Diabetes Nurse Clinic Intervention Guidelines (1-4)

2nd Edition

Association of Hong Kong Diabetes Nurses

June 2010

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We would like to express our appreciation to those who helped in the preparation of the Guideline. We would particularly thank all local diabetes nurses for providing their expert and valuable information, and for making useful suggestions for improvement.

Preface

The Association of Hong Kong Diabetes Nurses (AHKDN) is dedicated to promoting diabetes care and education standard in Hong Kong through developing educational materials, standards and guidelines, position statement and training curricula.

In 2008, the Association has incorporated the international standards and adopted them to local culture to produce the 1st Diabetes Nurse Clinic Intervention Guidelines (1-4). The content of the Guideline reflects the mission and philosophy of AHKDN and the document has been widely adopted by different local diabetes nurse clinics and served as a yardstick of care standard for service implementation and evaluation since its publication. In this 2nd edition, we maintained the four sets of guidelines but have updated the previous version with the best available evidence, changed the layout to reflect changes in our approach and intent in diabetes treatment and care practices. This Guideline is intended to guide practice but is not intended to serve as a comprehensive text on diabetes management and education. It is hoped that nurses can consider the needs of individual patients, use judgment, and work with best available organization support and resources to integrate these standards into their day to day practice.

I would like to take this opportunity to express my sincere thanks to the Guideline Working Group and Review Panel for their contributions and valuable support to make this 2nd edition of Diabetes Nurse Clinic Intervention Guidelines possible.

Cheng Mei Wan, Winnie
President
AHKDN (2008-2010)

June 2010

The Guideline (2nd Ed) Working Group (2010)

Ms LEUNG Yat Sze, Annie
Nurse Specialist (Diabetes Care), Yan Chai Hospital

Ms HUNG Siu Chan, Veronica
Advanced Practice Nurse (Diabetes Care), Pok Oi Hospital

Ms KOO Wai Kuen
Advanced Practice Nurse (Diabetes Care), Queen Elizabeth Hospital

Ms LEE Kar Bik
Ward Manager (Paediatrics), Queen Mary Hospital

Ms YEUNG Hoi Ming, Theresa
Advanced Practice Nurse (Diabetes Care), Prince of Wales Hospital

The Guideline Review Panel

Ms CHENG Mei Wan, Winnie
Nurse Specialist (Diabetes Care), Queen Elizabeth Hospital

Ms KAN Ching Yee, Eva
Nurse Specialist (Diabetes Care), Alice Ho Miu Ling Nethersole Hospital

Dr. CHAN Chung Ngor, Juliana
Professor, Department of Medicine and Therapeutics, the Chinese University of Hong Kong

Dr. WONG Kam Yuet, Frances
Professor, School of Nursing, the Hong Kong Polytechnic University

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Diabetes Nurse Clinic Intervention Guideline (1):

Adults with Type 1 or Type 2 Diabetes

1. Assessment

Assessments of patients should include the physical, psychosocial and educational aspects:

1.1 Physical

- Background information: educational level, marital status, employment status, occupation, type of DM, duration of disease, family history of DM, smoking and drinking habit
- Significant symptoms (e.g. angina, erectile dysfunction, weight loss)
- History of operations and procedures and other medical conditions
- History of acute (including hypoglycemia and hyperglycemia requiring admissions) and chronic complications
- Concurrent drug use
- Other physical parameters: blood pressure (BP), body mass index (BMI), waist circumference/ WHR
- Biochemical parameters: blood tests for HbA1c, fasting plasma glucose (FPG), lipid profile, renal/liver functions, urate and haematology[2] (for type 1 diabetes, blood tests for thyroid function and C-peptide may be considered), urine tests for protein and ketone

1.2 Psychosocial

- Disease acceptance
- Self-efficacy
- Employment status
- Eating and activity habit
- Social support: family and financial hardships
- Health beliefs and values
- Perceived impact of diabetes and emotions
- Specific concerns
- Anxiety, depression and distress

1.3 Educational

- Knowledge of nature of diabetes and skills of self-care, such as causes, pathophysiology, consequences of diabetes, treatment, dietary concept, management of hypoglycemia and hyperglycemia, self monitoring of diabetes, foot care, sick day management and traveling tips, etc.
- Importance of effects of energy balance (e.g. diet, walking exercise and avoidance of energy dense foods) and psychological well being on glycemic control

2. Planning

Planning should be based on the interpretation of data from these assessments to identify goals and prioritize interventions:

2.1 Therapeutic: to determine i) individualized metabolic control targets[2,5] and ii) treatment modification and/or initiation of therapy (diet, physical activities and anti-diabetic medications)[3,4]

2.2 Educational: to determine patient's readiness to learn, what knowledge and skills to be taught or reinforced, and what strategies and resources to be used

2.3 Counseling: to identify the effective mode(s) of intervention, such as reflective listening, value clarification, verbal persuasion, explanation, referral, advice and/or self-efficacy enhancement

2.4 Determining any need of referral to other specialist(s) or other resource support e.g. medical social workers, dietician, or podiatrist

3. Intervention

Nursing interventions should include:

3.1 Self-management education:

The goals of diabetes education is to improve overall health status by empowering the patients to i) acquire skills and knowledge ii) develop confidence and motivation to perform the appropriate self-care behaviors iii) develop the problem-solving and coping skills to overcome any barriers to self-care behavior

3.1.1 To enable patients to have a basic understanding of diabetes, importance of self-management in chronic disease and the need to prevent, recognize and treat acute short-term complications of hyperglycemia and severe hypoglycemia. Education should include the following topics:

- What is diabetes - symptoms, causes and consequences, is a progressive disease
- Treatment of diabetes and targets of control of multiple risk factors
- Acute and chronic complications of diabetes
- Dietary reinforcement and energy balance
- Treatment options and insulin management (if applicable)
- Physical activity e.g. exercise plan
- Self-monitoring of blood glucose level (and ketone for type 1 diabetes) and interpretation of its results
- Recognition and management of hypoglycemia & hyperglycemia
- Personal hygiene e.g. foot, skin and dental care
- Information about resources and continuous support

3.1.2 To enable patients to achieve individualized metabolic control targets, reduce the risk of long-term complications and facilitate the adjustment to live with diabetes.

Education should include the following topics:

- More facts about diabetes e.g. honeymoon period of type 1 DM
- Healthy food choices e.g. eating out tips
- The interrelations between food, exercise, emotions (including sleep deprivation), body weight, medicines and blood glucose levels
- Different treatment strategies (insulin and oral drugs)
- Interpretation and application of results of self-monitoring
- Hypoglycemia (Somogyi effect)
- Hyperglycemia (Dawn phenomenon)
- Management during illness
- Management during traveling
- Alcohol, smoking and diabetes
- Sexual health and plan for pregnancy
- Risk factors assessment

3.1.3 To empower patients to live with diabetes and improve/ maintain healthy lifestyle throughout their lives. Education should include the following topics:

- ♦ Coping with stress
- ♦ Choice of treatment
- ♦ Dosage adjustment of insulin
- ♦ Seven self-care behaviors[1] (healthy eating, being active, monitoring, taking medication, problem solving, reducing risks, healthy coping)
- ♦ Training patients to be leaders and motivators in order to improve diabetes self-care, to serve as community role models, and provide peer support e.g. Peer support programs in diabetes[6]

3.2 Setting behavioral goals and action planning

3.3 Negotiating/ prescription of self-care tasks to be achieved

3.4 Adjustment of medications (oral anti-diabetic drugs and insulin) and arrangement of biochemical investigation

3.5 Counseling: to encourage disease acceptance and psychosocial adjustment

3.6 Symptom management: i) to verify the origin(s) of symptoms and presentation, and ii) to use appropriate means (i.e. physical, psychological and/ or educational, such as teaching relaxation therapy) for symptoms control

3.7 Periodical assessment of risk factors and complications

3.8 Referral to specialists (e.g. medical social workers, dietician, podiatrist or behavioral therapist) and/or other resources (e.g. diabetic association or self-help group)

3.9 Provide support between clinic visits via telephone contact or e-contact for monitoring, ad hoc problem shooting or enquiry, such as reporting blood glucose readings and insulin dosage adjustment

4. Evaluation

Evaluations should include reviewing and planning of the following issues:

4.1 Disease acceptance and psychosocial adjustment

4.2 Patient's response to treatment and understanding of the education provided

4.3 Accomplishment of self-care behaviors and life-style modification

4.4 Control on metabolic and risk factors

4.5 Prevention of acute complications

4.6 Behavior change

4.7 Satisfaction with service

4.8 Symptoms control

4.9 Planning of next follow-up action

5. Documentation

Provision of nursing interventions and education should be documented in patient record:

5.1 All components of diabetes self-management education (DSME)

5.2 Adjustment of medications (if any)

5.3 Plan of follow-up action and referral

Reference

1. AADE Position Statement (2008). AADE7™ Self-care behaviors. *Diabetes Educator 34*(3): 445-449

2. Asian-Pacific Type 2 Diabetes Policy Group (2005). *Type 2 Diabetes Practical Targets and Treatment (p45), 5th Ed.*

3. HA Clinical Practice Guideline (2008). *Management of type 2 diabetes*

4. Nathan et al (2009). Medical management of hyperglycemia in type 2 DM: a consensus from ADA and the EASD. *Diabetes Care 32*(1): 193-203

5. Silverstein, J. et al. (2005). Care of children and adolescent with type 1 diabetes: A statement of American Diabetes Association. *Diabetes Care 28*(1): 186-212

6. World Health Organisation (2007). *Peer support programs in diabetes. Report of a WHO consultation*

Diabetes Nurse Clinic Intervention Guideline (2):

Children or Adolescents with Type 1 or Type 2 Diabetes

1. Assessment

Assessments of patients should include physical, psychosocial and educational aspects:

1.1 Physical

- Background information: duration of disease, type of DM, family history of DM, and history of substance abuse, such as smoking or alcohol consumption
- Other significant medical/ health conditions, autoimmune disease and chronic diabetic complication status
- Current drug use for diabetes and other conditions
- History of hospitalizations for acute hypoglycemia and hyperglycemia
- Health status: frequency of infection, number of sick day
- Other physical parameters: growth status and pubertal development, immunizations, blood pressure (BP with reference to age-appropriate normal levels), height, weight and body mass index (BMI) (compare to age and sex-specific norms), waist circumference/ WHR
- Skin (sites for injection and sites for finger prick) or any acanthosis nigricans
- Existing nutrition plan
- Biochemical parameters: blood tests for HbA1c, FPG, renal/ liver functions, lipid profile, electrolytes, urine tests for protein and ketone, thyroid function, ± islet autoantibodies/ plasma C-peptide level

1.2 Psychosocial

- Family structure (genogram)
- Marital relationship of parents
- Parents/ guardian's socioeconomic status
- Family functionality: problem solving, beliefs and values, family communication, emotional life & coping of the family, alliances and boundaries (relationship with parents, caregivers and siblings)
- Specific family rituals or issue(s)
- Family commitment and demand in life
- Psychological status: anxiety, worry, reaction to finger prick/ injection, any needle phobia
- Children and parents' past experience on diabetes or other diseases
- Disease acceptance and attitudes (both of the patient and family), ability, readiness and motivation to learn
- Social support: family, friends, school personnel
- Cultural background: health beliefs and value

1.3 Educational (patients and carers)

- Education level and learning abilities
- Knowledge of DM (e.g. nature of diabetes and treatment, and risk of complications), history of related education by DM nurse, dietician and podiatrist
- Disease management skills: type of medication (oral anti-diabetic drugs/ insulin), insulin delivery devices (syringe/ pens/ insulin pump), insulin dosage adjustment for glycemic control, food & exercise, balanced diet and meal planning, physical activity, self monitoring of blood glucose control target, management of hypoglycemia and hyperglycemia (including sick days management) and traveling, etc.

1.4 Maturity and development of the patient

- Rating of cognitive, emotional and sexual maturities
- Psychosocial developmental stage
- Academic performance and social network

1.5 Life-style and routine of the patient

- School/ work life and activity pattern
- Holiday routine
- Hobbies and habits

2. Planning

Planning should be based on the interpretation of data from these assessments to identify goals and prioritize interventions:

2.1 Diabetes education should be adaptable and personalized appropriate for the age, stage of diabetes, maturity, culture and lifestyle of the patient concerned

2.2 Therapeutic: to educate and reinforce on i) individualized metabolic control targets and ii) treatment modification (diet, physical activities and anti-diabetic medications)[3,5]

2.3 Educational: to determine patient's, parents' and/ or caregiver's readiness to learn, and what knowledge and skills to be taught or reinforced

2.4 Counseling: to determine the effective mode(s) of intervention, such as verbal counseling skills, play therapy, use of activities or media such as miniature animals, clays or various forms of art. Encourage children to tell their stories or consider to counsel children in group if they have the common problems or experiences[2]

2.5 Training patients on coping skills or applying peer support network

2.6 Determining any need of referral to other specialist(s) or other resources support

2.7 Preparing school letter and information of DM management to school personnel. Arranging school visit

2.8 Planning transition to adult diabetes care (if appropriate)

3. Intervention

Nursing interventions should also involve parents and/ or caregiver:

3.1 Self-management education[1]

The goals of diabetes education is to improve overall health status by empowering the people with diabetes to i) acquire skills and knowledge ii) develop confidence and motivation to perform the appropriate self-care behaviors iii) develop the problem-solving and coping skills to overcome any barriers to self-care behavior

3.1.1 To enable patients to have a basic understanding of diabetes, importance of self-management in chronic disease and the need to prevent, recognize and treat acute short-term complications of hyperglycemia and severe hypoglycemia. Education should include the following topics:

- Types of diabetes and overview of disease process
- Treatment options
- Action and adverse reactions for medications
- Insulin and glucagon preparation and administration (for type 1 diabetes)
- Age-appropriate dietary management and nutritional management
- Exercise program and its precautions

- ♦ Self-monitoring of blood glucose (and ketone monitoring for type 1 DM)
- ♦ The target range of blood glucose according to different age groups
- ♦ Recognition, treatment and prevention of hypo and hyperglycemia
- ♦ Personal care e.g. foot and skin care
- ♦ Honeymoon period for type 1 DM and its management

3.1.2 To enable patients to achieve individualized metabolic control targets, reduce the risk of long-term complications and facilitate the adjustment to live with diabetes.

Education should include the following topics:

- ♦ Guidelines on food exchange and diet during holiday
- ♦ Management of physical activity and its effect on blood glucose levels
- ♦ Interpretation and application of monitoring information
- ♦ Hypoglycemia (Somogyi effect)
- ♦ Hyperglycemia (Dawn phenomenon)
- ♦ Management on sick day
- ♦ Management of traveling especially sleeping over in a friend's house
- ♦ Age-appropriate explanation of risk of DM complication

3.1.3 To empower patients to live with diabetes and improve/ maintain healthy lifestyle throughout their lives. Education should include the following topics:

- ♦ Coping with stress (parents, caregivers, patient and siblings)
- ♦ Lifestyle modification
- ♦ Knowledge on safe sex and contraception
- ♦ The risk of smoking, alcohol consumption and drug abuse
- ♦ Social issue: e.g. health insurance and driving
- ♦ Introduce advanced monitoring and insulin device
- ♦ Seven self-care behaviors[1] (healthy eating, being active, monitoring, taking medication, problem solving, reducing risks, healthy coping)

3.2 Setting of behavioral goals[4]: negotiating and planning self-care tasks with patients/ parents, emphasizing on age and developmental appropriateness

3.3 Counseling: to encourage disease acceptance and psychosocial adjustment.

3.4 Symptom management: i) to verify the origin(s) of symptoms and presentation; and ii) to use appropriate means (i.e. physical or psychological and/or educational, such as teaching relaxation therapy) for symptoms control

3.5 Referral to specialists (e.g. medical social workers, dietician or behavioral therapists) and/or other resources (e.g. diabetic association and self-help group)

3.6 Provide published guidelines for school personnel

3.7 Provide between-visit support via telephone contact or e-contact for monitoring, ad hoc problem shooting or enquiry, such as reporting blood glucose readings and insulin dosage adjustment

4. Evaluation

Evaluations should include reviewing and planning of action of the following issues):

4.1 Disease acceptance and psychosocial adaptation by patient and of the family

4.2 Patient's and family's response to treatment and education

4.3 Accomplishment of self-care behaviors and life-style modification
4.4 Barriers to successful diabetes management
4.5 Risk factors and metabolic control by age
4.6 Physical development and well-being on growth and pubertal development
4.7 Rate of acute complications
4.8 Prevention of microvascular and cardiovascular complications
4.9 Symptoms control
4.10 Goal achievement of diabetes care
4.11 Planning of next follow up action

5. Documentation

Provision of nursing interventions and education should be documented in the patient record:

5.1 All components of diabetes self-management education (DSME)
5.2 Adjustment of medications (if any)
5.3 Plan of follow up action

Reference

1. AADE Position Statement (2008). AADE7™ Self-care behaviors. *Diabetes Educator*, 34(3): 445-449

2. Geldard, K & Geldard, D (2008). *Counselling children. A practical introduction (3rd Ed).* London: Sage Publication

3. HA Clinical Practice Guideline (2008). *Management of type 2 diabetes*

4. Hanas, R. (2004). *Type 1 diabetes in children, adolescents and young adults: How to become an expert on your own diabetes (2nd Ed).* London: Class Publication.

5. Silverstein, J. et al. (2005). Care of children and adolescents with type 1 diabetes: A statement of American Diabetes Association. *Diabetes Care, 28*(1): 186-212.

Diabetes Nurse Clinic Intervention Guideline (3):

Management of Diabetes in Pregnancy

This is written to facilitate Diabetes Nurses to give individualized care for women who are pregnant with pre-existing diabetes. It also serves as a guide for managing women who develop Gestational Diabetes Mellitus (GDM).

1. Assessment

Assessments of patients should include physical, psychosocial and educational aspects:

1.1 Physical

- Background information: age, educational level, occupation, type of pre-existing diabetes, duration of disease, family history of diabetes mellitus or history of GDM, smoking and drinking habit
- Other significant medical conditions, concurrent medical treatment and medications
- Obstetrical history: previous unexplained stillbirth, neonatal death or second trimester abortion; previous macrosomic baby (BW ≥4kg); previous history of GDM
- Physical parameters: blood pressure (BP), weight and body mass index (BMI) (before pregnancy)
- Bio-chemical parameters: HbA1c/Fructosamine, CBP, FBS, lipid profile, R/LFT, urine tests for protein and ketone
- Ultrasonography: assessment for fetal growth

Addition for women with pre-existing diabetes

- Any existing micro-or macro-vascular complications
- Fundi examination, to rule out the risk of development or progression of diabetic retinopathy

1.2 Psychosocial

- Perceived impact of diabetes on daily living and maternal/ fetal health concern
- Specific concerns on diabetic complications related to maternal/fetal health
- Social support: family, financial and/ or occupational supports

1.3 Educational

- Knowledge of diabetes & pregnancy, complications, treatment plan and treatment goals[1]
- Self management skills: meal planning, physical activities, self-monitoring of blood glucose and urine ketone level, insulin injection technique (if applicable), management of hypoglycemia (if on insulin therapy) and hyperglycemia

2. Planning

Planning should be based on the interpretation of the data from the above assessments, to identify goals and prioritize interventions:

2.1 Therapeutic: to determine i) metabolic control targets[1]; ii) treatment modification and/or initiation of therapy; and iii) weight gain according to maternity data

2.2 Educational: to tailor the level of knowledge to be delivered to facilitate patient's self-management throughout pregnancy and post-delivery period according to the mother's attributes

2.3 Counseling: to identify the effective mode(s) of intervention to help patient coping with the critical period

2.4 To determine any need of referral to other specialists

3. Intervention

Nursing interventions should include:

3.1 Patient education in self-management of diabetes during pregnancy

- Diagnostic criteria of gestational diabetes
- Risks to mother and baby with suboptimal glycemic control
- Management plan, including obstetric status and diabetes control
- Need for intensive monitoring on weight gain, blood pressure, glycemic control and fetal growth
- Dietary advice, including nutritional therapy in management of glycemic control and nourishment for mother and baby
- Strategies for initiation and titration of insulin
- Self-monitoring: pre and post meals blood glucose monitoring and fasting blood/ urine for ketone
- Use of insulin injection device and education on self-injection technique (if applicable)
- The need for frequent contact with diabetes healthcare team
- Management of labour for women with gestational diabetes or pre-existing diabetes

3.2 Patient education in self-management of diabetes after delivery and postnatal care

- Breastfeeding and the use of insulin throughout lactation period (for women with pre-existing diabetes)
- Treatment target after delivery
- Post-partum follow-up
- For women with GDM: A 2-hr 75g OGTT should be checked at 6 weeks to rule out any persisting diabetes
- Family planning/ contraceptive issues

3.3 Behavioral changes, goal setting and prescription of self-care tasks

3.4 Treatment:

- Discontinuation of oral anti-diabetic drugs (OAD) for those women with pre-existing diabetes and initiation of insulin therapy (if indicated)
- Adjustment of insulin (if applicable)
- Consulting endocrinologist/ diabetes specialist for resuming or titration of medication as pre-pregnant state for women with pre-existing diabetic after delivery
- Reviewing meal plan after delivery

3.5 Monitoring: blood pressure, blood glucose level, urine tests for protein and ketone, weight gain, fetal growth and ophthalmology examination

3.6 Counseling throughout the pregnancy to console psychological burdens. After delivery, counseling for prevention of type 2 diabetes for those with GDM is also important

3.7 Symptoms management: morning sickness, hypoglycemia (if on insulin therapy)

3.8 Referral to specialists if necessary

3.9 Provide support between visits via telephone contact or e-contact for monitoring, ad hoc problem shooting or enquiry, such as reporting blood glucose readings and insulin dosage adjustment

4. Evaluation

Evaluation should include reviewing and planning of action:

4.1 Maternal progress (glycemic control, fetal growth, weight gain) and prevention of diabetic complications throughout pregnancy

4.2 Patient's response to treatment and education

4.2 Accomplishment of self-care behaviors and life-style modification during pregnancy

4.4 Knowledge of family planning and early detection of GDM for the next pregnancy

4.5 Knowledge of prevention and early detection of type 2 diabetes for women with GDM

4.6 Resume or titrate pre-pregnant medication for women with pre-existing diabetes

4.7 Planning of the next follow-up action

5. Documentation

Provision of nursing interventions and education should be documented in the patient record:

5.1 All components of diabetes self-management education (DSME)

5.2 Adjustment of medications (if any)

5.3 Plan of follow-up action and referral

Reference

1. American Diabetes Association (2004). Gestational Diabetes Mellitus (Position Statement). *Diabetes Care, 27* (suppl.1): S88-90.

Diabetes Nurse Clinic Intervention Guideline (4):

Diabetic Chronic Complication Screening

1. Assessment

1.1 Background DM information: type of DM, year of diagnosis, family history, smoking and drinking habits

1.2 Other significant medical history (e.g. CHD, HT, CHF, stroke, dialysis), history of TB or kidney transplant, and any erectile dysfunction

1.3 Current treatment (e.g. anti-diabetic drugs, insulin, anti-hypertensive agents, anti-platelet drugs, lipid lowering agents)

1.4 Physical measurements: BMI, WHR, and BP

1.5 Biochemical tests: blood for HbA1c, fasting glucose, lipids profile, R/LFT/urate, CBP, and urine tests for protein or microalbumin

1.6 Eye examination: visual acuity and fundi examination

1.7 Foot examination: skin changes, foot deformities, neurological examination, vascular assessment, any ulcer/ amputation

1.8 Knowledge of self-care management of diabetes e.g. importance of regular assessment of risk factors and chronic diabetic complications, targets of control, medications, hypoglycemia management and healthy eating

1.9 Self management skills, such as self monitoring of blood glucose level and insulin injection technique, control of body weight, dietary and exercise, management of negative emotions

2. Intervention

Nursing interventions should include:

- Interpretation of screening results and educating patients on the status of their risk factors and complications
- Identification of complications and failure of attainment of treatment goals
- Empowerment of preventive care through reinforcement of healthy life-style, regular assessment of risk factor control and self management
- Referral for subsequent education if needed
- Counseling to encourage individual's active surveillance of chronic complication and living with diabetes
- Referral to other specialists (e.g. podiatrist, ophthalmologist, dietician, etc) if needed

3. Evaluation

Evaluations should include the following items (if patient is capable):

- Patients' understand on the need of the regular screening for risk factors and complications
- Patients' understand on his/ her own risk profile, long term target and ways to maintain a healthy lifestyle and positive health behaviors (e.g. cessation of smoking and weight control)

4. Documentation

Provision of nursing interventions and education should be documented in the patient record:

- Documentation of results using the electronic template for complications screening (DM Info/ metabolic risk assessment module/form) and patient record after the assessment is completed

Reference

1. Diabetes Educators Group. Hong Kong Society of Endocrinology, Metabolism and Reproduction (2006). *Diabetic Complication Screening Manual*

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