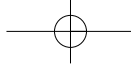


# Competency Based CPD Workbook

Competencies and skills required  
to develop & deliver comprehensive  
pharmaceutical care services to the  
patient with type 2 diabetes mellitus



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## Introduction

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### How can this workbook help me with my Continuing Professional Development?

This workbook is designed to help **You** improve the pharmaceutical care service you will deliver to patients over the next 3-5 years. Few community pharmacists will have evidence for all these competencies when first starting the workbook. Indeed this workbook will act as a tool to constantly prompt you into identifying learning needs and developing your service further.

This workbook will provide documented evidence of continuing professional development as required by the Royal Pharmaceutical Society.

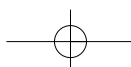
### How do I complete this workbook?

This document should be tackled in bite-sized chunks. First you could go through the workbook and consider the services you provide at present. The competencies on page 1 is probably a good starting place covering activities such as dispensing and counselling. By writing what you do at present in the "From" change in performance column on the left hand page, and then what you would like to achieve in the "To" column, you can now consider what you must do to change your practice. These suggestions would then be documented under the "Analysis of personal learning needs" (what do I need to learn?). Perhaps these learning needs might best be addressed by going on a training course, reading a book or shadowing another practitioner. This would become your "Personal action plan" (what do I need to do?). Once your plan has been completed, how your service has changed would be your "Evidence of change" (What have I changed?).

Once you feel that you have improved your existing services, the competencies that you are not currently achieving at present could be tackled. This workbook will thus stimulate ideas on how to develop your service.

### Aids to help you complete the workbook

Examples of entries are documented in red in the left hand pages. There is duplication of activities with different competencies. This has been done purposely so that one activity may fulfil several competencies. An index on page 36 has been created to help you link these competencies and thus allow you to complete the workbook much quicker.



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**Contents**

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**Competency Descriptor 1**

Participates as a member of the multidisciplinary team, in the care of a person with diabetes

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Pages 1 - 15**Competency Descriptor 2**

Has knowledge of the tests and assessments carried out in diabetes care and of the devices used

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Pages 16 - 18**Competency Descriptor 3**

Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care

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Pages 19 - 29**Competency Descriptor 4**

Can demonstrate that personal knowledge of multidisciplinary diabetes care is up-to-date and based on local and national standards and guidelines

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Pages 30 - 32**Competency Descriptor 5**

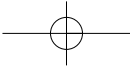
Contributes to the continuing education of the patient and family/carers about diabetes and diabetes care

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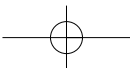
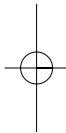
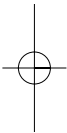
Pages 33 - 35

## Competency Descriptor 1 -

Participates as a member of the multidisciplinary team,  
in the care of a person with diabetes

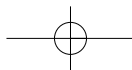


# Competency Descriptor 1



## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
Personal role in diabetes care as a member of the multidisciplinary team	2, 4-10	<p>Identifying patients' need for support by patient interview/assessment</p> <p>Helping patients maintain a patient-held diabetes record booklet (if applicable) to be shared by other members of the multidisciplinary team</p>
Maintaining the patient focus of diabetes care	3	Maintaining a standard pharmaceutical clinical record that would be shared with other members of the multidisciplinary team
The role in diabetes care of other members of the multidisciplinary team	2, 4-10	Monitoring the patients for signals for assessment and referral to other members of the multidisciplinary team
Personal accountability and that of other members of the multi-disciplinary team  Managed clinical networks in diabetes care  Decision making networks and processes in diabetes care	1,2,3,4	<p>Dispensing prescriptions and counselling patients appropriately. Receiving and integrating information about patients' treatment goals and medical/drug history obtained from the multidisciplinary team into the standard pharmaceutical clinical record to optimise benefits</p> <p>Sharing plans with the patients and other members of the diabetic team to ensure:-</p> <ul style="list-style-type: none"> <li>• Suitability of medication for preventing cardiovascular disease</li> <li>• Suitable drug treatment for neuropathy</li> <li>• Suitability of medication in the presence of renal impairment</li> <li>• Suitability of medication in the presence of visual impairment</li> </ul> <p>Adjusting doses to optimise benefits (after suitable training) of:-</p> <ul style="list-style-type: none"> <li>• Hypertension treatment</li> <li>• Cardioprotective medicines-lipid lowering drugs, beta blockers, ACE inhibitors, anti-anginal treatment</li> <li>• Antibiotics</li> <li>• Analgesics</li> <li>• Oral hypoglycaemics</li> </ul>

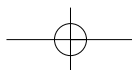


## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <b>e.g. Patient self-referring to pharmacist.</b>		<b>To</b> (What do I want to be doing in the future?)  <b>Patient needs identified through assessment.</b>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <b>Use of assessment tool.</b>	<b>Personal learning plan</b> (What do I need to do?)  <b>Become familiar with Diabetes Model Scheme.</b>	<b>Evidence of change?</b> (What have I changed?)  <b>Now using assessment tool to identify patient's needs.</b>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

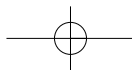


### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

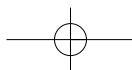


### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
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Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)



## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
<p>Systems for referral of patients to other disciplines who contribute to the care of the person with diabetes</p> <p>The need for, and components of, clinical review</p> <p>Understanding of the effects of other conditions on the care of the person with diabetes</p>	2, 4-10	<p>Monitoring the patient for signals for review by the GP in a situation where:-</p> <ul style="list-style-type: none"> <li>• Identification of co-prescribed or purchased medicines used for co-morbidity interact with treatment</li> <li>• Significant changes in the control of blood glucose, HbA1c, ketones, BP, weight or cardiovascular risk are recorded in the patient held diabetes record booklet (if applicable)</li> <li>• Infection, other complication or new symptoms</li> <li>• Failure to reach personalised treatment goals</li> </ul>
<p>Team contribution to the design of services for the care of people with diabetes</p> <p>Managed Clinical networks in diabetes care</p>	2, 4-10	Involvement in relevant local committees
<p>How primary and secondary care services interface in the care of the person with diabetes</p> <p>Contribution to planning, including discharge planning and follow up, for the care of the person with diabetes</p>	2, 4-10	<p>Receiving and integrating information about patients' treatment goals and medical/drug history received from the multidisciplinary team into the standard pharmaceutical clinical record</p> <p>Using a standard patient-held diabetes record book (if applicable) to liaise with primary care, secondary care and GPs</p>
Involving patients and their families and carers in the planning of care	2, 4-10	<p>Supporting the motivation of the patient and family in:-</p> <ul style="list-style-type: none"> <li>• Self care</li> <li>• Treatment goals</li> <li>• Preventing and dealing with loss of diabetic control</li> </ul>

## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <i>e.g. Dispensing diabetic medication as stated on prescription without thinking about beneficial drugs which patient could also be taking.</i>		<b>To</b> (What do I want to be doing in the future?)  <i>Recommend cardioprotective drugs for patient to take directly with G.P.</i>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <i>Up to date knowledge of beneficial drugs in diabetes.</i>	<b>Personal learning plan</b> (What do I need to do?)  <i>Attend NES session. Complete NES book. Take part in Diabetes Model Schemes.</i>	<b>Evidence of change?</b> (What have I changed?)  <i>During model Scheme, I referred many of the patients who were not taking aspirin 75mg by way of the referral form.</i>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

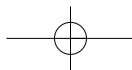
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<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
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### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
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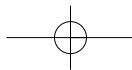


### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

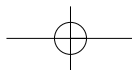
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<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)



## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
Local and national guidelines relating to the care of people with diabetes	2, 4-10	Obtaining a working knowledge of national and local guidelines
Access to sources of up-to-date information on diabetes care (eg professional bodies, local and national guidelines)	3,4	
Quality assurance systems to monitor the standard of services for people with diabetes		Sharing examples of practice through individual cases within a group of pharmacists or within a multiprofessional group
Need for and components of audit of care		Sharing reflections of your best performance in practice within a uniprofessional or multiprofessional group
Importance of risk assessment and management in diabetes care		
Contribution to the development, implementation and evaluation of clinical guidelines in diabetes care	2, 4-10	With appropriate experience and expertise critically reviewing current published papers on advances on diabetic care within a group of pharmacists
Current research relating to the care of the person with diabetes		
Joint research and audit programmes	2,4-10	Becoming involved in audit and/or becoming part of a research project
Communication systems and methods of record keeping employed by the multidisciplinary team in diabetes care	1,2	Creating a register to identify patients with diabetes
National and local clinical management systems for the identification and follow-up of people with diabetes		Using a standard pharmaceutical clinical record to record the delivery of pharmaceutical care to patients
		Using a standard referral process to share information with other members of the multidisciplinary diabetic team
		Receiving information about patients treatment goals and medical/drug history from the multidisciplinary team which would be integrated into the standard pharmaceutical clinical record

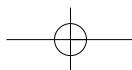


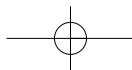
## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <b>e.g.</b> Little knowledge of national and local guidelines.		<b>To</b> (What do I want to be doing in the future?)  Working knowledge of national and local guidelines.
<b>Analysis of personal learning needs</b> (What do I need to learn?)  Find out what local and national guidelines exist.	<b>Personal learning plan</b> (What do I need to do?)  Obtain these guidelines and read.	<b>Evidence of change?</b> (What have I changed?)  Aware of all guidelines and can now apply them to everyday practice.

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
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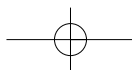


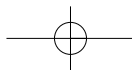
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Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)



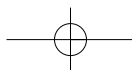


## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

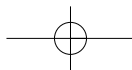
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<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
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## Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
<p>Maintaining standards for data capture and coding and record keeping</p> <p>The role of the individual in the general practice or hospital team responsible for data processing</p>	1,2	<p>Maintaining the pharmaceutical clinical record in respect of the following items of information:-</p> <ul style="list-style-type: none"> <li>• Patient demographics name/address/CHI no. GP name and address</li> <li>• Choice of antidiabetic agent</li> <li>• Patient's status in respect of diabetic complications eg cardiovascular, neuropathy, nephropathy</li> <li>• Identification of cardioprotective medication</li> <li>• Dietary goals needing to be addressed eg obesity/poor diet</li> <li>• Problems in blood glucose control requiring balancing the food intake and insulin dose</li> <li>• General advice on the use of insulin therapy</li> <li>• Advice given on self-monitoring of glycaemic control</li> <li>• Records of targets agreed with the patient on HbA1c, BP, cholesterol, frequency of hypoglycaemic episodes</li> </ul>
<p>Establishing and maintaining methods of communication with other members of the multidisciplinary team</p> <p>Provision of high quality information to patients and their family/carers, tailored to the needs of the individual</p>	1,3	<p>Helping patients maintain a patient-held diabetes record booklet (if applicable) on:-</p> <ul style="list-style-type: none"> <li>• Changes in prescribed medication</li> <li>• Changes in purchased medicines</li> <li>• Self-reporting of symptoms</li> <li>• Episodes of hypoglycaemia</li> <li>• Documentation of achievement of personalised treatment goals</li> </ul> <p>Helping to individualise the patients' oral antidiabetic treatment. This will include:-</p> <ul style="list-style-type: none"> <li>• Checking and following up the drug/dose regimen</li> <li>• Identifying unsatisfactory treatment</li> <li>• Monitoring for signs and symptoms of toxicity</li> </ul>
Involving service users in the evaluation of services	3	Using patient evaluation questionnaires

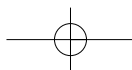


### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
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Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
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### Competency Descriptor 1 - Participates as a member of the multidisciplinary team, in the care of a person with diabetes (cont)

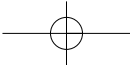
Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

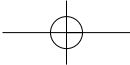
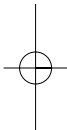
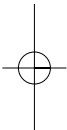
Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

## Competency Descriptor 2 -

Has knowledge of the tests and assessments carried out in diabetes care and of the devices used



# Competency Descriptor 2



## Competency Descriptor 2 - Has knowledge of the tests and assessments carried out in diabetes care and of the devices used

### Key content (knowledge, skills and attitudes)

Knowledge of the specific tests used in diabetes care (eg HbA1c, blood pressure, random total lipids, eye examination, urinalysis(proteinuria), renal function, foot examination, BMI) and why and how they are carried out

Knowledge of when and how often tests should be carried out according to individual need

Interpretation, recording and reporting the results of tests

Operation of devices and equipment used in testing in diabetes care

### NHSQIS Standard(s)

4-10

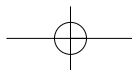
4-10

### Activities of required knowledge and skills to be demonstrated

Maintaining the pharmaceutical clinical record with respect to targets agreed with the patient on:-

- HbA1c
- Blood pressure
- Cholesterol
- Frequency of hypoglycaemic episodes

Maintaining the pharmaceutical clinical record with respect to advice given on self-monitoring of glycaemic control eg frequency, technique, calibration of meters

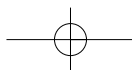


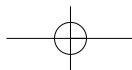
## Competency Descriptor 2 - Has knowledge of the tests and assessments carried out in diabetes care and of the devices used (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <b>e.g. No knowledge of local agreed targets.</b>		<b>To</b> (What do I want to be doing in the future?)  <b>Having agreed targets with other members of diabetic team.</b>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <b>Identify and read local and national guidelines on diabetic targets.</b>	<b>Personal learning plan</b> (What do I need to do?)  <b>Agree targets with other members of a diabetic team.</b>	<b>Evidence of change?</b> (What have I changed?)  <b>Working knowledge of agreed local targets for HbA1c, BP, cholesterol.</b>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)



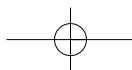


## Competency Descriptor 2 - Has knowledge of the tests and assessments carried out in diabetes care and of the devices used (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

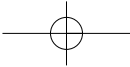
Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

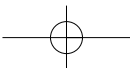
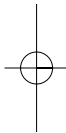
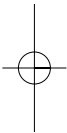


## **Competency Descriptor 3 -**

**Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care**



# Competency Descriptor 3



## Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care

### Key content (knowledge, skills and attitudes)

Clinical management of a person with diabetes in relation to:-

- Cardiovascular system

- Glycaemia

- Renal function

- Neuropathy

### NHSQIS Standard(s)

4-10

### Activities of required knowledge and skills to be demonstrated

Sharing plans with the patients and other members of the diabetic team to ensure suitability of medication for preventing cardiovascular disease

Maintaining a pharmaceutical clinical record in respect of:-

- Patient's cardiovascular disease.
- Identification of cardioprotective medication

Adjusting doses (after suitable training) of cardioprotective medicines; lipid lowering drugs, beta blockers, ACE inhibitors

Individualising patients' oral antidiabetic treatment incorporating checking and following-up the drug/dose regimen

Maintaining the pharmaceutical clinical record in respect of problems in blood glucose control requiring balancing the food intake and insulin dose

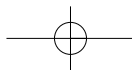
Adjusting doses (after suitable training) of oral hypoglycaemics

Maintaining the pharmaceutical clinical record with respect to advice given on self-monitoring of glycaemic control eg frequency, technique, calibration of meters

Maintaining the pharmaceutical clinical record in respect of patient's diabetic nephropathy

Sharing plans with the patients and other members of the diabetic team to ensure suitability of medication in the presence of renal impairment

Sharing plans with the patients and other members of the diabetic team to ensure suitable drug treatment for neuropathy

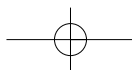


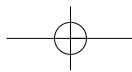
### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <i>e.g. Advising customers on hypoglycaemia only if they ask.</i>		<b>To</b> (What do I want to be doing in the future?)  <i>Being proactive and asking diabetic patients if they know what to do in the event of a hypoglycaemic event.</i>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <i>Check current recommendations for hypoglycaemia.</i>	<b>Personal learning plan</b> (What do I need to do?)  <i>Read guidelines in Model Scheme pack.</i>	<b>Evidence of change?</b> (What have I changed?)  <i>Giving advice to diabetic customers, who when questioned do not know what action to take during a hypoglycaemic attack.</i>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)



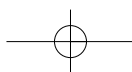


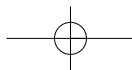
### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>



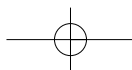


### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

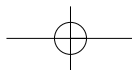
Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)



### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
<p>Clinical management of a person with diabetes in relation to:-</p> <ul style="list-style-type: none"> <li>• Management of eyes</li> </ul>	4-10	<p>Sharing plans with the patients and other members of the diabetic team to ensure suitability of medication in the presence of visual impairment</p> <p>Advising patients on what action should be taken in the event of a hypoglycaemic event</p>
Pharmaceutical interventions in diabetes care, their actions, interactions and possible side effects	4-10	Individualising patients' oral antidiabetic treatment incorporating checking and following up the drug/dose regimen
	4-10	Maintaining the pharmaceutical clinical record in respect of choice of antidiabetic agent
Pharmaceutical interventions in diabetes care, their actions, interactions and possible side effects	4-10	<p>Monitoring the patient for signals for review by the GP in a situation where identification of co-prescribed or purchased medicines used for co-morbidity interact with treatment</p> <p>Adjusting doses to optimise benefits (after suitable training) of:-</p> <ul style="list-style-type: none"> <li>• Hypertension treatment</li> <li>• Cardioprotective medicines-lipid lowering drugs, beta blockers, ACE inhibitors, anti-anginal treatment</li> <li>• Antibiotics</li> <li>• Analgesics</li> <li>• Oral hypoglycaemics</li> </ul>
The influence of diet and nutrition diabetes and diabetes care	4-10	<p>Maintaining the pharmaceutical clinical record in respect of dietary goals needing addressed eg obesity/poor diet</p> <p>Providing education on how to limit tissue damage through weight control</p> <p>Maintaining the pharmaceutical clinical record in respect of problems in blood glucose control requiring balancing the food intake and insulin dose</p>
The influence of physical activity on diabetes and diabetes care		

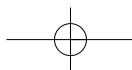


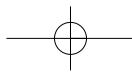
### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <i>e.g. No literature available and unsure of current advice on nutrition in diabetes.</i>		<b>To</b> (What do I want to be doing in the future?)  <i>Providing good advice and literature to patients on nutrition.</i>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <i>Contact specialist diabetes dietician for current advice.</i>	<b>Personal learning plan</b> (What do I need to do?)  <i>Sit in with dietician during diabetes clinic. Read any material supplied.</i>	<b>Evidence of change?</b> (What have I changed?)  <i>Now offering good nutritional support to diabetics and have a range of literature available.</i>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)



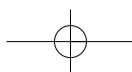


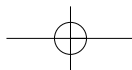
### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)

Changes in Performance (How do I improve my performance?)		
From (What are you doing at present?)		To (What do I want to be doing in the future?)
Analysis of personal learning needs (What do I need to learn?)	Personal learning plan (What do I need to do?)	Evidence of change? (What have I changed?)



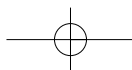


### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)



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**Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)**

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**Key content  
(knowledge, skills and attitudes)****NHSQIS Standard(s)****Activities of required knowledge  
and skills to be demonstrated**

Recognition of the signs and symptoms of complications in the person with diabetes

4-10

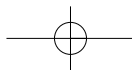
Maintaining the pharmaceutical clinical record in respect of diabetic complications eg cardiovascular, neuropathy, nephropathy, hyperglycaemia, hypoglycaemia

Health promotion in addition to therapeutic interventions for secondary prevention

4-10

Providing education on how to limit tissue damage through smoking cessation

Prevention through health promotion and health education

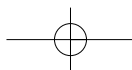


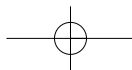
### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<i>From</i> (What are you doing at present?)		<i>To</i> (What do I want to be doing in the future?)
<i>Analysis of personal learning needs</i> (What do I need to learn?)	<i>Personal learning plan</i> (What do I need to do?)	<i>Evidence of change?</i> (What have I changed?)



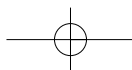


### Competency Descriptor 3 - Shows an understanding of the diagnosis of diabetes and therapeutic interventions in diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

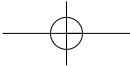
Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

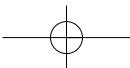
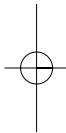
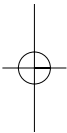


## Competency Descriptor 4 -

Can demonstrate that personal knowledge of multidisciplinary diabetes care is up-to-date and based on local and national standards and guidelines

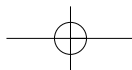


# Competency Descriptor 4



### Competency Descriptor 4 - Can demonstrate that personal knowledge of multidisciplinary diabetes care is up-to-date and based on local and national standards and guidelines

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
Cultural issues that may affect the care of the person with diabetes	3	Having a working knowledge of patient cultures and implications of the disease states
Identification of educational opportunities specific to their specialty	2	Sharing reflections of where your performance leaves room for improvement within a group of pharmacists
Interdisciplinary learning in diabetes	2	Taking part in a local multidisciplinary mentoring group

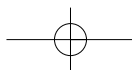


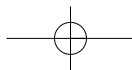
**Competency Descriptor 4 - Can demonstrate that personal knowledge of multidisciplinary diabetes care is up-to-date and based on local and national standards and guidelines (cont)**

<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>



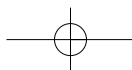


**Competency Descriptor 4 - Can demonstrate that personal knowledge of multidisciplinary diabetes care is up-to-date and based on local and national standards and guidelines (cont)**

<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

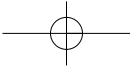
<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

<b>Changes in Performance (How do I improve my performance?)</b>		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

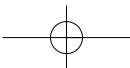
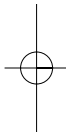
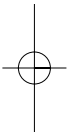


## **Competency Descriptor 5 -**

**Contributes to the continuing education of the patient and family/carers about diabetes and diabetes care**

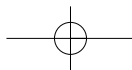


# Competency Descriptor 5



## Competency Descriptor 5 - Contributes to the continuing education of the patient and family/carers about diabetes and diabetes care

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
Screening processes for the detection of diabetes: information for patient/carer	3,4	Providing appropriate information on the screening process to patient and carer. Referral of patient if necessary
Relating the importance of concordance with therapeutic regimens in diabetes care to patients/carers	3-10	Providing timely patient counselling to patients and carers. Monitoring compliance from their patient medication records
Maintaining the patient focus of diabetes care	3	Continually educating and encouraging the patient and carer to be proactive in their disease.
Maintaining knowledge about the care of the individual person with diabetes		
Lifestyle factors that contribute to the maintenance of health and reduce the risk of complications	3-10	Providing appropriate information on lifestyle advice and health promotion
Principles of health promotion and education		Providing appropriate education on how to limit tissue damage through smoking cessation and weight control
Treatment options in diabetes care, and possible side effects: patient/carer involvement	3-10	Helping to individualise the patients' oral antidiabetic treatment. This will include <ul style="list-style-type: none"> <li>• Checking and following-up the drug/dose regimen</li> <li>• Identifying unsatisfactory treatment</li> <li>• Monitoring for signs and symptoms of toxicity</li> </ul> Providing advice and appropriate information on treatment options and possible side effects
Identifying, with patients and their families and carers, opportunities for learning	3	Advising on sources of learning or appropriate support groups. Critically reviewing sources of information for the patient and carer
Critically appraising information about diabetes from a variety of formats (eg leaflets, pamphlets, CD-Rom, Websites, mass media)		

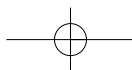


## Competency Descriptor 5 - Contributes to the continuing education of the patient and family/carers about diabetes and diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)  <i>e.g. Not spending enough time actively educating and counselling patients and their carers.</i>		<b>To</b> (What do I want to be doing in the future?)  <i>Continually educating and encouraging patients and their carers to be proactive in their disease.</i>
<b>Analysis of personal learning needs</b> (What do I need to learn?)  <i>Organise time more effectively.</i>	<b>Personal learning plan</b> (What do I need to do?)  <i>Delegate, allowing me time to always check PHR for compliance.</i>	<b>Evidence of change?</b> (What have I changed?)  <i>Spending more time checking for compliance and counselling and educating patients on their condition.</i>

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)

Changes in Performance (How do I improve my performance?)		
<b>From</b> (What are you doing at present?)		<b>To</b> (What do I want to be doing in the future?)
<b>Analysis of personal learning needs</b> (What do I need to learn?)	<b>Personal learning plan</b> (What do I need to do?)	<b>Evidence of change?</b> (What have I changed?)



## Competency Descriptor 5 - Contributes to the continuing education of the patient and family/carers about diabetes and diabetes care (cont)

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

Changes in Performance (How do I improve my performance?)		
<i>From (What are you doing at present?)</i>		<i>To (What do I want to be doing in the future?)</i>
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<i>Analysis of personal learning needs (What do I need to learn?)</i>	<i>Personal learning plan (What do I need to do?)</i>	<i>Evidence of change? (What have I changed?)</i>

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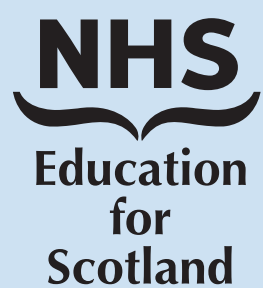
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### **A Standard Pharmaceutical Clinical Record**

Refers to either a pharmaceutical care needs assessment form, a standard pharmaceutical care plan, electronic patient medication record or patient-held diabetes record, whichever is most appropriate in your practice.

### **NHSQIS Standard(s)**

The Clinical Standards Board for Scotland (CSBS) in 2001-now part of NHS Quality Improvement Scotland (NHSQIS)-produced clinical standards for diabetes. These standards will be used by NHSQIS to assess the quality of clinical services provided in both community and hospital settings throughout Scotland for people with diabetes.



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