diabetes care • Be aware of required screening tests for retinal screening and albuminuria • Demonstrate awareness of the recommended blood pressure measurements in diabetes • Demonstrate awareness of dental health and the importance of maintaining healthy gums • Educate PWD in prevention and importance of screening for complications • Demonstrate awareness of the psychosocial impact of living with diabetes complications • Consult or refer as required			

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HYPERTENSION/ CARDIOVASCULAR DISEASE (CVD)	**To care for people with hypertension and/or CVD you should be able to:**	1, 2, 3 & 4		
General	• Demonstrate awareness of risk factors for CVD and PVD • Demonstrate knowledge of the pathophysiology of vascular disease • Undertake ongoing assessment and monitoring as requested			
Blood pressure	• Perform blood pressure measurement according to NZGG (2012): Assessment and management of cardiovascular risk • Demonstrate awareness of the recommended blood pressure measurements in diabetes as per current national guidelines			
Lipid management	• Describe recommended targets for lipid profile in diabetes according to national guidelines • Demonstrate knowledge of screening and monitoring frequency as per guidelines			
RETINOPATHY	**To care for people at risk of or with retinopathy you should be able to:**	1 & 2		
	• Demonstrate knowledge of the pathophysiology of diabetic retinopathy • Demonstrate awareness of those PWD at risk of retinopathy • Recognise the need for regular retinal screening • Demonstrate awareness of screening intervals and local referral process			

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HIGH RISK FOOT	**To care for people at risk of or with a high risk foot you should be able to:**	1 & 2		
	• Demonstrate knowledge of diabetes 'Foot Screening & Risk Stratification Tool, (NZSSD, 2014) • Demonstrate knowledge of Diabetes Foot Assessment & Treatment Form (NZSSD PodSIG) • Demonstrate ability to undertake a diabetes foot assessment, in particular identify peripheral pulses and touch sensation • Identify 'At Risk' foot, refer as per guidelines and provide education as required • Explain principles of recommended foot care for PWD • Report changes in pain, sensitivity, skin integrity, colour or temperature immediately and refer as appropriate • Assess for pain related to possible claudication, angina, neuropathic or musculoskeletal origin • Demonstrate foot assessment and required documentation • Identify foot problems requiring referral and how to make appropriate referrals			
NEUROPATHY	**To care for people at risk of or with neuropathy you should be able to:**	1, 2 & 3		
	• Demonstrate knowledge of the pathophysiology of diabetic neuropathy • Demonstrate ability to identify risk of neuropathy and of Charcot foot • Describe peripheral neuropathy • Explain purpose of monofilament testing • Demonstrate competence in correct use of monofilament testing • Report changes in pain, sensitivity, skin integrity, colour or temperature and refer as appropriate			

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NEPHROPATHY	**To care for people at risk of or with nephropathy you should be able to:**	1 & 2		
	• Describe the basic function of the kidney • Demonstrate knowledge of the pathophysiology of diabetic nephropathy • Describe key prevention strategies for minimising risk of nephropathy • Demonstrate understanding of albumin/creatinine ratio screening and interpretation of results • Demonstrate awareness of classifications of chronic kidney disease (CKD) • Demonstrate awareness of Best Practice Advocacy Centre (BPAC) electronic tool and other local pathways to guide the management of CKD			
ORAL HEALTH	**To care for people at risk of oral health problems you should be able to:**			
	• Describe oral health risks in relation to diabetes • Describe preventative strategies to support optimum oral health • Describe local referral options and when to refer			
IDENTIFICATION & TREATMENT DURING CONCURRENT ILLNESS	**To manage concurrent illness you should be able to:**	1, 2, 3 & 4		
	• Demonstrate ability to perform a comprehensive assessment and patient history • Demonstrate knowledge of effect of concurrent illness on glycaemic control and management strategies required • Document and report any abnormal findings in observations and consult/refer as appropriate • Demonstrate awareness of basic sick day guidelines			

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MANAGING DIABETES IN HOSPITAL	**To prepare a person for hospital or to manage diabetes in hospital you should be able to:**	1, 2 & 4		
	• Provide advice or care to ensure adequate nutrition and fluids, blood glucose monitoring • Explain the potential for alteration in diabetes medications during a hospital admission • Demonstrate ability to treat a hypoglycaemic episode • Demonstrate awareness and application of local guidelines, policies and procedures related to caring for PWD in hospital • Demonstrate understanding of Glucose, Insulin, Potassium (GIK) infusions • Demonstrate awareness of need for optimal glycaemic control prior to elective surgery and refer as necessary • Consult with experts to develop management plan for investigative procedures requiring fasting • Demonstrates ability to undertake foot screen at each admission and how to refer as necessary			
BARIATRIC SURGERY	**To prepare a person with diabetes for bariatric surgery you should be able to:**			
	• Refer to Specialist Diabetes Services for pre-operative assessment, advice and management and peri-operative advice • Understand the individual's current diet patterns and the difference between this and the pre- and post-operative diets • Explain to a person with diabetes that their diabetes will not necessarily be cured post-operatively • Explain pre-operative requirements such as self blood glucose monitoring, changes in diabetes medications as directed by specialist services • Explain need for ongoing follow-up of blood glucose levels and weight post-operatively • Demonstrate awareness of need for an individualised care plan for post-operative complication screening • Describe considerations for women in child bearing age, e.g. need for contraception and pre-conception diabetes care			

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TRAVEL HEALTH	**To support the individual prepare for international travel you should be able to:**			
	• Describe the effects of international travel on blood glucose levels • Describe the effects of changes in daily routine on blood glucose levels • Describe the need for adjustment in diabetes medications and/or insulin during international travel • Refer to specialist service for diabetes travel plan as appropriate			
PREGNANCY – PRE-CONCEPTION CARE FOR WOMEN WITH PRE-EXISTING DIABETES	**To support the individual in preparation for pregnancy you should be able to:**	2 & 4		
	• Demonstrate awareness of the need for pre-conception care for women of childbearing age with pre-existing Type 1 or Type 2 diabetes by Specialist Diabetes Services and need for immediate referral to specialist services • Demonstrate knowledge of the appropriate referral system to specialist services for women with Type 1 or 2 diabetes planning a pregnancy • Discuss need for contraception for all women of child bearing age with diabetes and communicate importance of continuing contraception until reviews are completed • Discuss need for all women planning a pregnancy to be taking Folic Acid at doses appropriate for women with diabetes • Describe recommendations for supplemental iodine in women throughout pregnancy and lactation • Demonstrate an awareness of pre-conception target blood glucose levels and HbA1c in pregnancy with diabetes • Demonstrate knowledge of the importance of up to date screening for diabetes related complications • Communicate awareness of efforts required by the woman with diabetes during pregnancy • Demonstrate awareness of ACEi and statins being contraindicated in pregnancy • Communicate the importance of support for the woman with diabetes during pregnancy			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
PREGNANCY – ANTENATAL AND POSTNATAL	**To support the individual during and after Gestational Diabetes Mellitus (GDM) in pregnancy you should be able to:**	1, 2, 3 & 4		
GDM	• Demonstrate understanding of the need for screening for GDM • Identify local diagnostic processes and criteria for GDM • Make immediate referral to specialist team with a positive screen • Demonstrate understanding of the effects of placental hormones on blood glucose tolerance			
Pre-existing diabetes	• Demonstrate awareness of healthy weight gain in pregnancy • Be aware of increased risk of diabetes post GDM • Demonstrate understanding of the need for postnatal HbA1c test and identify ongoing screening recommendations • Demonstrate understanding of risk reduction for development of Type 2 diabetes and support woman to achieve this • Identify referral process to specialist service for those women with pre-existing diabetes, immediately pregnancy is confirmed • Demonstrate awareness of need to immediately discontinue ACEi and statins			
CHILDREN & YOUTH*	*Nurses across all levels must have access to a Specialist multidisciplinary team trained in paediatric diabetes and sensitive to the challenges of childhood and adolescent diabetes to safely manage children and adolescents with diabetes mellitus.* *Youth/young people: While the terms adolescent and young person may be used loosely and interchangeably, the World Health Organisation (WHO) defines young people as aged 10–24 years. This age bracket includes the overlapping categories of adolescents, aged 10 to 19 years, and youth aged 15–24 years. It is acknowledged that Māori consider Tamariki as inclusive of 0–18 years.			
	To care for children and youth with diabetes you should be able to:			
Clinical assessment	• Describe physiological differences between Type 1, and Type 2 diabetes in childhood and adolescence • Describe clinical presenting features of Type 1 diabetes in childhood and adolescence			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
	• Describe presenting features and screening procedures for Type 2 diabetes in childhood and adolescence • Describe physical signs of concern during concurrent illness and identify clinical indicators for assessment in primary care and urgent referral to Emergency Department is required • Describe local referral process for children and adolescents with diabetes mellitus • (***NB:*** All children and adolescents under the age of 16 years regardless of diabetes type **must** be managed by specialist paediatric and adolescent teams.)			
Physical assessment	• Describe unique aspects of care and management for childhood and adolescence including: • Describe changes in insulin sensitivity related to physical growth and sexual maturation • Describe variation in insulin absorption in childhood and implications for insulin administration technique • Demonstrate ability to support self – care and/or family's ability to provide care • Describe supervision requirements in early childhood and school environments • Neurological vulnerability to hypoglycaemia and hyperglycaemia in young children			
Acute complications	• Describe the presenting features of Diabetic Ketoacidosis • Describe signs and symptoms of mild-moderate hypoglycaemia • Describe management of mild-moderate hypoglycaemia • Describe the presenting features of severe hypoglycaemia and principles of management with Glucagon			
Chronic complications	• Describe recommended screening for long term complications (renal, retinal, cardiovascular, other auto-immune conditions) for both Type 1 and Type 2 diabetes			
Social functioning	• Describe how family dynamics (cultural, educational, behavioural, and emotional), developmental stages and physiological sexual maturation impact on diabetes management of the child/adolescent and their family • Demonstrate ability to assess children and youth "at risk" and work collaboratively to protect them from harm			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
Oral health	• Describe oral health risks in relation to diabetes in childhood • Describe preventative strategies to support optimum oral health			
Nutrition and Exercise	• Describe basic nutritional and healthy lifestyle requirements across the developmental continuum of childhood and adolescence in relation to appropriate growth and development • Demonstrate an understanding of effects of increased activity on blood glucose levels • Identify rationale and local process for referral to Specialist Dietitian			
Psychosocial	• Assess psychosocial issues and family stressors that may be affecting diabetes management • Demonstrate knowledge of local agencies and referral processes for management of psychosocial or mental health concerns • Demonstrate knowledge of neglect and abuse in the context of diabetes management and recognises children/adolescents at risk working collaboratively to protect them • Demonstrate understanding of rationale for and process of referral to statutory agencies • Demonstrate knowledge of local community support groups, e.g. Diabetes Youth NZ, where available and appropriate **Specifically for youth:** • Demonstrate understanding and the ability to carry out an appropriate comprehensive youth specific assessment such as the HEEADSSS assessment and works under guidelines for when referral to specialist services is indicated • Describe considerations for contraception and pre-conception diabetes care • Demonstrate understanding of the importance of this transitional stage to adulthood and how this may impact on self-management • Describe characteristics of 'at risk' youth and who to refer to			

9. Proficient Diabetes Nurse: Nurses Providing Care For People With Diabetes Who Are At High Risk, With Increasing Complexity

N.B. As a Proficient Diabetes Nurse builds on the knowledge and skills detailed in All Nurses before starting assessment against Proficient Diabetes Nurse, ensure all knowledge and skill requirements for All Nurses. have been met

Proficient knowledge within the speciality demonstrated at PDRP Level 3 and NDNKSF All Nurses, plus:

Responsibilities and activities as for All Nurses, plus:	**Met**	**Not Met**
• Provide proficient diabetes care and education to the PWD and their family or whānau in a manner that the PWD determines as culturally appropriate and safe	☐	☐
• Demonstrate an awareness of the individual's and family/whānau health literacy and promote and strengthen where possible	☐	☐
• Use sound judgment to advise on or develop diabetes clinical management plans	☐	☐
• Use a collaborative approach to negotiate care/changes in care or management plan	☐	☐
• Enhance health outcomes through proficient assessment, care planning, continuing care and management, evaluation and referrals made – and document this care	☐	☐
• Actively impart evidence-based knowledge in a variety of settings	☐	☐
• Practise nursing in a manner that is meaningful and accessible	☐	☐
• Role model the application of the te Tiritio o Waitangi principles in nursing practice	☐	☐
• Lead or participate in clinical audit of diabetes care within practice setting	☐	☐
• Lead or contribute to local and/or national clinical guideline development, or service development	☐	☐
• Act as a change agent to influence practice development	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

[2]It is expected that all RNs in NZ have undergone te Tiriti o Waitangi and cultural safety training in fulfilment of meeting the competencies as a RN as set by the NCNZ.

Aspect of Care	NA	DEV	COM	MET:RTE	EXC
Diabetes	☐	☐	☐	☐	☐
Glycaemic control – tablets	☐	☐	☐	☐	☐
Glycaemic control – insulin	☐	☐	☐	☐	☐
Insulin pumps	☐	☐	☐	☐	☐
Monitoring glycaemic control	☐	☐	☐	☐	☐
Nutritional plan and weight management	☐	☐	☐	☐	☐
Promoting self-management	☐	☐	☐	☐	☐
Hypoglycaemia	☐	☐	☐	☐	☐
Hyperglycaemia	☐	☐	☐	☐	☐
Complications	☐	☐	☐	☐	☐
Hypertension/cardiovascular and peripheral vascular disease	☐	☐	☐	☐	☐
Retinopathy	☐	☐	☐	☐	☐
High risk foot	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐
Nephropathy	☐	☐	☐	☐	☐
Oral health	☐	☐	☐	☐	☐
Concurrent illness	☐	☐	☐	☐	☐
Managing diabetes in hospital	☐	☐	☐	☐	☐
Bariatric surgery	☐	☐	☐	☐	☐
Travel heath	☐	☐	☐	☐	☐
Pregnancy – preconception care	☐	☐	☐	☐	☐
Pregnancy – antenatal and postnatal care	☐	☐	☐	☐	☐
Children and Youth	☐	☐	☐	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
DIABETES	**For the delivery of safe diabetes care you should be able to:**	1 & 2		
	As for All Nurses plus: • Demonstrate comprehensive understanding of pathophysiology of Type 2 diabetes • Demonstrate comprehensive understanding of pathophysiology of Type 1 diabetes • Demonstrate comprehensive understanding of the role of insulin in glucose, lipid and protein metabolism • Demonstrate fundamental understanding of physiology of diabetes in pregnancy • Demonstrate fundamental understanding of the pathophysiology of diabetes in children and young people • Demonstrate understanding of the impact of diabetes on life expectancy is magnified by a younger age at diagnosis, highlighting the importance of glycaemic control, blood pressure management and prevention of kidney disease in younger people with diabetes			
GLYCAEMIC CONTROL – ORAL THERAPY	**For the safe administration and appropriate use of diabetes tablets you should be able to:**	1 & 2		
	As for All Nurses plus: • Describe factors that may influence prescribing patterns • Describe contraindications/cautions for individual diabetes tablets • Demonstrate knowledge of therapeutic doses • Demonstrate knowledge of the timing of doses, especially in relation to meals • Demonstrate ability to recognise when diabetes tablets need to be adjusted • Demonstrate knowledge of the progressive nature of Type 2 diabetes and the treatment changes required over time, which may include insulin therapy			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
GLYCAEMIC CONTROL – INSULIN THERAPY	**For the safe administration and appropriate use of insulin you should be able to:**	2		
	As for All Nurses plus: • Demonstrate a broad knowledge of different insulins available i.e. action, type, side effects • Describe various methods of insulin delivery and administration including insulin pens, inject-ease and IPORTS • Demonstrate awareness of insulin pump therapy • Demonstrate knowledge of criteria for insulin pump therapy • Describe factors that may influence prescribing patterns • Recognise when insulin therapy needs to be adjusted • Describe lipohypertrophy – how to prevent and how to treat it			
INSULIN PUMPS	**To care for people using insulin pumps you should be able to:**	2		
	As for All Nurses plus: • Demonstrate a knowledge of insulin pumps and pump consumables • Describe the referral criteria for insulin pump therapy • Demonstrate an awareness of carbohydrate counting and need to refer to a Specialist Diabetes Dietitian • Refer to appropriate specialist services in preparation for insulin pump start and ongoing management			

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MONITORING GLYCAEMIC CONTROL	**For the safe and appropriate use of blood glucose monitoring and associated equipment you should be able to:**	2, 3 & 4		
	As for All Nurses plus: • Teach self blood glucose monitoring procedure to PWD/carer, including frequency of testing, interpretation of results and required action • Review blood glucose monitoring technique and provide further education if necessary • Demonstrate knowledge of HbA1c and need for individualised targets • Identify appropriate target range for blood glucose levels and explain course of action to follow if outside target range • Explain how/where to source diabetes supplies for PWD or health professional use • Demonstrate knowledge of the prescription entitlements for PWD • Demonstrate baseline knowledge of continuous glucose monitoring systems (CGMS) and how to access and refer to specialist services			
NUTRITIONAL PLAN AND WEIGHT MANAGEMENT	**To meet the individual's nutritional needs you should be able to:**	2 & 3		
	As for All Nurses plus: • Explain the role of weight management as first line therapy dietary goal in management of Type 2 diabetes and metabolic syndrome • Explain relationship between dietary fat and cholesterol • Work in partnership with a PWD, their whānau, or their family to identify and reduce health risk and reducing saturated fat in the diet • State why diabetes is associated with an increased risk of cardiovascular disease • Discuss benefits of reduced salt in diet • Promote regular physical activity as appropriate/able including the impact and management for those on insulin • Explain the relationship between nutrition plans and glycaemic control in the context of different action insulin profiles • Identify the need for referral to a dietitian and local referral criteria			

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PROMOTING SELF MANAGEMENT OF DIABETES, HEALTHY LIFESTYLE AND WELLBEING	**To support individuals to self-manage their diabetes you should be able to:**	2, 3 & 4		
Education & behaviour change	As for All Nurses plus: • Demonstrate ability to assess the PWD and provide tailored education and support to optimise self-care skills and promote informed decision-making about life style choices • Provide health education in a manner that the PWD determines as culturally safe and supports health literacy • Demonstrate an understanding of the potential effect of life events on self-care management of the PWD • Assess need for external social support services to support self-management of diabetes and refer as appropriate • Demonstrate ability to produce diabetes management plan with PWD to maximise independence and self-care • Recognise the need for diabetes management plans in times of ill health • Be aware of diabetes 'apps' and other interactive sites and media, and be able to objectively evaluate presented 'apps' for appropriateness of use • Demonstrate application of teaching and learning principles according to different ages and stages • Identify potential barriers to adherence to self-care and possible strategies to overcome these			
Physical activity	• Explain beneficial effects of physical activity on blood glucose levels and weight management • Demonstrate ability to assess suitability/safety for exercise, e.g. foot screen, retinopathy • Describe local support services such as Green Prescription			

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Smoking Cessation	• Demonstrate knowledge of impact of smoking on development of cardiovascular disease and other diabetes complications • Describe how smoking cessation has health benefits for smokers of all ages • Identify level of stage of change and provide smoking cessation advice • Refer PWD for assistance with smoking cessation as appropriate			
Driving	• Explain precautions for safe driving for a PWD on insulin or oral therapy • Demonstrate awareness of NZTA regulations and guidelines			
Psychological	• Demonstrate understanding of association between depression and diabetes and appropriate screening tools • Demonstrate awareness of the prevalence of depression in a PWD • Demonstrate awareness of the psychosocial impact of living with diabetes • Demonstrate knowledge of effects of mental health drugs on diabetes • Demonstrate awareness of local psychological support services available & how to refer • Demonstrate knowledge of appropriate online support resources			
HYPOGLYCAEMIA	**For the appropriate prevention, identification and treatment of hypoglycaemia you should be able to:**	1, 2, 3 & 4		
	As for All Nurses plus: • Work in partnership with PWD and their whānau, or their family to identify possible causes of hypoglycaemia • Explain normal counter regulatory response to hypoglycaemia • Explain the effect of hypoglycaemia on the central nervous and cerebral vascular systems • Develop plan with PWD to prevent recurrence of hypoglycaemia • Describe action of glucagon • Demonstrate ability to teach relevant person when and how to prepare and administer glucagon and post-administration care • Recognise when treatment may need to be adjusted, according to local and national guidelines/policy and refer/advise appropriately • Demonstrate ability to provide education on hypoglycaemia to health professionals and carers			

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HYPERGLYCAEMIA	**For the appropriate identification and treatment of hyperglycaemia you should be able to:**	2, 3 & 4		
	As for All Nurses plus: • Work in partnership with PWD, their whānau or their family to identify possible causes of hyperglycaemia and how to minimise risk • Demonstrate ability to anticipate development of hyperglycaemia in the presence of other medications, e.g. steroids and make a care and communication plan – consult/ refer as necessary • Demonstrate knowledge of possible treatment options for hyperglycaemia • Discuss risk of diabetic ketoacidosis (DKA); and hyperglycaemic, hyperosmolar non ketotic syndrome (HHNKS) • Identify signs and symptoms associated with DKA and HHNKS syndrome • Discuss management plan for avoiding DKA and HHNKS • Explain relationship between hyperglycaemia and long-term complications of diabetes • Demonstrate awareness of ketosis prone Type 2 diabetes • Identify when to consult or refer			
COMPLICATIONS	**To care for people with microvascular or macrovascular complications you should be able to:**	2 & 4		
	As for All Nurses plus: • Demonstrate comprehensive knowledge of the pathophysiology of microvascular disease • Demonstrate comprehensive knowledge of the pathophysiology of macrovascular disease • Demonstrate comprehensive knowledge of complications and prevention strategies • Identify required screening tests and how/when to refer • Describe prevention strategies and importance of screening for complications • Demonstrate knowledge of the effect of dental health on diabetes • Demonstrate knowledge of the effects of diabetes on sexual health and function • Identify when to consult or refer			

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HYPERTENSION/ CVD	**To care for people with hypertension and/or CVD you should be able to:**	1, 2, 3 & 4		
General	As for All Nurses plus: • Demonstrate comprehensive knowledge of pathophysiology of cardiovascular and peripheral disease • Demonstrate comprehensive knowledge of required relevant investigations • Act on interpretation of results – risk assessment history and interpretation • Identify when to consult or refer • Demonstrate awareness of the psychosocial impact of living with vascular disease			
RETINOPATHY	**To care for people at risk of or with retinopathy you should be able to:**	2, 3 & 4		
	As for All Nurses plus: • Educate PWD in prevention and importance of retinal screening • Identify risk factors for development of diabetic retinopathy • Refer to appropriate person if retinal screening results are abnormal and plan follow-up • If PWD is visually impaired, describe how obtain and use low vision aids • Identify when to consult or refer			
HIGH RISK FOOT	**To care for people at risk of or with a high risk foot you should be able to:**	2 & 4		
	As for All Nurses plus: • Plan and provide individual patient care and education • Negotiate personal diabetes plans to modify risk factors • Identify methods of screening for 'At Risk Foot' and diabetic foot disease • Describe strategies for minimising risk of injury • Identify when to consult or refer			

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NEUROPATHY	**To care for people at risk of or with neuropathy you should be able to:**	2 & 4		
	As for All Nurses plus: • Demonstrate ability to identify risk factors and screen for neuropathy according to local guidelines • Identify peripheral neuropathic pain management strategies • Identify when to consult or refer			
NEPHROPATHY	**To care for people at risk of or with nephropathy you should be able to:**	2, 3 & 4		
	As for All Nurses plus: • Demonstrate knowledge of classifications of chronic kidney disease • Demonstrate ability to perform albuminuria screening, blood pressure measurement and blood tests according to local and national guidelines • Demonstrate understanding of Creatinine and eGFR and interpretation of the results • Demonstrate understanding importance of albumin/creatinine ratio (ACR) and interpretation of the results • Identify recommended follow-up • Demonstrate knowledge of guidelines for use of Metformin in PWD and CKD • Demonstrate knowledge of recommended medications for treatment of hypertension for PWD • Demonstrate knowledge of BPAC goals in CKD • Identify when to consult or refer			
ORAL HEALTH	**To care for people at risk of or with oral disease you should be able to:**			
	As for All Nurses plus: • Describe preventative strategies to support optimum oral health • Describe understanding of periodontal disease and relationship to diabetes • Demonstrate awareness of local referral options			

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IDENTIFICATION & TREATMENT DURING CONCURRENT ILLNESS	**To manage concurrent illness you should be able to:**	1, 2, 3 & 4		
	As for All Nurses plus: • Interpret blood glucose and ketone results and initiate appropriate action • Support the PWD in managing diabetes during concurrent illness • Demonstrate knowledge of sick day management according to local guidelines (frequency of blood glucose and ketone monitoring, food and fluids, insulin and/or tablet therapy) • Recognise the need for diabetes management plan in times of ill health/steroid use • Recognise when pharmacological treatment may need adjusting, according to local guidelines and consult as necessary • Be able to provide education to health professionals/carers about sick day management			

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MANAGING DIABETES IN HOSPITAL	**To prepare a PWD for hospital admission or to manage diabetes in hospital you should be able to:**	2 & 4		
	As for All Nurses plus: • Demonstrate knowledge of in-patient blood glucose targets according to hospital policy • Demonstrate awareness of effects of concurrent illness on glycaemic control • Demonstrate knowledge of correctional rapid acting insulin regimens according to hospital policy • Demonstrate knowledge of care surrounding intravenous glucose/insulin/potassium (GIK) infusion • Demonstrate knowledge of care surrounding pre- and post-operative procedures • Describe the rationale for optimising glycaemic control in anticipation of pre-elective surgery • Demonstrate knowledge of need to titrate diabetes medication/insulin in accordance with current health state • Demonstrate knowledge of care surrounding investigative procedures • Demonstrate knowledge of the effects of high dose steroids on blood glucose levels • Demonstrate awareness of effects of total parental nutrition and nasogastric feeding on blood glucose levels • Demonstrates ability to undertake foot screen at each admission and how to refer as necessary • Acknowledges the benefit of family support and input and works together with the PWD and their family/support network to prepare for safe discharge from hospital as appropriate • Ensures PWD has appropriate follow-up post-discharge • Demonstrate understanding of educational requirements of ward nurses/medical staff and provide education as required • Identify when to consult or refer			

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BARIATRIC SURGERY	**To prepare or support a PWD for bariatric surgery you should be able to:**	1, 2, 3 & 4		
	As for All Nurses plus: • Demonstrate an understanding of the importance of blood glucose monitoring to guide therapy adjustments • Demonstrate an understanding of the surgical options and how they may impact on glycaemic control • How to recognise and treat hypoglycaemia and hyperglycaemia pre- and post-operatively • Demonstrate awareness of need for medication adjustment peri-operatively and ensure specialist services are involved in care • Post-operatively and long term – understand the need for ongoing blood glucose monitoring • Describe understanding of a potential need for continuation or reintroduction of insulin and/or sulphonylureas post-operatively and when to seek further advice • Be aware of potential nutritional deficits and need for lifelong supplementation post- bariatric surgery • Identify when and how to refer to dietitian for medical nutrition therapy			
TRAVEL HEALTH	**To support the PWD in preparation for international travel you should be able to:**	2		
	As for All Nurses plus: • Describe the effects on blood glucose levels of international travel through multiple time zones • Describe the effects of changes in daily routine on blood glucose levels • Describe the need for adjustment in diabetes medications and/or insulin during international travel • Demonstrate knowledge of sick day management • Identify when and how to refer to specialist service for diabetes travel plan			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
PREGNANCY – PRE-CONCEPTION CARE FOR WOMEN WITH PRE-EXISTING DIABETES	**To support the individual in preparation for pregnancy you should be able to:**	2 & 4		
	As for All Nurses plus: • Demonstrate knowledge of the key aspects of pre-conception care in Type 1 and Type 2 diabetes • Demonstrate knowledge of contraceptive options for all women with diabetes of childbearing age • Demonstrate knowledge of recommendation to refer to specialist services for preconception care • Describe knowledge of increased Folic Acid requirements for women with diabetes from preconception to 12 weeks gestation			
PREGNANCY – ANTENATAL AND POSTNATAL	**To support the woman during and after pregnancy you should be able to:**	2 & 4		
GDM	As for All Nurses plus: • Describe recommendations regarding screening and referral for GDM according to local guidelines • Discuss gestational diabetes, implications and management strategies • Provide initial dietary advice and refer to Specialist Diabetes Dietitian • Describe antenatal and postnatal recommendations for diabetes management • Describe target blood glucose levels in pregnancy as per local guidelines • Describe indications for initiation of treatment • Describe need for ongoing review, assessment and treatment adjustments throughout pregnancy • Advise on management during labour and delivery • Advise postnatal screening and follow-up according to local service provision			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
Pre-existing diabetes in pregnancy	**Primary Care based:** • Demonstrate awareness of need to refer to specialist multidisciplinary services immediately upon confirmation of pregnancy • Describe knowledge of increased Folic Acid requirements for women with diabetes from preconception to 12 weeks gestation **Secondary Care Specialist service only:** • Demonstrate understanding of placental hormone effects on glucose tolerance in each trimester • Demonstrate understanding of risks for mother and baby associated with hyperglycaemia and hypoglycaemia throughout pregnancy • Demonstrate understanding of insulin regimens appropriate in pregnancy, e.g. multiple daily injections, insulin pump therapy • Demonstrate understanding of need and frequency of complication surveillance and frequency in pregnancy, e.g. retinal screening and ACR • Describe the indications for Mini-dose glucagon rescue and can explain how to contact specialist services for guidance with administration changes in hypoglycaemia awareness that may occur in pregnancy and how to manage			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
CHILDREN & YOUTH*	*Nurses across all levels must have access to a Specialist multidisciplinary team trained in paediatric diabetes and sensitive to the challenges of childhood and adolescent diabetes to safely manage children and adolescents with diabetes mellitus.* *Youth/young people: While the terms adolescent and young person may be used loosely and interchangeably, the World Health Organisation (WHO) defines young people as aged 10–24 years. This age bracket includes the overlapping categories of adolescents, aged 10–19 years, and youth aged 15–4 years. It is acknowledged that Māori consider Tamariki as inclusive of 0–18 years.			
	To care for children and youth with diabetes you should be able to:			
Clinical Assessment	As for All Nurses plus: • Understand the physiology of and be able to articulate the diagnostic criteria for Type 1 and Type 2 diabetes in childhood and adolescence • Describe clinical presenting features of Type 1 diabetes in childhood and adolescence • Describe presenting features and screening procedures for Type 2 diabetes in childhood and adolescence • Describe physical signs of concern during concurrent illness and explain clinical indicators for assessment in primary care and urgent referral to Emergency Department • Describe local referral process for children and adolescents with diabetes mellitus • (N.B. All children and adolescents under the age of 16 years regardless of diabetes type must be managed by specialist paediatric and adolescent teams) • Demonstrate an understanding that the impact of diabetes on life expectancy is magnified by a younger age at diagnosis highlighting the importance of glycaemic control blood pressure management and prevention of kidney disease in younger people with diabetes			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
Physical Assessment	• Describe the unique aspects of care and management for childhood and adolescence including: • Changes in insulin sensitivity related to physical growth and sexual maturation • Variation in insulin absorption in childhood and implications for insulin administration technique • Ability to provide self – care and/or family's ability to provide care • Supervision in early childhood and school environments • Neurological vulnerability to hypoglycaemia and hyperglycaemia in young children			
Acute Complications	• Describe the presenting features of Diabetic Ketoacidosis • Describe management of mild-moderate hypoglycaemia • Describe the presenting features of severe hypoglycaemia and principles of management with Glucagon • Describe the indications for Mini-dose glucagon rescue and can explain how to contact specialist services for guidance with administration			
Long term Complications	• Describe recommended screening for long term complications (renal, retinal, cardiovascular, auto-immune conditions) for Type 1 and Type 2 diabetes • Describe the presenting symptoms of hypoglycaemia unawareness and explains the process for referral for specialist assessment			
Social Functioning	• Describe how family dynamics (cultural, educational, behavioural, and emotional), developmental stages and physiological sexual maturation impact on diabetes management of the child/adolescent and their family • Demonstrate ability to assess children and youth "at risk" and work collaboratively with family or whānau, the multidisciplinary team and relevant agencies to protect them from harm			
Oral Health	• Describe oral health risks in relation to diabetes in childhood and preventative strategies to support optimum oral health			

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
Nutrition and Exercise	• Describe basic nutritional and healthy lifestyle requirements across the developmental continuum of childhood and adolescence in relation to treatment regimens • Demonstrate an understanding of effects of increased activity on blood glucose levels • Identify rationale for and local process for diabetes specialist dietitian referral			
Psychology	• Be able to assess psychosocial issues and family or whānau stressors that may be affecting diabetes management • Demonstrate knowledge of local agencies and referral processes for management of psychosocial or mental health concerns • Demonstrate knowledge of neglect and abuse in the context of diabetes management and recognises children/adolescents at risk working collaboratively to protect them. **Specifically for youth:** • Demonstrate understanding and the ability to carry out an appropriate comprehensive youth specific assessment such as the HEEADSSS assessment and works under guidelines for when referral to specialist services is indicated			

10. Specialist Diabetes Nurse: Clinical Nurse Specialist/ Nurse Leader

N.B. As a Specialist Diabetes Nurse builds on the knowledge and skills detailed in All Nurses and Proficient Diabetes Nurses, before assessment against Specialist Diabetes Nurse, ensure knowledge and skill requirements for All and Proficient Nurses have been met.

Expert knowledge within the speciality demonstrated at PDRP Level 4 and NDNKSF Proficient Diabetes Nurse, plus:

	Met	Not met
• Relevant experience	☐	☐
• Qualifications at post-graduate level or equivalent	☐	☐
• Advanced assessment and clinical reasoning skills	☐	☐
• Expert management of interpersonal relationships across disciplines and at a high	☐	☐
• Organisational level	☐	☐
• Sound written skills	☐	☐
• Time management and planning skills	☐	☐

Specific responsibilities and activities	**Met**	**Not met**
As for All Nurses and Proficient Diabetes Nurse plus:		
Clinical		
• Demonstrate advanced clinical judgment and decision making, role modelling best practice	☐	☐
• Provide clinical care and advice to people with advanced disease and significant co-morbidities	☐	☐
• Uses a collaborative approach to negotiate and plan care/changes to care and management plan	☐	☐
• Document assessment, care plan, continuing care and management plan, evaluation and referrals	☐	☐
• Practise nursing in a manner that the PWD determines as culturally appropriate and safe	☐	☐
• Promote and strengthen the development of health literacy	☐	☐
• Provide education to PWD and family about complications/possibility of co-morbidities	☐	☐
• Role model the application of the Treaty of Waitangi principles in nursing practice	☐	☐
• Practises within the context of a specialist multidisciplinary team	☐	☐
• Is engaged in scholarly enquiry	☐	☐

[3]It is expected all RNs in NZ have undergone te Tiriti o Waitangi and cultural safety training to meet the competencies of a RN as set by the NCNZ.

Leadership and Management	**Met**	**Not met**
• Mentoring, advising, teaching, supervising or directing other nurses	☐	☐
• Recognition of team diversity and utilisation of other team members for their strengths	☐	☐
• Contributes to the development, implementation and evaluation of diabetes clinical guidelines, locally and nationally	☐	☐
• Consistently demonstrate effective nursing leadership and management and consultancy, working across settings and within interdisciplinary environments	☐	☐
• Ensures quality assurance systems are in place to monitor the standard of services for PWD	☐	☐
• Identifies service deficits and develops strategic plan for the service	☐	☐
• Initiates and leads research, and promotes evidence-based practice	☐	☐
• Represents nursing at a strategic level of interdisciplinary planning, advocating for and promoting nursing practice	☐	☐
• Demonstrate collaborative relationships with tertiary educational institutes and other educational providers	☐	☐
• Clinical audit of service and change management	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

Aspect of Care	NA	DEV	COM	MET:RTE	EXC
• Diabetes	☐	☐	☐	☐	☐
• Glycaemic control – tablets	☐	☐	☐	☐	☐
• Glycaemic control – insulin	☐	☐	☐	☐	☐
• Insulin pumps	☐	☐	☐	☐	☐
• Monitoring glycaemic control	☐	☐	☐	☐	☐
• Nutritional plan and weight management	☐	☐	☐	☐	☐
• Promoting self-management	☐	☐	☐	☐	☐
• Hypoglycaemia	☐	☐	☐	☐	☐
• Hyperglycaemia	☐	☐	☐	☐	☐
• Steroid induced hyperglycaemia	☐	☐	☐	☐	☐
• Complications	☐	☐	☐	☐	☐
• Hypertension/cardiovascular and peripheral vascular disease	☐	☐	☐	☐	☐
• Retinopathy	☐	☐	☐	☐	☐
• High risk foot	☐	☐	☐	☐	☐
• Neuropathy	☐	☐	☐	☐	☐
• Nephropathy	☐	☐	☐	☐	☐
• Oral health	☐	☐	☐	☐	☐
• Concurrent illness	☐	☐	☐	☐	☐
• Managing diabetes in hospital	☐	☐	☐	☐	☐
• Bariatric surgery	☐	☐	☐	☐	☐
• Travel heath	☐	☐	☐	☐	☐
• Pregnancy – preconception care	☐	☐	☐	☐	☐
• Pregnancy – antenatal and postnatal care	☐	☐	☐	☐	☐
• Children and Youth	☐	☐	☐	☐	☐
• Leadership and management	☐	☐	☐	☐	☐

Nurse's name _____ **Signature** _____ **Date** _____

Assessor's name & designation _____ **Signature** _____ **Date** _____

Aspect of Care	Level of Knowledge and Skill Rating Scale NA = Not Applicable DEV = Developmental COM = Competent MET:RTE = Met with Requirement to Enhance EXC = Excellent	NCNZ COMP DOMAIN	SELF ASSESSMENT RATING AND EVIDENCE	ASSESSOR RATING & EVIDENCE
DIABETES	**For the delivery of safe diabetes care you should be able to:**	1 & 2		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate in-depth understanding of pathophysiology of Type 2 diabetes • Demonstrate in-depth understanding of pathophysiology of Type 1 diabetes • Demonstrate knowledge of potential co-existing autoimmune conditions (with Type 1 diabetes) and effect on diabetes management • Demonstrate in-depth understanding of pathophysiology of other types of diabetes such as MODY and Mitochondrial diabetes • Demonstrate in-depth understanding of the role of insulin in glucose, lipid and protein metabolism			
GLYCAEMIC CONTROL – ORAL THERAPY	**For the safe administration and appropriate use of oral hypoglycaemic medication you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate knowledge of pharmacokinetics and pharmacodynamics of diabetes indications • Demonstrate knowledge of impact of concurrent medical conditions on prescribing decisions • Facilitate and support education relating to diabetes medications for individuals/ groups of PWD, their whānau, and family and health professionals • Demonstrate the ability to prescribe or titrate oral therapies according to safe and legal prescribing practices			

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GLYCAEMIC CONTROL – INSULIN THERAPY	**For the safe administration and appropriate use of insulin you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate proficient knowledge of insulin and insulin regimens and act as a resource for PWD and their family, and health care professionals • Demonstrate the ability to prescribe or titrate insulin according to safe and legal prescribing practices • Demonstrate ability to adjust insulin doses for atypical events, e.g. intense exercise, travel across time zones • Describe potential insulin regimens and appropriate use/s of different regimens according to individual circumstances • Explain how to manage insulin administration errors • Assess PWD educational needs about their medications & deliver appropriate education • Provide care and education to assist with the safe transition from oral therapy to insulin therapy • Demonstrate ongoing contemporary knowledge of current practice & new developments			
INSULIN PUMPS	**For the safe and appropriate use of insulin pump therapy and associated equipment you should be able to:**			
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate an in-depth knowledge of insulin pump therapy • Demonstrate knowledge of the indications for insulin pump therapy and PHARMAC special authority criteria • Demonstrate knowledge of carbohydrate counting principles and ability to modify these by working in conjunction with a specialist dietitian • Demonstrate knowledge of how to calculate insulin sensitivity factor for corrections • Demonstrate knowledge of technical aspects associated with insulin pumps • Demonstrate ability to troubleshoot insulin pump problems • Demonstrate awareness of local, national and international guidelines on insulin pump therapy			

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MONITORING GLYCAEMIC CONTROL	**For the safe and appropriate use of blood glucose monitoring and associated equipment you should be able to:**	1 & 2		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate ability to utilise results to optimise treatment interventions according to evidence base guidelines, incorporating patient preferences • Demonstrate ability to Individualise target blood glucose and HbA1c levels • Demonstrate knowledge of conditions that interfere with obtaining a reliable HbA1c result • Demonstrate knowledge of CGMS systems and appropriate application • Demonstrate ability to advise on 'flash monitoring' as appropriate			
NUTRITIONAL PLAN AND WEIGHT MANAGEMENT	**To meet the individual's nutritional needs you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • List types of nutrients (carbohydrate, protein and fat), their basic functions in the body, their relationship to insulin, and their effect on blood glucose and lipid levels • Describe how to evaluate food products from information on food labels • Demonstrate knowledge of carbohydrate counting and its application in practice, in conjunction with a specialist dietitian • Describe how lifestyle and pharmacological factors interlink with diet to affect glycaemic control in delaying progression of Type 2 diabetes • Demonstrate awareness of multifaceted approach to weight loss and maintenance • Demonstrate ability to provide PWD with appropriate & evidence based weight loss advice • Discuss when pharmacotherapy can be considered for assistance with weight loss and how this would be prescribed • Demonstrate knowledge and skills to facilitate behaviour modification • Explain the effect of alcohol on carbohydrate and lipid metabolism • Explain food modification required to manage concurrent illness • Describe need for referral to dietitian for medical nutrition therapy			

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PROMOTING SELF MANAGEMENT OF DIABETES, HEALTHY LIFESTYLE AND WELLBEING	**To support individuals to self-manage their diabetes you should be able to:**	1, 2, 3 & 4		
Education and behaviour change	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate knowledge of theoretical frameworks and educational philosophies underpinning behaviour change • Demonstrate knowledge and application of range of teaching skills and modes of education delivery • Demonstrate knowledge of behaviour change strategies to facilitate goal setting, risk factor reduction, problem solving and lifestyle modification • Demonstrate ability to create a learning environment to suit the needs of individuals or groups • Demonstrate ability to assess educational ability and literacy of individuals to tailor the information provided to their abilities • Demonstrate ability to work with PWD to facilitate lifestyle changes in response to changes in diabetes and/or circumstances			
Physical activity	• Explain the benefits of regular exercise and a suitable plan to safely integrate increased physical activity in daily routine • Explain recommended duration of physical activity per day • State need to adjust food or medication for planned and unplanned physical activity • Perform risk assessment to ensure safety to exercise (exclude active proliferative retinopathy, hypertension) • Explain risk associated with physical activity and how to minimise risk • Refer for physical assessment if necessary prior to commencement of exercise • Explain benefits of regular physical activity on risk of cardiovascular disease morbidity and mortality, blood lipid profiles, and weight loss/maintenance			

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Smoking cessation ***Driving*** ***Psychological***	• Identify first and second line pharmacotherapies for smoking cessation • Discuss driving and strategies for avoidance of hypoglycaemia • Demonstrate awareness that all PWD should be screened for depression and distress and offered appropriate therapies • Demonstrate ability to undertake psychological interview/assessment with appropriate screening tools • Demonstrate awareness that the presence of micro and macrovascular complications is associated with a higher prevalence of depression and lower quality of life			
HYPOGLYCAEMIA	**For the appropriate prevention, identification and treatment of hypoglycaemia you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Identify factors that may contribute to hypoglycaemia • Discuss effects of hypoglycaemia on the central nervous and cerebral systems • Describe effects of physical activity and advise on how to minimise hypoglycaemia • Describe the rebound hypoglycaemia following a hypoglycaemic episode • Discuss risk associated with hypoglycaemia and driving and other high risk activities and advise management strategies • Discuss possible impact of hypoglycaemia risk to employment • Discuss effect of alcohol on liver and increased risk of hypoglycaemia • Describe hypoglycaemic unawareness and underlying pathophysiology • Identify those at risk of hypoglycaemic unawareness • State strategies to minimise risk of hypoglycaemic unawareness • Demonstrate knowledge of effect of other medications on hypoglycaemic awareness • Describe systemic risks of hypoglycaemia • Educate other health professionals and carers about hypoglycaemia			

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HYPERGLYCAEMIA	**For the appropriate identification and treatment of hyperglycaemia you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Identify reasons for hyperglycaemia and how to minimise risk • Identify medications that may cause hyperglycaemia • Demonstrate knowledge of effect of counter-regulatory hormones on blood glucose levels • Discuss and advise management plans for the PWD and other health professionals for hyperglycaemia • Demonstrate knowledge of the effects of high dose steroids on blood glucose levels and how to manage hyperglycaemia • Refer/consult as necessary for medical assessment/treatment of underlying cause of hyperglycaemia			
COMPLICATIONS	**To care for people with microvascular or macrovascular complications you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate in-depth knowledge of the pathophysiology of microvascular disease • Demonstrate in-depth knowledge of the pathophysiology of macrovascular disease • Demonstrate in-depth knowledge of complications and prevention strategies • Demonstrate working knowledge of screening guidelines • Educate PWD in prevention and importance of screening for complications • Provide psychosocial and educational support for people with complications • Consult or refer as required			

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HYPERTENSION/ CVD	**To care for people with hypertension and/or CVD you should be able to:**	1, 2, 3 & 4		
General	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate in-depth knowledge of pathophysiology of diabetes and the development of vascular complications • Describe the steps in assessing cardiovascular risk in context of diabetes • Discuss benefits of intervention: lifestyle, cardioprotective dietary patterns, weight management, physical activity • Demonstrates ability to prescribe and titrate cardiovascular drugs according to safe prescribing practice and relevant guidelines			
Blood pressure	• State general target ranges for PWD for: BP, lipid fractions, and HbA1c according to national guidelines • Demonstrate ability to individualise targets according to age and/or co-morbidities • Explain the benefits of maintaining optimal BP, lipid profile and HbA1c • Describe antihypertensive agents in diabetes and rationale for use • Describe contraindications for antihypertensive agents across the lifespan			
Lipid management	• Describe benefits of lipid modifying agents, mode of action • Describe indications and contraindications for lipid lowering agents across the lifespan			
RETINOPATHY	**To care for people at risk of or with retinopathy you should be able to:**			
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate an in-depth knowledge of pathophysiology of diabetes and the development of background, pre-proliferative, proliferative retinopathy and maculopathy • Describe national guidelines for screening and monitoring – who, when, where and how often • Provide or refer for psychological support as required			

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HIGH RISK FOOT	**To care for people at risk of or with a high risk foot you should be able to:**			
	As for All Nurses, and Proficient Diabetes Nurse plus: • Identify characteristics of the high risk foot • Describe interventions for the 'At risk foot' and diabetic foot disease • Demonstrate ability to undertake comprehensive foot assessment using NZSSD Foot screening and risk stratification tool • Demonstrate awareness of when and how to refer to a podiatrist • Provide support or contribute to specialist clinics as able, e.g. Wound care/Pain management clinics • Integrate management of diabetes with other contributing conditions • Co-ordinate care within the multidisciplinary team as appropriate • Monitor treatment for effectiveness and refer appropriately • Implement and monitor use of local guidelines • Participate in research and disseminate evidence-based practice			
NEUROPATHY	**To care for people at risk of or with neuropathy you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate an in-depth knowledge of pathophysiology of diabetes and the development of peripheral and autonomic neuropathy • Demonstrate knowledge of the assessment, screening and management strategies for peripheral and autonomic neuropathy • Demonstrate ability to provide education to the PWD about their neuropathic condition and its management • Demonstrate knowledge of conditions and management of the diabetic foot, e.g. Charcot Arthropathy • Demonstrate awareness of neuropathic pain management strategies			

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NEPHROPATHY	**To care for people at risk of or with nephropathy you should be able to:**	1, 2 & 3		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate an in-depth knowledge of pathophysiology of diabetes and the development of nephropathy • Conduct a holistic assessment of patient to identify modifiable risk factors for nephropathy and the ability to self-care to reduce risk • Identify strategies to reduce the impact and progression of nephropathy • Demonstrate understanding of effect of renal replacement therapies, e.g. haemodialysis and renal transplant, on diabetes management			
ORAL HEALTH	**To care for people at risk of oral health problems you should be able to:**	1, 2 & 3		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Describe preventative strategies to support optimum oral health • Describe in-depth understanding of periodontal disease and relationship to diabetes • Demonstrate awareness of local referral options			
IDENTIFICATION & TREATMENT DURING CONCURRENT ILLNESS	**To manage concurrent illness you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Describe the physiological effects of illness on blood glucose levels, ketone levels and fluid and electrolyte balance • Demonstrate ability to provide advice for clinical management plans during concurrent illness as appropriate • Actively contribute and implement evidence-based practice in relation to management of concurrent illness • Demonstrate knowledge of the effects of high dose steroids on blood glucose levels and how to manage hyperglycaemia • Provide education to other health care professionals on sick day management • Demonstrate knowledge of signs and symptoms of DKA, how to prevent it and when to refer for further input or seek further advice			

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MANAGING DIABETES IN HOSPITAL	**To prepare a person for hospital procedure or admission/or manage diabetes in hospital you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Trouble-shoot and provide advice on unusual/complex cases relating to the care of PWD in hospital • Advise on appropriate peri-operative management of diabetes, in partnership with the PWD and with allied health professionals wherever possible • Describe potential hormonal and metabolic disturbances that can occur peri-operatively • Discuss strategies to minimise hormonal and metabolic disturbances • Describe rationale for IV GIK infusion • Describe appropriate time to discontinue IV GIK for a person treated with insulin • Support the individual to maintain/re-establish self-management of their diabetes • Educate nurses and other carers about the care of a PWD undergoing surgery • Demonstrate knowledge of the effects of high dose steroids on blood glucose levels control and advises treatment/management options • Demonstrate knowledge of effects of TPN and NG feeding on blood glucose levels control and advises on glycaemic (i.e. insulin or oral therapy) treatment/management options • Demonstrate knowledge of effects of infection on glycaemic control and advise treatment/management options • Demonstrate knowledge of need to titrate diabetes medication/insulin in accordance with current health state • Demonstrate ability to undertake foot screen at each admission, provide education to the PWD and ward staff and refer as required. • Acknowledge the benefit of family support and input and work in partnership with the PWD and their family/support network to prepare for safe discharge from hospital as appropriate • Ensure patient follow-up post-discharge as appropriate			

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BARIATRIC SURGERY	**To prepare a PWD for bariatric surgery you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Demonstrate a comprehensive understanding of the surgical options and how they may impact on glycaemic control • Demonstrate ability to advise PWD and health professionals how to recognise, treat and avoid hypoglycaemia and hyperglycaemia pre- and post-operatively • Demonstrate knowledge of medication adjustment pre-operatively and ensure all relevant specialist services are involved in care • Post-operatively and long term – the need for ongoing blood glucose monitoring and interpretation of results • Advise PWD and their primary care provider that there may be a need for continuation or reintroduction of insulin and/or sulphonylureas post-operatively and provide advice as required • Describe the need for Specialist Diabetes Dietitian involvement in care for medical nutrition therapy			
TRAVEL HEALTH	**To support the PWD in preparation for international travel you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: • Describe the effects of international travel through multiple time zones on blood glucose levels and provide a travel plan • Describe the effects of changes in daily routine on blood glucose levels and advise on how to adjust therapy accordingly • Describe the potential need for adjustment in diabetes medications and/or insulin during international travel and advise accordingly • Demonstrate knowledge of sick day management in context of travelling • Demonstrate ability to advise on how to avoid hypoglycaemia when travelling and teach glucagon administration to travelling companion			

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PREGNANCY – PRE-CONCEPTION CARE FOR WOMEN WITH PRE-EXISTING DIABETES	**To support a woman with diabetes in preparation for pregnancy you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: **Primary health care based:** • Demonstrate awareness that pre-conception diabetes management for Type 1 and Type 2 diabetes should occur in secondary specialist services and to refer immediately according to local guidelines **Secondary Care Specialist services only:** • Demonstrate in-depth knowledge of physiology of pregnancy and how it is complicated by diabetes • Assess diabetes complication status and provide advice and/or refer accordingly • Demonstrate awareness of retinal and renal screening in pregnancy • Demonstrate awareness of medications contraindicated in pregnancy and advise to discontinue as appropriate, e.g. ACEi and statins • Provide education and support to achieve targets pre-conceptually • Assess and advise on appropriate contraception pre-conceptually • Describe requirement for higher dose (5mg) of Folic Acid in women with diabetes pre-conceptually • Describe need for Specialist Diabetes Dietitian involvement in care for medical nutrition therapy			

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PREGNANCY – ANTENATAL AND POSTNATAL	**To support a woman with diabetes during and after pregnancy you should be able to:**	1, 2, 3 & 4		
	As for All Nurses, and Proficient Diabetes Nurse plus: **Secondary Care Specialist services only** • Demonstrate in-depth understanding of placental hormone effects on glucose tolerance in each trimester • Demonstrate a working knowledge of local, national and international guidelines, in particular knowledge of glycaemic targets in pregnancy • Demonstrate understanding of risks for mother and baby associated with hyperglycaemia and hypoglycaemia throughout pregnancy • Demonstrate ability to work with pregnant women with diabetes to develop treatment plans to reduce the risks for mother and baby associated with hyperglycaemia and hypoglycaemia throughout delivery and immediately post partum • Demonstrate and understanding of insulin regimens appropriate in pregnancy and post partum, e.g. multiple daily injections, insulin pump therapy • Describe requirement for iodine in women in pregnancy and post partum • Demonstrate ability to advise other health professionals on appropriate treatment/ management plans, e.g. when admitted to hospital • Demonstrate understanding of required complication surveillance and frequency in pregnancy, e.g. retinal monitoring and ACR and ensures referrals are made • Demonstrate in-depth understanding of placental hormone effects on glucose tolerance in each trimester and be able to explain this to the pregnant woman • Demonstrate ability to provide fundamental nutrition & carbohydrate awareness advice • Demonstrate awareness of the need to immediately refer to diabetes specialist dietitian for medical nutrition therapy in pregnancy • Provide appropriate gestation specific education including sick day management and avoidance of DKA • Initiate or be involved in the development of peri-natal management protocols • Demonstrate ability to be an effective clinical resource to nurses, midwives and obstetric physicians			

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CHILDREN & YOUTH*	*Nurses across all levels must have access to a Specialist multidisciplinary team trained in paediatric diabetes and sensitive to the challenges of childhood and adolescent diabetes to safely manage children and adolescents with diabetes mellitus.* *Youth/young people: While the terms adolescent and young person may be used loosely and interchangeably, the World Health Organisation (WHO) defines young people as aged 10–24 years. This age bracket includes the overlapping categories of adolescents, aged 10–19 years, and youth aged 15–24 years. It is acknowledged that Māori consider Tamariki as inclusive of 0–18 years.			
	To care for children and youth with diabetes you should be able to:			
Clinical Assessment	As for All Nurses, and Proficient Diabetes Nurse plus: • Describe the physiology of and diagnostic criteria for Type 1, Type 2, monogenic, cystic fibrosis related and medication induced diabetes • Describe clinical presenting features and initial acute management of Type 1 diabetes • Describe presenting features, screening procedures and goals of treatment for Type 2 diabetes • Describe initial management of concurrent illness (fluids, monitoring requirements, insulin and/or oral therapy adjustment) in Type 1 and Type 2 diabetes and clinical indications for Emergency Department referral • Describe local referral process (N.B. all children and adolescents under the age of 16 years regardless of diabetes type **must** be assessed and followed up by specialist paediatric and adolescent teams) • Demonstrate understanding of the unique differences in use of technological treatments such as insulin pump therapy and continuous blood glucose monitoring in children and adolescents as compared to adults (for example differences in pump settings and site selection in relation to developmental stage)			

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Physical Assessment	Describe unique aspects of care and management including: • Changes in insulin sensitivity related to physical growth and sexual maturation • Ability to provide self – care and/or family's ability to provide care • The need for supervision in early childhood and school environments • Neurological vulnerability to hypoglycaemia and hyperglycaemia in young children • Describe the effects of Type 1 and Type 2 diabetes on development throughout childhood and into adolescence			
Acute complications	• Describe the presenting features of Diabetic Ketoacidosis, potential adverse neurocognitive effects and the principles of initial management • Describe management of mild-moderate hypoglycaemia • Describe the presenting features of severe hypoglycaemia and principles of management with the Glucagen™ Hypo Kit. • Describe the indications and principles of use for "Mini-Dose" Glucagon Rescue • Describe potential adverse effects of concurrent illness and principles of sick day management for Type 1 and Type 2 diabetes • Describe the principles of a patient centred MD team approach for those requiring repeated admissions for acute complications and intensive follow-up			
Chronic complications	• Describe recommended screening for long term complications (renal, retinal, cardiovascular, other auto-immune conditions) for Type 1 and Type 2 and other forms of diabetes (Monogenic, Cystic Fibrosis related diabetes, medication induced diabetes) • Describe treatment options for diagnosed chronic complications • Describe the physiology, presenting symptoms and management of hypoglycaemia unawareness			

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Social functioning	• Describe how family dynamics (cultural, educational, behavioural, and emotional), developmental stages and physiological sexual maturation impact on diabetes management incorporating the information into a comprehensive care plan addressing: – Engagement with the health care team inclusive of the GP, Plunket/Tamariki Ora – Respect for socio-cultural identity as outlined in the te Tiriti o Waitangi – Health literacy levels and strategies for addressing knowledge deficit in creative ways (use of technology/apps, visual aids, games – Collaboration with early childhood education and school environments (NZQA requirements for special conditions around a chronic health condition) – Support for social community environment (friends, sports personnel, babysitters, social media) • Describe the principles of effective transition planning from paediatric and/or adolescent diabetes services to adult services • Demonstrate understanding of principles of education relating to "high risk" activities and diabetes management; for example sexual health, contraception and pregnancy, driving, use of alcohol and drugs, smoking, and eating disorders • Demonstrate ability to assess children and youth at risk and work collaboratively to protect them from harm			
Oral health	• Describe oral health risks in relation to diabetes in childhood and preventative strategies to support optimum oral health			
Nutrition & exercise	• Describe basic nutritional and healthy lifestyle requirements across the developmental continuum of childhood and adolescence in relation to treatment regimes • Demonstrate an understanding of nutritional and insulin adjustment in relation to increased levels of activity • Identify rationale for and local process for Diabetes Specialist Dietitian referral			

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Psychology	• Describe developmentally appropriate family involvement in diabetes management tasks and the potential adverse effects of premature or reluctant transfer of carer responsibilities • Assess psychosocial issues and family stressors that may be affecting diabetes management • Demonstrate knowledge of common psychological conditions associated with diabetes in childhood and adolescence (e.g. anxiety, needle phobia, eating disorders, depression), most common presenting features and rationale for referral to specialist services • Demonstrate knowledge of local agencies and referral processes for management of psychosocial issues or mental health concerns • Demonstrate knowledge of neglect and abuse in the context of diabetes management and recognises children/adolescents at risk working collaboratively to protect them • Demonstrate understanding of rationale for and process of referral to statutory agencies **Specifically for Youth:** • Demonstrate in-depth understanding and the ability to carry out a HEEADSSS assessment, update as required, refer as appropriate and adjust the care plan taking into account living with a long term chronic condition • Describe an understanding of promoting resilience in adolescents			
Prescribing & drug administration	• Describe the practical differences in the prescribing and administration of insulin therapy in children and adolescents (for example less subcutaneous fat in younger children = higher risk intramuscular injection, developmental considerations with doses – low doses in infancy and pre-school years, large doses due to insulin resistance during puberty) • Describe the principles of insulin dose adjustment during the honeymoon period for children and adolescents with Type 1 diabetes mellitus • Describe the principles and risks of oral therapy treatment therapy for children and adolescents in both Type 1 and Type 2 diabetes • Describe knowledge of and/or appropriate prescribing, and risk/benefit considerations, of cardiovascular drugs in youth with long term complications			

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LEADERSHIP & MANAGEMENT	**To ensure safe and effective nursing practice and outcomes you should:**			
Clinical leadership	• Consistently demonstrate clinical leadership responsibilities, using an expert level of judgment, decision making and innovation • Provide mentoring, advising, teaching, supervision or direction of other nurses			
Legislation	• Consistently provide leadership, educate, and act as a resource to others in relevant legislation, codes and regulations			
Ethics	• Consistently apply ethical principles/reflection in own nursing practice, facilitate ethical reflection and debate			
Standards	• Ensure that clinical education occurs within area of practice and support is given to resource nurses ensuring that area specific skills of team meet required standards • Promote a practice environment that encourages learning and evidence-based practice			
Performance development	• Be involved in performance development and appraisals • Be a resource and support to nursing staff and others as relevant • Effectively manage complex clinical performance issues			
Policy development	• Contribute to/participate in the development of health/socioeconomic policies at a local level and relevant national involvement			
Change management	• Collaborate with others to take a co-ordinated approach to implement change effectively			
Research	• Use research and scholarship to bring about significant improvement to outcomes, presenting or publishing findings			

11. Outcome Indicators

In 2014 the MoH published a set of Quality Standards for Diabetes Care (the Standards) encompassing wide ranging aspects of diabetes care. The objective of the Standards is to guide DHB planning and funding departments, managers, clinicians and consumers involved in the design and delivery of health services, on what and how services could be provided across the continuum of care (prevention, primary health and secondary care specialist services) and the full spectrum of diabetes (lifespan, pregnancy, complications and other vulnerable groups). The Standards also provide guidance on the measurement of meaningful outcomes (MoH, 2014).

The NDNKSF articulates the knowledge and skill a nurse requires to deliver care to people with diabetes according to their area of practice. Although most nurses providing care for the person with diabetes do so in the context of a multidisciplinary team, it is important nurses take some responsibility for monitoring outcomes relating to their own practice and practice environment. Nurses should determine locally relevant quality improvement, assurance and monitoring measures to demonstrate their contribution to improving diabetes standards of care, care processes and health outcomes.

From a national perspective the Living Well with Diabetes Plan (MoH, 2016) identifies a number of measures to be used to track progress in improving health outcomes for people with diabetes.

These have been arranged into three groupings and are presented below:

1. Reduce the personal burden of disease for people with diabetes
2. Provide consistent services across the country
3. Reduce the cost of Type 2 diabetes.

11.1 Reduce the Personal Burden of Disease for People With Diabetes

- A 20% reduction in complications and disability experienced by people with diabetes under the age of 75 years by 2020; with a 25–30% reduction for high-risk population groups.
- Reduce the rate of amputations per 1000 people with diabetes by 20% from that over 2010–14 by 2019, and by 30% for Māori and Pacific peoples.
- Reduce the rate of renal replacement per 1000 people with diabetes by 20% from that over 2010–14 by 2019, and by 30% for Māori and Pacific peoples.
- A 20% decrease in the proportion of people with HbA1c levels >100, by 2020, with better improvement for high–risk population groups.

11.2 Provide Consistent Services Across the Country

- By 2020, 85% of people with diabetes will participate in an annual review across all population groups.
- A 10% reduction in the proportion of premature mortality (at < 75 years) due to diabetes by 2019, with a 20% decline for Māori and Pacific peoples. This to be replaced when available by life expectancy and DALY targets.
- By 2020 DHBs will have implemented quality standards for diabetes care.

11.3 Reduce the Cost of Type 2 Diabetes

- Reduce prevalence by a 20% reduction in the rate of increase of new cases of Type 2 diabetes, by 2020; with a faster rate of reduction for high-risk population groups (30% for Māori and Pacific).
- Reduce the rate of hospital admissions primarily due to diabetes (per 1000 people with diabetes) by 20% from that in 2014, and by 30% for Māori and Pacific peoples – by 2019.

Other more detailed structure, process and outcome measures are described in the **Quality Standards for Diabetes Care Tool kit** according to each Standard and these also may be useful in developing the a quality monitoring framework specific to your practice environment.

12. Continuing Education Resources

Online learning websites

There are many online learning programmes for diabetes care that will enhance learning and knowledge development. The nurse should be judicious when choosing an online programme and check credentials of the host to ensure the source of knowledge is contemporary and founded on best practice evidence. A widely used New Zealand online learning platform for nurses is healthmentoronline and can be accessed via www.healthmentoronline.com. This programme of learning provides content over a number of modules pertaining to knowledge and skill for All Nurses and a certificate is issued by NZSSD on completion for specified number of professional development hours.

13. Suggested Websites for General Information

New Zealand Society for the Study of Diabetes	www.nzssd.org.nz
Diabetes New Zealand	www.diabetes.org.nz
Diabetes Youth NZ	www.diabetesyouth.org.nz
New Zealand Ministry of Health	www.govt.nz/diabetes
New Zealand Ministry of Health Diabetes Plan	http://www.health.govt.nz/publication/living-well-diabetes
New Zealand Ministry of Health Quality Standards	http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/quality-standards-diabetes-care
New Zealand Ministry of Health Quality Standards Tool Kit	http://www.health.govt.nz/publication/quality-standards-diabetes-care-toolkit-2014
Health Quality and Safety Commission: Atlas of Healthcare Variation	http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/diabetes/
Health Navigator: Diabetes	http://www.healthnavigator.org.nz/health-topics/diabetes/
Best Health Outcomes for Māori	https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf
NCNZ Guidelines for Cultural Safety, Treaty of Waitangi, and Māori health in nursing education and practice	http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses
Healthmentoronline	www.healthmentoronline.com
New Zealand Ministry of Health – Health Strategy	http://www.health.govt.nz/publication/new-zealand-health-strategy-2016
New Zealand Ministry of Health – Health Strategy Road Map	http://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-roadmap-actions-2016
New Zealand Ministry of Health – Maori Health Strategy	http://www.health.govt.nz/publication/guide-he-korowai-oranga-maori-health-strategy
New Zealand Ministry of Health – Maori Health Strategy Work plan	http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
New Zealand Ministry of Health – Pacific Health	http://www.health.govt.nz/our-work/populations/pacific-health

New Zealand Ministry of Health – Health of Older Adult Strategy	http://www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update
New Zealand Ministry of Health – Mental health and Addictions Strategy	http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health
New Zealand Mental health and Addictions Service Development Plan	http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017
New Zealand Ministry of Health - Pre-diabetes and self-management guidance	http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/pre-diabetes-and-self-management-long-term-conditions
New Zealand Ministry of Health – Self-management support guidance	http://www.health.govt.nz/publication/self-management-support-people-long-term-conditions
NZ Guidelines Group- Primary Care Handbook	https://www.health.govt.nz/system/files/documents/publications/nz-primary-care-handbook-2012.pdf
NZ Guidelines Group – Cardiovascular Risk assessment	https://www.health.govt.nz/system/files/documents/publications/cardiovascular-disease-risk-assessment-updated-2013-dec13.pdf
New Zealand Ministry of Health – Gestational diabetes screening and management	http://www.health.govt.nz/publication/screening-diagnosis-and-management-gestational-diabetes-new-zealand-clinical-practice-guideline
New Zealand Ministry of Health – Guidance for healthy weight gain in pregnancy	http://www.health.govt.nz/publication/guidance-healthy-weight-gain-pregnancy
Heart Foundation Guide to Eating for a Healthy Heart	https://www.heartfoundation.org.nz/wellbeing/healthy-eating/eating-for-a-healthy-heart
Heart Foundation – Is butter good for you?	https://www.heartfoundation.org.nz/wellbeing/healthy-eating/nutrition-facts/is-butter-good-for-you
New Zealand Ministry of Health – Chronic Kidney Disease	http://www.health.govt.nz/publication/managing-chronic-kidney-disease-primary-care
New Zealand Ministry of Health – Retinal Screening Guidelines	http://www.health.govt.nz/publication/diabetic-retinal-screening-grading-monitoring-and-referral-guidance
Diabetes Project Trust Project	www.dpt.org.nz
Starship Child and Youth Clinical Network	https://www.starship.org.nz/for-health-professionals/new-zealand-child-and-youth-clinical-networks/clinical-network-for-children-and-young-people-with-diabetes/
Australasian Paediatric Endocrine Group (APEG)	https://apeg.org.au/
APEG 2011 National Evidence-Based Clinical Care Guidelines for Type 1 Diabetes in children, adolescents and adults	https://apeg.org.au/clinical-resources-links/diabetes/

ISPAD Clinical Practice Consensus guidelines, 2014	https://www.ispad.org/?page=ISPADClinicalPract
Wellington Youth with Type 1 diabetes website	www.diabeteslive.co.nz
Scottish Intercollegiate Guidelines Network (SIGN) Guideline 116 Management of diabetes	http://www.sign.ac.uk/guidelines/fulltext/116/
National Institute for Health Care and Excellence	https://www.nice.org.uk/guidance/Conditions-and-diseases/Diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/Diabetes
American Association of Clinical Endocrinologists (AACE)	www.aace.com
American Association of Diabetes Educators (AADE)	www.addenet.org
American Diabetes Association (ADA)	www.diabetes.org
Medical Standards of Care	http://professional.diabetes.org/content/clinical-practice-recommendations
Canadian Diabetes Association (CDA)	www.diabetes.ca http://guidelines.diabetes.ca/
Centers for Disease Control and Prevention (CDC)	www.cdc.gov/diabetes
Diabetes Australia Multilingual Resource (Chinese, Hindi, Thai, Vietnamese, Greek, Indonesian, Italian, Turkish, Ukrainian, Arabic as well as English)	www.multilingualdiabetes.org
Diabetes Education Study group of the European Association for the Study of Diabetes	www.desg.org
Diabetes India	www.diabetesindia.com
Diabetes UK	www.diabetes.org.uk
IDF (Europe) Guidelines	www.staff.ncl.ac.uk/philip.home/guidelines
International Society for Paediatric and Adolescent Diabetes	www.ispad.org
Juvenile Diabetes Research Foundation International (JDRF)	www.jdf.org
PubMed (National Library of Medicine's search service – free)	www.ncbi.nlm.nih.gov/PubMed

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Mission statement
NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/New Zealand through participation in health and social policy development.

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