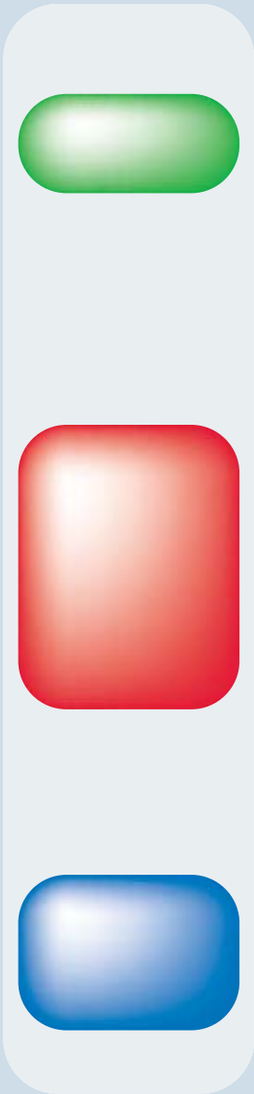
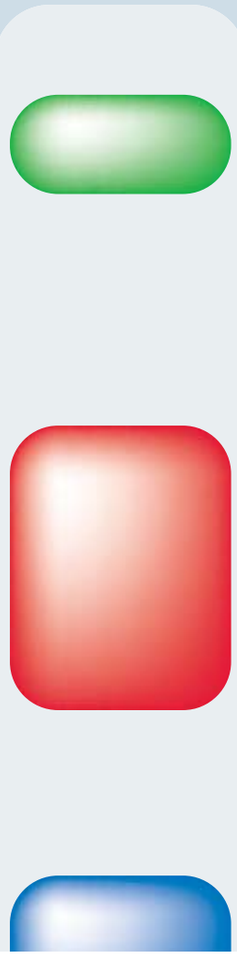
Competency Based CPD Workbook

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





Introduction

Diabetes mellitus is a growing health problem for people of all ages across the countries of Europe. An estimated 10 million people face ill health and shortened life expectancy associated with this condition. As long ago as 1989, in the St Vincent Declaration, the World Health Organisation (WHO) Regional Office for Europe International Diabetes Federation (IDF), European Region, and diabetes experts from all European countries called for a systematic approach to dealing with the disease. They stated: "Plans for the prevention, identification and treatment of diabetes, and in particular its complications – blindness, renal failure, gangrene and amputation, aggravated coronary heart disease and stroke - should be formulated at local, national and European levels. Investments now will earn great dividends in the reduction of human misery and in massive savings of human and material resources."

In Our National Health (2000), the Scottish Executive signalled its commitment to raising standards of diabetes care in Scotland. This commitment included the publication of a Scottish Diabetes Framework (SDF) to "draw together existing guidance and best practice". The framework document states: "An effective diabetes service requires all staff to be trained, competent and skilled in their components of diabetes care and able to work with other members of the multidisciplinary team needed to provide an integrated service to people with diabetes." The SDF specifically mentions pharmacists as part of the team and recommends further development of their role.

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.

One method of delivering high quality care is by using professional competencies needed to achieve the desired contribution to care. In this workbook, the competencies and pharmacy activities are combined within a continuing professional development portfolio in order to enable practitioners to measure their level of competence in specified areas of practice and identify where they need to develop further skills or knowledge. In this way practitioners' personal and professional development and a universally consistent approach to education and training programmes can be assured simultaneously.

For this workbook, the agreement of "Key Content" of what might be called generic competencies relevant to a range of disciplines was drafted by the nursing profession, and sent out for consultation throughout Scotland across the relevant professions involved in diabetes care. Direct links were made from each competency to the relevant section of the NHSQIS standards. This work was then built upon by NHS Education for Scotland (Pharmacy) and the Department of Pharmaceutical Sciences at the University of Strathclyde in the form of a Delphi Questionnaire and a focus group to interested community pharmacists. That exercise has identified agreed activities, the required knowledge and the skills needing to be demonstrated by the community pharmacist delivering pharmaceutical care to the patient with diabetes mellitus type 2.

Introduction

This workbook is designed to help you improve the pharmaceutical care service you will deliver to your patients over the next 5 years. Very few practitioners would have evidence for all of these competencies at present. Indeed this document acts as a benchmark and aims to constantly prompt you into identifying learning needs associated with continuous improvement of the service you provide to meet the needs of your patients. It will cover two important action points identified in the Scottish Executive Document, The Right Medicine (2002) to:-

1. Support the roll-out of the pharmaceutical care model schemes, including the development of chronic disease management schemes in line with national priorities.

2. Support the early implementation of a compulsory obligation for pharmacists to undertake and document their CPD as a requirement for registration to practice.

This document should be tackled in bite-sized chunks, first you could go through the booklet and consider the services you provide at present. How can you improve these? By writing first what you do 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 must now consider what you must do to change your practice. These suggestions would then be documented under "Analysis of Personal Learning Needs". Perhaps these learning needs might best be addressed by going on a training course, reading a book, shadowing another practitioner. This would become your "Personal Learning Action Plan". Once your plan had been completed, how your service has changed would be your "Evidence of Change".

Once you feel that you have improved your existing services, the competencies that you are not currently achieving at present could be tackled. The workbook may thus stimulate ideas on how to develop your services in line with not only the national pharmacy vision, but also with the multiprofessional diabetes forum.

Terminology

Throughout the workbook, "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.

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	Identifying patients' need for support by patient interview/assessment Helping patients maintain a patient-held diabetes record booklet (if applicable) to be shared by other members of the multidisciplinary team
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

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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)

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

NHSQIS Standard(s)

1,2,3,4

Activities of required knowledge and skills to be demonstrated

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

Sharing plans with the patients and other members of the diabetic team to ensure:-

- Suitability of medication for preventing cardiovascular disease
- Appropriate footcare
- Suitable drug treatment for neuropathy
- Suitability of medication in the presence of renal impairment
- Suitability of medication in the presence of visual impairment

Adjusting doses to optimise benefits (after suitable training) of:-

- Hypertension treatment
- Cardioprotective medicines-lipid lowering drugs, beta blockers, ACE inhibitors, anti-anginal treatment
- Antibiotics
- Analgesics
- Oral hypoglycaemics
- Insulin

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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)

Systems for referral of patients to other disciplines who contribute to the care of the person with diabetes

The need for, and components of, clinical review

Understanding of the effects of other conditions on the care of the person with diabetes

NHSQIS Standard(s)

2, 4-10

Activities of required knowledge and skills to be demonstrated

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
- 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)
- Infection, other complication or new symptoms
- Failure to reach personalised treatment goals

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
Team contribution to the design of services for the care of people with diabetes Managed Clinical networks in diabetes care	2, 4-10	Involvement in relevant local committees
How primary and secondary care services interface in the care of the person with diabetes Contribution to planning, including discharge planning and follow up, for the care of the person with diabetes	2, 4-10	Receiving and integrating information about patients' treatment goals and medical/drug history received from the multidisciplinary team into the standard pharmaceutical clinical record Using a standard patient-held diabetes record book (if applicable) to liaise with primary care, secondary care and GPs
Involving patients and their families and carers in the planning of care	2, 4-10	Supporting the motivation of the patient and family in:- • Self care • Treatment goals • Preventing and dealing with loss of diabetic control

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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 Access to sources of up-to-date information on diabetes care (eg professional bodies, local and national guidelines)	2, 4-10 3,4	Obtaining a working knowledge of national and local guidelines
Quality assurance systems to monitor the standard of services for people with diabetes Need for and components of audit of care Importance of risk assessment and management in diabetes care		Sharing examples of practice through individual cases within a group of pharmacists or within a multiprofessional group Sharing reflections of your best performance in practice within a uniprofessional or multiprofessional group
Contribution to the development, implementation and evaluation of clinical guidelines in diabetes care Current research relating to the care of the person with diabetes	2, 4-10	With appropriate experience and expertise critically reviewing current published papers on advances on diabetic care within a group of pharmacists

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
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 National and local clinical management systems for the identification and follow- up of people with diabetes	1,2	Creating a register to identify patients 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)

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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)

Maintaining standards for data capture and coding and record keeping

The role of the individual in the general practice or hospital team responsible for data processing

NHSQIS Standard(s)

1,2

Activities of required knowledge and skills to be demonstrated

Maintaining the pharmaceutical clinical record in respect of the following items of information:-

- Patient demographics name/address/CHI no. GP name and address
- Choice of antidiabetic agent
- Patient's status in respect of diabetic complications eg cardiovascular, neuropathy, nephropathy
- Identification of cardioprotective medication
- Dietary goals needing to be addressed eg obesity/poor diet
- Problems in blood glucose control requiring balancing the food intake and insulin dose
- General advice on the use of insulin therapy
- Advice given on self-monitoring of glycaemic control
- Records of targets agreed with the patient on HbA1c, BP, cholesterol, frequency of hypoglycaemic episodes

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
Establishing and maintaining methods of communication with other members of the multidisciplinary team Provision of high quality information to patients and their family/carers, tailored to the needs of the individual	1,3	Helping patients maintain a patient-held diabetes record booklet (if applicable) on:- • Changes in prescribed medication • Changes in purchased medicines • Self-reporting of symptoms • Episodes of hypoglycaemia • Documentation of achievement of personalised treatment goals Helping to individualise the patients' oral antidiabetic treatment. This will include:- • Checking and following up the drug/dose regimen • Identifying unsatisfactory treatment • Monitoring for signs and symptoms of toxicity
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)

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
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	4-10	Maintaining the pharmaceutical clinical record with respect to targets agreed with the patient on:- • HbA1c • Blood pressure • Cholesterol • Frequency of hypoglycaemic episodes
Operation of devices and equipment used in testing in diabetes care	4-10	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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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

Key content (knowledge, skills and attitudes)	NHSQIS Standard(s)	Activities of required knowledge and skills to be demonstrated
Clinical management of a person with diabetes in relation to:- • Cardiovascular system	4-10	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
• Glycaemia		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, insulin Maintaining the pharmaceutical clinical record with respect to advice given on self-monitoring of glycaemic control eg frequency, technique, calibration of meters
• Renal function		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
• Neuropathy		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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
Clinical management of a person with diabetes in relation to:- • Footcare	4-10	Sharing plans with the patients and other members of the diabetic team to ensure appropriate footcare
• Management of eyes		Sharing plans with the patients and other members of the diabetic team to ensure suitability of medication in the presence of visual impairment
• Management of acute episodes		Advising patients on what action should be taken in the event of a hypoglycaemic event
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

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
Pharmaceutical interventions in diabetes care, their actions, interactions and possible side effects	4-10	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 Adjusting doses to optimise benefits (after suitable training) of:- • Hypertension treatment • Cardioprotective medicines-lipid lowering drugs, beta blockers, ACE inhibitors,anti-anginal treatment • Antibiotics • Analgesics • Oral hypoglycaemics • Insulin
The influence of diet and nutrition diabetes and diabetes care The influence of physical activity on diabetes and diabetes care	4-10	Maintaining the pharmaceutical clinical record in respect of dietary goals needing addressed eg obesity/poor diet Providing education on how to limit tissue damage through weight control Maintaining the pharmaceutical clinical record in respect of problems in blood glucose control requiring balancing the food intake and insulin dose

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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
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 Prevention through health promotion and health education	4-10	Providing education on how to limit tissue damage through smoking cessation

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

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 Maintaining knowledge about the care of the individual person with diabetes	3	Continually educating and encouraging the patient and carer to be proactive in their disease.
Lifestyle factors that contribute to the maintenance of health and reduce the risk of complications Principles of health promotion and education	3-10	Providing appropriate information on lifestyle advice and health promotion 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 • Checking and following-up the drug/doseregimen • Identifying unsatisfactory treatment • Monitoring for signs and symptoms of toxicity Providing advice and appropriate information on treatment options and possible side effects
Identifying, with patients and their families and carers, opportunities for learning Critically appraising information about diabetes from a variety of formats (eg leaflets, pamphlets, CD-Rom, Websites, mass media)	3	Advising on sources of learning or appropriate support groups. Critically reviewing sources of information for the patient and carer

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

Change in performance		Analysis of personal learning needs	Personal learning action plan	Evidence of change
(Desired outcomes)				
From	*To*			

NHS
Education
for
Scotland

NHS Education for Scotland (Pharmacy)
3rd Floor, 2 Central Quay
89 Hydepark Street
Glasgow G3 8BW

Tel: (0141) 223 1600

www.nes.scot.nhs.uk