



International Diabetes Federation

International Standards for Diabetes Education

developed by the Consultative Section on Diabetes Education

The mission of the International Diabetes Federation is to work with our member associations to enhance the lives of people with diabetes.



Foreword

This document represents a revision to the *International Consensus Standards of Practice for Diabetes Education* published in 1997 by the IDF Consultative Section on Diabetes Education. This revision has been based not only on other published standards but also on comments and feedback from diabetes educators working in various settings in many parts of the world. Every attempt has been made to set standards that are seen to be reasonable and achievable not only to those in developed countries, but perhaps more importantly to those who are in the process of building diabetes education programmes in less developed countries. As the incidence of diabetes increases worldwide, we must look for new ways to provide education. Diabetes education will be provided by health care professionals and non professionals. These Standards provide a basis on which to develop programmes. It is not expected that all diabetes services will meet all Standards, but that all services will be in the process of working towards meeting all the Standards. The process of diabetes education is dynamic and this document will be revised again in several years. Your comments on these Standards and how useful they have or have not been would be much appreciated.

Anne Belton, *Editor-in-Chief*

Member, International Diabetes Federation Consultative Section on Diabetes Education

As the growing epidemic of diabetes impacts globally, the requirement for people with diabetes to become more and more involved in self-management will be paramount. This can only be achieved by high standards of therapeutic patient education delivered by skilled practitioners. Serving as a basis for the development of quality diabetes education services this document will guide the health care provider in such areas as leadership, communication, documentation, the need for ongoing professional education, physical requirements to be able to provide services, evaluation and research. The standards outlined in this document are comprehensive and will serve as benchmarks against which the quality of the care delivered by organizations and individual diabetes educators can be evaluated.

I am delighted with this revision of the document International Standards for Diabetes Education and believe it will prove to be a very valuable tool to assist health care providers worldwide in establishing, evaluating and improving their diabetes education services. In particular, I would like to thank sincerely Ms Anne Belton for her wisdom and hard work as Editor-in-Chief. I also extend my appreciation to the eclectic mix of health professionals from around the world who commented on drafts enabling this document to be truly international.

Marg McGill

Chair, International Diabetes Federation Consultative Section on Diabetes Education



International Standards for Diabetes Education

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Introduction

The IDF Consultative Section on Diabetes Education (DECS) became a recognised section of the International Diabetes Federation (IDF) in Kobe, Japan, during the Fifteenth IDF Congress in 1994. The formation of a section devoted to diabetes education recognised the integral part that education has in the management of people with diabetes and the increasing emphasis placed on education by the IDF management.

The major objective of DECS is to improve the knowledge of health professionals, policy-makers and the community, in order to improve the management and education of people with diabetes. Improvements in these areas will lead to better health outcomes for people with diabetes.

Living with diabetes is not easy. The young person with type 1, whose life depends on daily injections of insulin, has to balance hypoglycaemia, with its unpleasant and sometimes dangerous consequences, and hyperglycaemia, and has to live with the threat of acute and chronic complications. For the person with type 2 diabetes, the diagnosis of diabetes often necessitates major changes in lifestyle and established life-long habits, as well as accepting that chronic complications may already be present at diagnosis, or a threat in the future.

Educating people with diabetes is an active process through which people come to learn about diabetes for their own survival and life quality. Active learning processes are facilitated by: using problem-based experiential learning processes; interactive educational methods and group teaching which emphasize the practical aspects and allow skills to be practiced; and being concrete rather than abstract.



Diabetes is a chronic, lifestyle disease. The aim of the learning process is to empower people with diabetes to make effective self-management decisions and use the health care system as a resource when necessary. Because active learning is preferred to passive teaching, it is useful in all learning situations for the trainee to define their major needs before the education process is started. The 'golden moment' of education is when the person with diabetes anticipates a problem regarding self-care and takes action by contacting their advisor, and discussing the problem so that together they can find a solution that works.

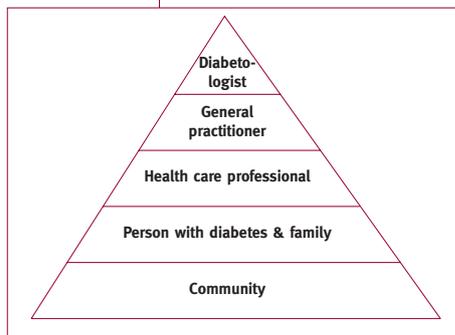
Setting the Standard

In 1998, Mrs Maria de Alva, then President of the IDF, stated: *It would be helpful, especially for Diabetes Associations working in developing countries, to have the IDF create and promote throughout the world one set of standards for medical care delivery for people with diabetes.*

The DECS has taken up Mrs de Alva's challenge by developing consensus standards for the diabetes education component of care. These standards were initially published in 1997. This document presents a revised and updated version of the 1997 standards.

As the incidence of diabetes increases around the world, it is recognised that models of diabetes health care delivery will have to be innovative in the services offered. There are simply not enough health care professionals to care for the increasing numbers of people with diabetes. These standards recognise that in many areas diabetes education will be offered by lay educators, and that the role of the health care provider may be to train these people.

It is recognised that the community will need to be trained to provide diabetes education to the masses of the population expected to develop diabetes in the near future. Only people with the more complicated conditions or co-morbidities will be able to see the health care professionals. It will be imperative that the health care professionals adequately prepare members of the community to take on the role of education and teaching self-management to those newly diagnosed.



Diabetes services provided in these circumstances may wish to use only parts of this document as they may be providing partial services. It is expected that few services will meet all the standards, but that all services will use the standards to strive towards the best possible outcomes for people with diabetes, within the context of their resources, culture and capabilities.

The practice of diabetes education has components of clinical care, education, health promotion, counselling, management/administration and research. Diabetes education does not exist on its own but is integrated into the total diabetes management plan.



The overall expected outcome of diabetes education is to:

- increase knowledge
- build skills
- develop attitudes that lead to improvements in metabolic status and quality of life
- reduce or prevent of complications
- facilitate responsible, decision-making and self-care for people with diabetes.

Primary objective

To facilitate the integration of high quality therapeutic education into diabetes care.

Goals

- To increase community awareness of diabetes, in order to reduce discrimination and inequalities;
- To reduce the socio-economic burden of diabetes at individual and societal levels;
- To provide a structure or framework to establish or further develop diabetes services;
- To develop knowledge and skills that enable people with diabetes to make appropriate choices to maintain or improve health.

Method of revision

The 1997 standards were revised through a consensus process. Wherever possible the standards are evidence based. However in many areas research is still required to provide the evidence.

Review of International Standards documents

Standards known to be in circulation were reviewed and compared. These included:

- American Diabetes Association – National Standards for Diabetes Self-Management Education, 1995
- Australian Diabetes Educators Association National Standards for Diabetes Education Programmes
- Canadian Diabetes Association – Standards for Diabetes Education in Canada, 2000
- Declaration of the Americas (DOTA) – Standards and Norms for Diabetes Education Programs for People with Diabetes in the Americas
- Finland – Development Programme for the Prevention and Care of Diabetes in Finland, 2000-2010
- Hong Kong – Guidelines for Specialty Nursing Service, 2001
- United Kingdom – National Service Framework for Diabetes: Standards. Department of Health, 2001.



Focus groups

A preliminary revised version, which represented the known standards, was then discussed by health care providers in focus groups. Countries represented in the focus groups were:

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| <ul style="list-style-type: none"> • Anguilla • Antigua • Argentina • Australia • Bahamas • Barbados • Belize • Bermuda • Canada • Denmark • Dominica • Guyana • India • Indonesia | <ul style="list-style-type: none"> • Jamaica • Korea • Malaysia • Philippines • Singapore • St. Lucia • Switzerland • Taiwan • Thailand • Trinidad & Tobago • Turkey • United Kingdom • United States |
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Input from the focus groups was integrated and reviewed by the Diabetes Education Consultative Section of IDF.

Standards

The standards contained in this document reflect the mission and philosophy of the International Diabetes Federation Consultative Section on Diabetes Education. It is not intended that the International Consensus Standards be adopted to the exclusion of existing standards. Regions that have developed their own standards should continue to use them but may want to integrate parts of the International Consensus Standards.

The standards do not describe a curriculum or the content of diabetes education programmes. Curriculum and content should be relevant to the identified needs of the population served and developed so that the outcome standards can be accomplished.

For more on the Curriculum please see the International Curriculum on Diabetes Health Professional Education available from the IDF Office in Brussels.



Standards serve to:

- assist in planning health services and defining care
- prioritise resource allocation
- lend support to the lobby for the funding and recognition of diabetes education
- protect consumers
- support the rationale for the funding and the recognition of diabetes education as an integral component of diabetes clinical care
- identify the competencies required of those who deliver diabetes education
- provide a benchmark against which the quality of the care delivered by organizations and individual diabetes educators can be evaluated
- provide a basis for the ongoing evaluation and improvement of diabetes services
- provide a basis for accrediting organizations and assist individual diabetes educators to acquire the necessary credentials.

Standards are, of necessity, dynamic and must be subject to regular review.

The standards in this document have been organized as Structure, Process and Outcome.

Structure Standards provide the framework for a diabetes service. They describe the personnel, resources and physical structure that should be in place in order to provide a diabetes education service.

Process Standards describe the process of diabetes education, the steps required in preparing for, implementing and evaluating diabetes education.

Outcome Standards describe the overall objective of diabetes education. If a service has been successful it will be able to measure and meet the stated outcome standards.

The implementation of the International Consensus Standards for Diabetes Education described in this document is the responsibility of the individual countries and diabetes organizations. However diabetes educators must continue to practise within the ethical and professional requirements of their particular profession, specified for the country in which they practise.



Glossary

ADVISORY COMMITTEE – a group that meets regularly to plan, review and advise regarding the operation of the diabetes service.

ADVOCATE – a person who speaks on behalf of another.

CLERICAL STAFF – a non health care professional member of the team who assists with operational functions, eg. receptionist, secretary.

COMMUNITIES – may be large or small, defined by geographic area, culture, age or other characteristics.

COMMUNITY LEADER – a member of the community who is respected and able to reach and influence the policy makers and funding decision-makers.

CONTINUOUS LEARNING – learning that continues throughout life as physiological, social & environmental changes occur.

CURRICULUM – a detailed plan for education.

DIABETES EDUCATION SERVICE – a service that offers an integration of clinical care and education for people with diabetes.

DIABETES SELF-MANAGEMENT – when a person with diabetes has adequate knowledge and skills to make adjustments to their daily management of medication, meal plan, exercise and other factors that impact on blood glucose.

EDUCATORS – a term used to describe anyone who undertakes the education, could be a nurse, dietician, physician, peer, lay educator, or other relevant person.

EMPOWERMENT – a term used to describe the process by which the educator assists the patient develop self-care strategies.

EVALUATION – a process by which the success, impact, outcomes or satisfaction with a set programme is determined.

HEALTHCARE TEAM – the person with diabetes is the core of this team, other members include anyone involved in the care and education of the person with diabetes.



MULTIDISCIPLINARY TEAM – a team made up of people from the different disciplines involved in managing diabetes.

ORGANIZATION – any body that is responsible for providing funding and administration of diabetes services.

OUTCOME – what is expected after the process has been completed.

PRIMARY CARE PHYSICIAN – the family doctor, general practitioner, physician working in the community.

PROCESS – the procedure or method by which something is done.

PROFESSIONAL PRACTICE – practice within the standards and norms of a specific profession.

PROFESSIONAL STANDARDS OF PRACTICE – standards developed by professional bodies to advise on accepted conduct of members of that profession.

RESEARCH – in this document research is used to describe quality assurance, quantitative and qualitative research, the expectation being that the appropriate method is used to address the research question and the method of controlling bias is appropriate to the method.

SPECIALIST PHYSICIAN – a physician with training in a specialty such as ophthalmology, endocrinology, nephropathy.

STAKEHOLDERS – anyone who has an interest in the service, could be the person with diabetes, the people working in the service, the administrator, the funding body or the community.

STRUCTURE – describes the framework and requirements of a programme.

SUPPORT PERSON – anyone who supports the person with diabetes in managing their disease, could be family member or friend.

THERAPEUTIC EDUCATION – education that results in the person being willing and able to self-manage their disease to the best of their ability using the health care professionals as resource. Therapeutic education is an essential part of the clinical care of diabetes and includes consideration of the physical, psychological, cultural and spiritual aspect of diabetes care to ensure a holistic approach is adopted.



Structure Standards

Organizational Support

Standard

S.1. There is documented evidence of organizational/institutional support for education as an integral part of diabetes care.

Indicators

- S.1.a. Diabetes education services are an integral component of the institution's strategic plan for diabetes care.
- S.1.b. Education is clearly part of the mission statement of the diabetes service.
- S.1.c. Education is clearly shown in the organizational structure.
- S.1.d. The goals of diabetes care are evidence-based where possible and are reflected in increased knowledge and application of knowledge by people with diabetes.
- S.1.e. Resource allocation to diabetes education is clearly documented and adequate.
- S.1.f. The practice of diabetes education is recognised as a speciality within each profession.

Co-ordination

Standard

S.2. One person will be identified to be responsible for the organization and administration of the diabetes education service in such a way that the process and outcome standards can be met.

Indicators

- S.2.a. The person responsible for the organization and administration is clearly identified.
- S.2.b. Responsibility for managing personnel and the budget is clearly stated.
- S.2.c. Lines of communication and authority are clearly defined.
- S.2.d. Decisions about human resource allocation are in the best interest of the person with diabetes and professional practice.
- S.2.e. A systematic model of care that addresses the increasing prevalence of diabetes & the need to improve quality and satisfaction of all members of the system is evident.
- S.2.f. A practice setting that supports educators' abilities to provide a quality service that is safe, effective and ethical is evident.
- S.2.g. An appropriate infrastructure of experienced personnel exists, such as health professionals, clerical staff, computer services.
- S.2.h. An environment that integrates continuous professional learning, evaluation and where possible research is evident.



Physical Space and Equipment

Standard

S.3. Physical space and education resources are conducive to learning and based on individual/community needs.

Indicators

S.3.a. Physical space and resources are conducive to learning. This may include:

- opportunity for privacy and confidentiality
- environment adequate for group education programmes and meetings
- comfortable seating, lighting and air quality
- waiting rooms
- toilets
- accessibility for the physically disabled
- literature and audio visual resources as appropriate to the education level and culture of the population.

S.3.b. Communication technology and appropriate equipment to support the multidisciplinary team are available, this must include:

- effective communication system eg. telephone service
- office supplies and equipment
- record keeping system, and may include:
 - access to computers
 - access to facsimile
 - access to internet/E-mail.



Advisory Committee/Board

Standard

S.4. An advisory committee is established to ensure that the views and values of all stakeholders are represented in the ongoing planning and delivery of diabetes education.

Indicators

- S.4.a. The advisory committee membership is reflective of the community and may consist of:
- a community leader
 - a specialist physician
 - a primary care physician
 - a home care or visiting nurse
 - a member of the local diabetes association
 - a person with diabetes
 - a parent of a child with diabetes
 - a nurse from inpatient services in the community hospital
 - diabetes nurse specialist
 - dietician from the diabetes education programme
 - representatives of community services
 - other team members where available.
- S.4.b. Terms of reference are developed to guide the committee processes and delineate its responsibilities.
- S.4.c. The committee annually reviews the diabetes service against the stated goals and outcomes.
- S.4.d. The committee makes recommendations for improvement based on the evaluation of the outcomes and the changing needs of the community.
- S.4.e. The committee meets at least twice a year, minutes are kept and reviewed for progress on action items at each meeting.
- S.4.f. The committee advocates for ongoing support for the diabetes service.
- S.4.g. There is an established link to regional committees where decisions about diabetes services are made, such as government agencies.



The Team/Teamwork

Standard

S.5. Teamwork and communication are evident among those providing diabetes education and management.

Indicators

S.5.a. The core diabetes education team will consist of:

- nurse
- dietician-nutritionist
- physician.

Other team members may include:

- pharmacists
- lay educators
- psychologists
- podiatrists/chiropractors
- health workers

S.5.b. Teamwork is evident through:

- respect for the expertise of all team members
- regular team meetings
- open discussion regarding patient management, decision making, problem solving and setting priorities
- a collaborative approach to the pursuit of common agreed goals and outcomes
- the establishment and maintenance of a clear communication system among members of the team and the person with diabetes

S.5.c. Minutes of team meetings are forwarded to members of the Advisory Committee.

S.5.d. The healthcare team and the person with diabetes together develop goals and a plan for management of diabetes appropriate to the individual's needs.

S.5.e. Staffing permits time for:

- individualised assessments
- educational programmes
- ongoing follow up as required.

S.5.f. Staffing permits timely access to diabetes services according to individual needs and professional judgement.

S.5.g. People with diabetes receive timely referrals to other health care professionals, such as pharmacists, medical specialists, social workers, psychologists, podiatrists/chiropractors, physiotherapist, Aboriginal or ethnic health workers as appropriate.

S.5.h. An effective communication system is implemented to ensure information is shared with all team members to promote the best possible outcome for people with diabetes.

S.5.i. Consistent professional and clinical policies and procedures are known and followed by all members of the team.



Professional Skill/Continuing Education

Standard

S.6.1. Personnel involved in diabetes education have a sound clinical understanding of diabetes, are knowledgeable about teaching and learning skills and diabetes self-management practices.

Indicators

S.6.1.a. Personnel wishing to practice diabetes education will undertake training in teaching skills, counseling skills, behavioural intervention and diabetes management.

S.6.1.b. Training courses for people intending to specialize in diabetes will follow the International Curriculum for Diabetes Health Care Professional Education.

S.6.1.c. Personnel providing diabetes education must be knowledgeable about topics such as:

- risk factors and prevention
- diagnosis
- management across the ages and stages of life
- psychosocial impact of living with diabetes
- screening for complications
- management of acute and chronic complications
- behaviour change and counseling techniques
- teaching principles and methods
- how psychosocial needs and cultural background relate to physical health needs
- alternative or complementary therapies, such as yoga, herbal preparations etc.

S.6.1.d. Personnel caring for children and adolescents have training and expertise specific to the special and changing needs of childhood and adolescence as per the International Society for Paediatric and Adolescent Diabetes clinical guidelines.

S.6.1.e. Educators use research and best practice evidence as a basis for practice.

Standard

S.6.2. The competence and performance of personnel involved in diabetes education is reviewed at least annually.

Indicators

S.6.2.a. Educators receive constructive feedback about their performance/professional practice from assessors, colleagues and people with diabetes.

S.6.2.b. Personnel involved in diabetes education participate actively in ongoing professional development/education related to diabetes education, such as:

- national and international conferences, workshops
- audiotapes, videotapes
- publications, journal clubs
- internet
- self-directed learning
- consultation with a mentor.



Standard

S.6.3. Professional staff in the diabetes service are appointed on a permanent basis, not on a rotational basis.

Indicators

S.6.3.a. There is no evidence of professional staff being removed from the diabetes service to fill vacancies in other areas.

S.6.3.b. Strategies are in place to encourage staff retention.

Curriculum

Standard

S.7. Diabetes education covers topics based on individual assessment and fosters acquisition of knowledge leading to self-management of diabetes.

Indicators

S.7.a. A written curriculum, with criteria for successful learning outcomes, is available. Assessed needs of the individual will determine which content areas are delivered and the degree of detail required. Suggested content areas are:

- Integrating psychosocial adjustment to daily life
- Describing the diabetes disease process and treatment options
- Incorporating culturally sensitive nutritional management
- Incorporating physical activity into lifestyle
- Managing medications (if applicable) for therapeutic effectiveness
- Monitoring blood or urine glucose, urine or blood ketones (when appropriate), and using the results to improve control
- Preventing, detecting, and treating acute complications
- Preventing (through risk reduction behaviour), detecting, and treating chronic complications
- Goal setting to promote health, and problem solving for daily living
- How and where to attain diabetes supplies
- Information about consumer organizations and support groups
- Information about roles of members in the diabetes team and how to contact them.

S.7.b. The curriculum should consist of:

- Information to be covered
- Objectives and outcomes to be achieved
- Outline of how the information will be delivered
- Evaluation strategies.

S.7.c. The content of the curriculum should be adapted to meet the specific cultural needs of the community.



Community

Standard

S.8. Relationships are fostered with available community resources such as diabetes associations, blind society, social services.

Indicators

S.8.a. Representatives of community services/resources sit on the Advisory Committee.

S.8.b. People with diabetes are referred to community services/resources, as appropriate, from the diabetes education service.



Process Standards

Assessment

Standard

P.1. Diabetes education is based on the ongoing learner-centered needs assessments of individuals and/or communities.

Indicators

P.1.a. Initial and ongoing needs assessments are conducted and documented, recognising the diversity and changing needs of children and adults with diabetes.

P.1.b. The assessment is based on the participation of the individual, support people and the multidisciplinary team.

P.1.c. The assessment process is appropriate to the situation and the individual.

Plan

Standard

P.2. Plans for individual diabetes education and diabetes education programmes are learner-centered and subject to ongoing review and modification.

Indicators

P.2.a. The person with diabetes, their relatives, friends and caregivers and/or the community, work with the multidisciplinary team to develop the education plan. This includes:

- Collaborative goal setting
- A process that is culturally appropriate
- A clear and full explanation of options and choices available to the individual to ensure informed choice
- Acceptance of individual's choice by all members of the team.

P.2.b. The education plan reflects an effective integration of:

- Current principles and practices of diabetes management
- Teaching/learning principles and practices
- Strategies for behaviour modification
- Lifestyle and health beliefs that impact on diabetes care
- Physical, psychosocial, spiritual, cultural and socioeconomic issues related to diabetes care
- Processes for determining the effectiveness/outcomes of the plan.

P.2.c. The education plan includes the identification of resources needed to support living with diabetes.

P.2.d. The education plan is verified with the person with diabetes, the support system and/or the community initially, and on an ongoing basis.



- P.2.e. The plan recognises the diversity of teaching situations, that is, some people may only want or need five minutes, others many hours.
- P.2.f. Cultural and age-appropriate resources are available.
- P.2.g. The plan reflects the need for review and changes to management over the lifespan and duration of diabetes.

Implementation

Standards

- P.3.1. Implementation of diabetes education is learner-centered and facilitates cognitive learning, behaviour change and self-management and is extended to families, caregivers and communities where appropriate.

Indicators

- P.3.1.a. The plan is implemented in a manner that reflects:
 - Relevant principles of teaching and learning
 - Appropriate behaviour change strategies
 - Strategies to enhance problem-solving skills and self-efficacy
 - Appropriate instructional methods and materials with respect to cultural sensitivity, age, language, reading level and special education needs.
- P.3.1.b. Education is a continuous process carried out by the multidisciplinary team.
- P.3.1.c. Education is conducted in an environment that facilitates questioning and learning.
- P.3.1.d. Implementation of the plan is appropriate to the individual, that is:
 - At a time and place easily accessible
 - At an appropriate cost, if any
 - In a non-threatening manner
 - In an open and participatory way.
- P.3.1.e. Small group programmes provided to different groups will be participatory in nature and result in increased self-efficacy in self-management.
- P.3.1.f. All people with diabetes will have the opportunity to individually discuss the management of their disease with members of the core diabetes education team.

Standard

- P.3.2. Education is provided in a professional and ethical manner and is learner-centered and evidence-based where possible.

Indicator

- P.3.2.a. Educator practice is consistent with professional standards of practice (where applicable), current knowledge and research findings.



Access

Standard

P.4. The diabetes education service will be recognised by and accessible to the community.

Indicators

P.4.a. People affected by diabetes in the community know how to access diabetes education.

P.4.b. Once a request or referral for diabetes education has been received, there is a response within a reasonable time. The amount of time that is reasonable will be determined by the Advisory Committee for each community.

P.4.c. Barriers to accessibility should be reviewed and minimized on an ongoing basis by the Advisory Committee. Barriers might include cost, travel, referral process.

Evaluation

Standard

P.5. The effectiveness and quality of education will be annually assessed, linked to outcomes, and the services will be reviewed on the basis of the assessment.

Indicators

P.5.a. Education plans for individuals are evaluated regularly.

P.5.b. Processes/methods are in place for feedback between the person with diabetes and the educators regarding the individual's progress towards achieving of identified learning goals.

P.5.c. The evaluation will take into account:

- Programme objectives
- Curriculum, methods and materials
- Participation of the multidisciplinary team
- Participant access and follow up to the programme
- Programme resources (space, personnel, budget).

P.5.d. Documentation exists on each individual and includes:

- Clinical status
- Assessment
- Education plan
- Intervention
- Evaluation
- Follow up plans
- Referrals made, if necessary.

P.5.e. The results of the evaluation are reviewed by the co-ordinator and the Advisory Committee and action is taken to improve outcomes.



Research

Standard

P.6. Educational and clinical research are undertaken to provide an evidence base for practice.

Indicator

- P.6.a. There is evidence of research activities taking place on an ongoing basis and that results from research are used to improve clinical practice.
- P.6.b. The opportunity to undertake research is open to all team members.
- P.6.c. Published research findings are regularly presented and discussed with team members.

Outcome Standards

Community – primary prevention

Standard

- O.1. Communities are aware of risk factors for the development of diabetes and actions that may delay the onset of diabetes mellitus and its potential complications.

Indicators

- O.1.a. Information regarding factors contributing to diabetes mellitus and its complications is made available to the public.
- O.1.b. People at risk of developing diabetes understand the contributing factors and preventative actions.
- O.1.c. People at risk of diabetes are able to access screening on a yearly basis.
- O.1.d. Communities make an effort to encourage healthy lifestyles by providing opportunities for physical activity and healthy living that are culturally sensitive and age related.
- O.1.e. Education about healthy living and prevention of obesity and diabetes is integrated into school curricula.

Community - support

Standard

- O.2. Communities are aware of the different types of diabetes mellitus and the needs and support available for individuals living with diabetes.

Indicators

- O.2.a. Diabetes education services assist the community to identify ways and promote action to alter social and environmental factors to facilitate healthy living for people with diabetes.
- O.2.b. There is evidence of community support for diabetes education, such as:
- Support groups/networks
 - Publicity about how and where to access diabetes education
 - Obtaining or advocating for resources or financial support for programmes and services.



Knowledge

Standard

- O.3. People with diabetes will understand, depending on their individual capabilities, how diabetes affects their bodies and the significance of maintaining a healthy lifestyle.

Indicators

- O.3.a. The person with diabetes can describe the:
- Factors involved in the development of diabetes
 - Components of treatment appropriate to the type of diabetes
 - Relationship between elevated blood glucose and the development of complications (e.g. heart disease, kidney disease etc).
- O.3.b. Individuals can describe the interrelationship between nutrition, physical activity, stress and medication and healthy living with diabetes.
- O.3.c. The person at high risk of developing diabetes is able to describe lifestyle changes that may delay or prevent the onset of the disease.

Application of knowledge

Standard

- O.4. Individuals with diabetes make informed decisions and take deliberate action towards healthy living with diabetes. These decisions occur in the context of their own spiritual and cultural values, socioeconomic needs and resources and desired quality of life.

Indicators

- O.4.a. Individuals take action to prevent hypoglycaemia and hyperglycaemia.
- O.4.b. The person with diabetes will recognize and treat the acute problems of hypoglycaemia and hyperglycaemia.
- O.4.c. Individuals make lifestyle changes that reduce risks of long term complications, such as stopping smoking, reducing saturated fat intake, increasing physical activity.
- O.4.d. Individuals advocate for early identification of risk factors for diabetes complications and treatment to minimize the impact of complications.
- O.4.e. Individuals demonstrate active problem-solving in their day-to-day lives.
- O.4.f. Diabetes-related absence from school/work is minimized.
- O.4.g. Individuals report or demonstrate increased ability to accomplish goals for healthy living with diabetes that are important or meaningful to them and consistent with their desired quality of life.
- O.4.h. People with diabetes demonstrate early help-seeking behaviour to reduce the need for visits to the emergency department or hospital admissions.
- O.4.i. Individuals know what resources are available to them and how to access the services.
- O.4.j. When necessary a member of the team will act as an advocate for the person with diabetes to help them access health care services.



Clinical outcomes

Standard

O.5. The physical, psychological and emotional health of the individual will be improved.

Indicators

- O.5.a. Regionally appropriate evidence based clinical targets are known by the healthcare team and people with diabetes.
- O.5.b. Health outcomes should be measured against goals determined by the person with diabetes and the health care team, such as:
- Clinical: Body mass index, serum lipid levels, blood/urine glucose, glycosylated haemoglobin, blood pressure, complication status
 - Growth and development in children and adolescents
 - Psychological health, attitudes, quality of life goals
 - Macrovascular risk reduction (weight control, decreased smoking, improved nutritional status, physical activity)
 - Microvascular risk reduction through early identification and prompt treatment if necessary.



Standards of Practice for Diabetes Education

Diabetes Education is a dynamic process and therefore the Standards will need to be revised again in several years. In order to assist with this process, it is appreciated if you would complete the following questionnaire.

1. In which country have you used the Standards?

2. Are you?

- healthcare professional
- non healthcare professional

3. For what purpose did you use these Standards?

4. Are there any Standards or Indicators you do not understand?

5. Are there any other Standards you believe should be included?

6. Are there any Standards you believe should not be in this document? Please indicate why.

Please fax this form to: International Diabetes Federation (IDF) - Avenue Emile de Mot, 19
B-1000 Brussels, Belgium - **Fax: 00 32 2 538 5114**









International Diabetes Federation

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