



UAEU

جامعة الإمارات العربية المتحدة  
United Arab Emirates University

# NATIONAL INSTITUTE FOR HEALTH SPECIALTIES

## NIHS Program Requirements for Specialty Training in Diabetes Nurse Specialist

*The Emirati Board in Diabetes Nurse Specialist is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.*

*Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophical statements are not program requirements and are therefore not citable.*

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## **Introduction**

### **Int. A. Preamble**

The UAE National Strategy for Nursing/Midwifery: A Roadmap 2026 focuses on human capital development highlighting the need to drive excellence in nursing/midwifery practice. One of the initiatives to achieve this is developing and implementing nursing/midwifery specialist programs.

Diabetes Nurse Specialist has been identified as one of the priorities for specialization in nursing in the Nursing Strategy and Model for specialization.

Residency is defined as the stage of postgraduate training and education leading to a qualification of independent practice in a core specialty (NHIS 2020:4). Essentially the purpose of the residency program is to equip nurses and midwives with the knowledge, attitude, and skills essential for specialist practice (Raman et al., 2019).

The clinical competence of nurses' outcomes, and the clinical competence of nurses and midwives is inextricably linked to the foundational knowledge of the specialist area which is continuously strengthened through lifelong learning by practitioners.

The need for the Diabetes Nurse Specialist program is confirmed by the following information:

- Increasing need to produce specialists in Diabetes Nursing (Ahmed et al., 2022; Al-Yateem, et al., 2021)

### **Int. B. Goals**

The Goal of this program is to enhance the quality of care through expanded knowledge and clinical expertise of registered Diabetes nurse specialists.

The program's objectives are to develop and strengthen:

- Develop and strengthen advanced clinical competence in systematic assessment, care provision, and documentation of critically ill adult patients in Specialty units, ensuring safe, evidence-based, and patient-centered practice.
- Apply critical thinking and clinical reasoning using a health systems approach to problem-solving and complex decision-making in intensive care settings.
- Lead quality improvement initiatives by designing, implementing, and evaluating patient safety and care enhancement strategies in Specialty units.
- Model leadership and professional excellence by guiding registered nurses in best practices, fostering teamwork, and enhancing Specialty management and operations.
- Influence Specialty nursing practice through active participation in institutional, national, or international policy development and healthcare reforms.
- Promote continuous learning and professional development by designing and implementing evidence-based teaching strategies for self-improvement and staff education in Specialty settings.

- Assess, plan, implement, and evaluate individualized diabetes care plans based on evidence-based practice and patient-centered approaches.
- Educate patients, families, and communities on diabetes prevention, management, and self-care, including nutrition, physical activity, and medication adherence.
- Monitor and analyze glycemic control, complications, and comorbidities to optimize clinical outcomes for individuals with diabetes.
- Collaborate effectively with multidisciplinary teams, including endocrinologists, dietitians, and pharmacists, to coordinate comprehensive diabetes care.
- Utilize emerging diabetes technologies, including insulin pumps and continuous glucose monitoring systems, to enhance patient management and self-management education.
- Conduct and contribute to diabetes-related research and quality improvement projects to advance clinical practice and policy in diabetes care.
- Advocate for patients with diabetes at institutional, community, and policy levels, promoting access to care, education, and resources.

### **Int. C. Definition of Specialty**

A Diabetes nurse Specialist is a licensed registered nurse (RN) or advanced practice nurse with specialized training, certification, and expertise in the prevention, education, management, and comprehensive care of individuals with diabetes.

They provide comprehensive support to individuals with Type 1, Type 2, and gestational diabetes across the lifespan, which includes:

- Conducting clinical assessments and ongoing monitoring,
- Delivering patient and family education tailored to individual needs,
- Managing insulin therapy and other diabetes-related medications,
- Offering lifestyle counseling to promote healthy behaviors and self-management,
- Coordinating care in collaboration with the interdisciplinary healthcare team,
- Teaching self-monitoring of blood glucose, insulin administration, and the use of diabetes technology such as insulin pumps and continuous glucose monitoring systems,
- Providing structured diabetes self-management education and support (DSMES) programs,
- Guiding patients in carbohydrate counting, nutrition planning, and meal-time insulin adjustment,
- Supporting behavior change strategies to improve adherence and long-term self-care,
- Advocating for patient access to diabetes care resources, medications, and technologies, and
- Contributing to community awareness, prevention programs, and professional education on diabetes management.

## **Int. D. Length of educational program**

The Diabetes Nurse Specialist Residency training program must be at least 24 months in total. <sup>(Core)</sup>

### **I. Oversight**

#### **I.A. Sponsoring Institution**

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate nursing education, consistent with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. <sup>(Core)</sup>

I.A.2. At least one site must be assigned for training to assume responsibility for the Diabetes Nurse Specialist residency program. <sup>(Core)</sup>

I.A.3. A letter of commitment, the need for the program and pledged support must be available. <sup>(Core)</sup>

I.A.4. Timely and effective internal relationships with all program teams and stakeholders must be evidenced by documentation of meetings and protocols for communication. <sup>(Core)</sup>

#### **I.B. Participating Sites**

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. <sup>(Core)</sup>

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. <sup>(Core)</sup>

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; <sup>(Core)</sup>

I.B.2.a)(2) be approved by the designated institutional official (DIO); <sup>(Core)</sup>

I.B.2.a)(3) specify the duration and content of the educational experience; <sup>(Core)</sup>

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; <sup>(Core)</sup>

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; <sup>(Core)</sup>

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. <sup>(Core)</sup>

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. <sup>(Core)</sup>

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. <sup>(Core)</sup>

I.B.4. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. <sup>(Core)</sup>

## **I.C. Resources**

I.C.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education, including lecture rooms, skills labs, recreation, and gender-sensitive amenities. <sup>(Core)</sup>

I.C.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for <sup>(Core)</sup>:

I.C.2.a) access to food while on duty; <sup>(Core)</sup>

I.C.2.b) security and safety measures appropriate to the participating site. <sup>(Core)</sup>

I.C.3. Residents must have ready access to diabetes nursing and other appropriate reference material in print or electronic format. This must include: <sup>(Core)</sup>

I.C.3.a) access to electronic medical literature databases with full text capabilities. <sup>(Core)</sup>

I.C.3.b) access to institutional diabetes nursing resources and other relevant electronic databases. <sup>(Core)</sup>

I.C.3.c) access to current clinical practice guidelines, protocols, and policy manuals; <sup>(Core)</sup>

I.C.3.d) access to simulation-based training tools and e-learning modules for diabetes care and technology. <sup>(Core)</sup>

I.C.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. <sup>(Core)</sup>

I.C.4.a) A sufficient population of patients with a variety of demographic, socioeconomic backgrounds, and disease patterns to allow for effective and comprehensive training experiences. <sup>(Core)</sup>

I.C.4.b) Residents must be provided with software resources, training and technical support for research, scholarly activities and presentations or manuscripts and other written assignments. <sup>(Core)</sup>

I.C.5. The program must provide a positive learning environment in a flexible, compassionate culture promoting teamwork and interdisciplinary and interprofessional learning environment. <sup>(Core)</sup>

#### **I.D. Other Learners and Other Care Providers**

The presence of other learners and other care providers, including, but not limited to, interns, residents from other programs (including medical) must enrich the appointed residents' education. <sup>(Core)</sup>

I.D.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). <sup>(Core)</sup>

## **II. Personnel**

### **II.A. Program Director**

II.A.1. There must be one faculty member appointed as program director for the Diabetes Nurse Specialist program with authority and accountability for the overall program, including compliance with all applicable program requirements. <sup>(Core)</sup>

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. <sup>(Core)</sup>

II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. <sup>(Core)</sup>

II.A.1.c) The Program Director position shall be assumed for a minimum of 3 years to ensure continuity. <sup>(Core)</sup>

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. <sup>(Core)</sup>

II.A.2.a) Additionally, the program director must be provided with:

II.A.2.a)(1) Workspace, equipment and technology, administration support, resources. <sup>(Core)</sup>

II.A.2.a)(2) A stated clear job description defining expectations and accountability and reporting structure. <sup>(Core)</sup>

II.A.2.a)(3) An associate program director to support the management of the residency program. <sup>(Core)</sup>

II.A.2.a)(4) Access to leadership development programs, mentorship, and continuing professional education in residency management. <sup>(Core)</sup>

II.A.3. Qualifications of the program director:

II.A.3.a) must include knowledge and/or experience in adult and/or pediatric learning principles and at least 6 years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; <sup>(Core)</sup>

II.A.3.b) must be licensed as a specialist in diabetes nursing or holder of master's degree in diabetes nursing or be registered nurse with additional postgraduate degree in Diabetes nursing or education. <sup>(Core)</sup>

II.A.3.c) must include appropriate staff appointment; <sup>(Core)</sup>

II.A.3.d) must include ongoing clinical activity. <sup>(Core)</sup>

II.A.3.e) must demonstrate scholarly activity such as publications, conference presentations, or leadership roles in professional societies. <sup>(Core)</sup>

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. <sup>(Core)</sup>

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; <sup>(Core)</sup>

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; <sup>(Core)</sup>

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Competency domains; <sup>(Core)</sup>

II.A.4.a)(4) develop and oversee a process to evaluate preceptors prior to approval as program faculty members for participation in the residency program education and at least annually thereafter; <sup>(Core)</sup>

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the residency program education at all sites; <sup>(Core)</sup>

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; <sup>(Core)</sup>

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; <sup>(Core)</sup>

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); <sup>(Core)</sup>

II.A.4.a)(9) provide a learning and working environment in which residents could raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; <sup>(Core)</sup>

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend, dismiss, not to promote, or not to renew the appointment of a resident; <sup>(Core)</sup>

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; <sup>(Core)</sup>

II.A.4.a)(12) document verification of program completion for all graduating residents; within 30 days; <sup>(Core)</sup>

II.A.4.a)(13) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Program Requirements. <sup>(Core)</sup>

II.A.4.a)(14) ensure implementation of procedures for training faculty and administrative staff and address concerns timely and fairly. <sup>(Core)</sup>

II.A.4.a)(15) Lead continuous quality improvement (CQI) initiatives for the residency program. <sup>(Core)</sup>

II.A.4.a)(16) Ensure alignment of resident training with evolving diabetes care technologies (e.g., insulin pumps, CGMs, digital health). <sup>(Core)</sup>

#### II.A.5. Associate Program Director (APD):

II.A.5.a) The sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities and to provides effective leadership and/or professional consultation to the program in achieving its mission, goals, and expected outcomes. <sup>(Core)</sup>

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration. <sup>(Core)</sup>

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. <sup>(Core)</sup>

### **II.B. Faculty/resident facilitators**

Faculty or resident facilitators provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. By employing a scholarly approach to patient care, faculty members, through the education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

II.B.1. At each participating site, there must be enough faculty members with competence to instruct and supervise all residents at that location.  
(Core)

II.B.1.a) The faculty-to-resident ratio will be maintained at a minimum of 1:4, in accordance with program requirements. Each cohort of four residents will be assigned to four specialized core faculty members through a structured rotational training model. Rather than being supervised by a single faculty member throughout the program, each resident will receive one-to-one supervision from one specialized core faculty member during each rotation period. This rotational model ensures that every resident gains comprehensive exposure to the major specialty areas of diabetes care while benefiting from individualized mentorship and competency-based training.

The four specialized core faculty areas include:

Faculty 1: Adult Diabetes Care

Faculty 2: Antenatal Diabetes Care

Faculty 3: Pediatric Diabetes Care

Faculty 4: Insulin Pump and Diabetes Technology

Each rotation will be conducted over a 3-month period (quarterly rotation schedule). Over the course of the program, each resident will complete rotations across all four specialty areas, ensuring broad clinical exposure and balanced skill development.

At any given time, each core faculty member will directly supervise one resident, maintaining individualized guidance and assessment. Collectively, the four faculty members will supervise a cohort of four residents per rotation cycle, while ensuring high-quality specialty training and competency development.

The rotational structure is illustrated in the table below.

<b>Table of rotation – Clinical placement</b>				
<b>Student</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>
Student 1	Faculty 1	Faculty 2	Faculty 3	Faculty 4
Student 2	Faculty 2	Faculty 3	Faculty 4	Faculty 1
Student 3	Faculty 3	Faculty 4	Faculty 1	Faculty 2
Student 4	Faculty 4	Faculty 1	Faculty 2	Faculty 3

II.B.1.b) Faculty allocation must ensure adequate coverage across all clinical rotations, specialty diabetes services, and community-based care settings. <sup>(Core)</sup>

II.B.1.c) The program must ensure that at least one faculty member at each rotational site has expertise in diabetes technology (e.g., CGM, insulin pumps, digital health platforms). <sup>(Core)</sup>

#### II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; must include knowledge and/or experience in adult and/or pediatric learning principles and at least 5 years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; <sup>(Core)</sup>

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; <sup>(Core)</sup>

II.B.2.c) demonstrate a strong interest in the education of residents; <sup>(Core)</sup>

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; <sup>(Core)</sup>

II.B.2.e) administer and maintain an educational environment conducive to educating residents; <sup>(Core)</sup>

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. <sup>(Core)</sup>

II.B.2.g) At least one member of the faculty should support resident scholarly activities. <sup>(Core)</sup>

II.B.2.h) Provide residents with structured mentorship in evidence-based practice, quality improvement, and ethical decision-making. <sup>(Core)</sup>

II.B.2.i) Actively contribute to program evaluation and continuous quality improvement initiatives. <sup>(Core)</sup>

#### II.B.3. Faculty Qualifications

II.B.3.a) Faculty member must be diabetes nurse specialist or holder of master's degree in diabetes nursing or be registered nurse with additional postgraduate degree in Diabetes nursing or education that are licensed to practice and hold appropriate institutional appointments. must include knowledge and/or experience in adult and/or pediatric learning principles and at

least 5 years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; <sup>(Core)</sup>

II.B.3.b) Administrative staff must have qualifications and experience suitable for their roles. <sup>(Core)</sup>

II.B.3.c) Faculty must be experienced registered nurses with a baccalaureate or graduate degree in nursing who guide and support nurse residents in classroom and clinical settings to achieve the goals of the residency program. This faculty's primary role is to facilitate learning sessions. <sup>(Core)</sup>

II.B.3.d) Faculty should demonstrate engagement in scholarly activities, such as research, publications, or conference presentations. <sup>(Core)</sup>

#### II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. <sup>(Core)</sup>

II.B.4.a) Core faculty members must be designated by the program director. <sup>(Core)</sup>

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. <sup>(Core)</sup>

### II.C. Program Coordinator

II.C.1. There must be a program coordinator. <sup>(Core)</sup>

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. <sup>(Core)</sup>

## III. Resident Appointments

### III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS-accredited program: <sup>(Core)</sup>

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. <sup>(Core)</sup>

III.A.1.b) Registered nurses who have completed a Bachelor of Science in Nursing (BSN) and a recognized transition-to-practice residency program. <sup>(Core)</sup>

III.A.1.c) Registered nurses holding a Bachelor of Science in Nursing (BSN), with at least one year of full-time clinical experience and a current license to practice." (Core)

III.A.1.d) Applicants holding a master's degree in diabetes nursing may qualify through a Recognition of Prior Learning (RPL) pathway, as defined by the sponsoring institution. This requires submission of a Portfolio of Evidence and/or successful completion of a qualifying examination. Applicants must meet institutional equivalency standards and be deemed prepared for final program assessment, including the exit examination. (Core)

### **III.B. Number of Residents**

III.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

## **IV. Educational Program**

The NIHS accreditation system is designed to encourage excellence and innovation in nursing education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful nurses who provide compassionate care.

### **IV.A. Curriculum Components**

The core curriculum must include didactic sessions including ward rounds, clinical meetings, case presentations, hands on training, morbidity and mortality reviews, lectures, journal clubs and evidence reviews, multidisciplinary meetings, seminars, workshops, videos, demonstrations, simulation, standardized patient activities, reflective and interactive activities. (Core)

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.2. There must be structured clinical experience (with the curriculum contributing to the overall goal of the program) incorporating exposure to emergency and acute in-patient care, chronic care, community, and

primary healthcare services, psychogeriatric, clinical psychology and counseling services, substance use services, and family-centered care and pediatric services. <sup>(Core)</sup>

IV.A.2.a) These must include structured rotations in specialized diabetes care units, including endocrinology clinics, insulin pump management, CGM utilization, and diabetes education programs. <sup>(Core)</sup>

IV.A.3. Overall educational goals for the program must exist and be communicated to residents and faculty. <sup>(Core)</sup>

IV.A.4. Competency-based goals and objectives for each educational experience are designed to promote progress on a trajectory to autonomous practice and must be available for assignments at each level. <sup>(Core)</sup>

IV.A.5. Residents must be provided with increasing responsibility in patient care and management, supervision, and administration according to the training stage. <sup>(Core)</sup>

IV.A.6. Residents must be equipped with essential research principles and competencies and residents and faculty must participate in research and scholarly activities. <sup>(Core)</sup>

IV.A.7. The implementation of guidelines on residents' education-service balance must be available consisting of at least 600 hours for knowledge development, 600 hours skills development, and placement in clinical practice for a minimum of 250 hours. <sup>(Core)</sup>

IV.A.7.a) There must be structured clinical experience with the curriculum contributing to the overall goal of the program providing learning opportunities in diabetes clinical care units. <sup>(Core)</sup>

IV.A.8. Diversity of training experiences for residents must be made available through rotations through different services providing diabetes nursing services. <sup>(Core)</sup>

IV.A.9. Residents must be provided with protected time to participate in structured didactic activities. <sup>(Core)</sup>

IV.A.9.a) Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. <sup>(Core)</sup>

IV.A.9.b) Didactic curriculum should integrate emerging diabetes technologies, patient self-management strategies, and psychosocial support approaches. <sup>(Core)</sup>

## **IV.B. Competency for Specialty/Diabetes Nurse Specialist**

### IV.B.1. Entry-to-Practice competencies for Nurse Specialist

**Specialty background:** *This document outlines the expected entry level competencies for Nurses Specialist.*

*This should guide the academic institutions on the outcomes that should be achieved for any Post graduate Nursing specialization.*

*These competencies are the benchmark for the knowledge, skills, and judgements individuals must demonstrate for safe, ethical, and effective Nurses specialist practice.*

#### IV.B.1.a) Patient Care

IV.B.1.a)(1) Patient relationship building and communication

Competent, entry-level nurses use appropriate communication strategies to create a safe and therapeutic environment for patient care. <sup>(Core)</sup>

IV.B.1.a)(1)(a) Clearly articulates the role of the Nurse Specialist when interacting with the patient. <sup>(Core)</sup>

IV.B.1.a)(1)(b) Use developmentally and culturally appropriate communication techniques and tools. <sup>(Core)</sup>

IV.B.1.a)(1)(c) Create a safe environment for effective and trusting patient interaction where privacy and confidentiality are maintained. <sup>(Core)</sup>

IV.B.1.a)(1)(d) Use relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships. <sup>(Core)</sup>

IV.B.1.a)(1)(e) Provide culturally safe care, integrating patients' cultural beliefs and values in all patient interactions. <sup>(Core)</sup>

IV.B.1.a)(1)(f) Identify personal beliefs and values and provide unbiased care. <sup>(Core)</sup>

IV.B.1.a)(1)(g) Recognize moral or ethical dilemmas, and take appropriate action if necessary (e.g., consult with others, involve legal system). <sup>(Core)</sup>

IV.B.1.a)(1)(h) Document relevant aspects of patient care in patient record. <sup>(Core)</sup>

#### IV.B.1.a)(2) Assessment

The competent, entry-level Nurse Specialist integrates an evidence-informed knowledge base with advanced assessment skills to obtain the necessary information to identify patient diagnoses, strengths, and needs.

IV.B.1.a)(2)(a) Establish the reason for the patient encounter: <sup>(Core)</sup>

- Review information relevant to the patient's encounter (e.g., referral information, information from other healthcare providers, triage notes) if available.
- Perform initial observational assessment of the patient's condition.
- Ask pertinent questions to establish the context for patient encounter and chief presenting issue.
- Identify urgent, emergent, and life-threatening situations.
- Establish priorities of patient encounters.

IV.B.1.a)(2)(b) Complete relevant health history appropriate to the patient's presentation: <sup>(Core)</sup>

- Collect health history such as symptoms, history of presenting issue, past medical and mental health history, family health history, pre-natal history, growth and development history, allergies, prescription and OTC medications, and complementary therapies.
- Collect relevant information specific to the patient's psychosocial, behavioral, cultural, ethnic, spiritual, developmental life stage, and social determinants of health.
- Determine the patient's potential risk profile or actual risk behaviors (e.g., alcohol, illicit drugs and/or controlled substances, suicide or self-harm, abuse, or neglect, falls, infections).

- Assess patient's strengths and health promotion, illness prevention, or risk reduction needs.

IV.B.1.a)(2)(c) Perform assessment: <sup>(Core)</sup>

- Based on the patient's presrequired andion and health history, identify level of assessment (focused or comprehensive) required and perform review of relevant systems.
- Select relevant assessment tools and techniques to examine the patient.
- Perform a relevant physical examination based on assessment findings and specific patient characteristics (e.g., age, culture, developmental level, functional ability).
- Assess mental health, cognitive status, and vulnerability using relevant assessment tools.
- Integrate laboratory and diagnostic results with history and physical assessment findings.

IV.B.1.a)(3) Diagnosis

The competent, entry-level Nurse Specialist is engaged in the diagnostic process and develops differential diagnoses through identification, analysis, and interpretation of findings from a variety of sources.

IV.B.1.a)(3)(a) Determine differential diagnoses for acute, chronic, and life-threatening conditions: <sup>(Core)</sup>

- Analyze and interpret multiple sources of data, including results of diagnostic and screening tests, health history, and physical examination.
- Synthesize assessment findings with scientific knowledge, determinants of health, knowledge of normal and abnormal states of health/illness, patient and population level characteristics, epidemiology, health risks.
- Inform the patient of the rationale for ordering diagnostic tests.
- Determine most likely diagnoses based on clinical reasoning and available evidence.
- Assume responsibility for follow-up of test results.
- Confirm most likely diagnoses.

IV.B.1.a)(3)(b) Explain assessment findings and communicate diagnosis to patient: <sup>(Core)</sup>

- Explain results of clinical investigations to patients.
- Communicate diagnosis to patients, including implications for short- and long-term outcomes and prognosis.
- Ascertain patient understanding of information related to findings and diagnoses.

#### IV.B.1.a)(4) Management

The competent entry-level nurse specialist, based on assessment and diagnosis, formulates the most appropriate plan of care for the patient, implementing evidence-informed therapeutic interventions in partnership with the patient to optimize health.

IV.B.1.a)(4)(a) Initiate interventions for the purpose of stabilizing the patient in urgent, emergent, and life-threatening situations (e.g., establish and maintain airway, breathing and circulation, suicidal ideation). <sup>(Core)</sup>

IV.B.1.a)(4)(b) Formulate plan of care based on diagnosis and evidence-informed practice: <sup>(Core)</sup>

- Determine and discuss options for managing the patient's diagnosis, incorporating patient considerations (e.g., socioeconomic factors, geography, developmental stage).
- Select appropriate interventions, synthesizing information including determinants of health, evidence-informed practice, and patient preferences.
- Initiate an appropriate plan of care (e.g. non-pharmacological, pharmacological, diagnostic tests, referral).
- Consider resource implications of therapeutic choices (e.g. cost, availability).

IV.B.1.a)(4)(c) Provide pharmacological interventions, treatment, or therapy: <sup>(Core)</sup>

- Counsel patient on pharmacotherapeutics, including rationale, cost, potential adverse

effects, interactions, contraindications, and precautions as well as reasons to adhere to the prescribed regimen and required monitoring and follow up.

- Establish a plan to monitor patient's responses to medication therapy.
- Apply strategies to reduce risk of harm involving controlled substances, including medication abuse, addiction, and diversion.

IV.B.1.a)(4)(d) Provide non-pharmacological interventions, treatments or therapies: <sup>(Core)</sup>

- Select therapeutic options (including complementary and alternative approaches) as indicated by diagnosis based on determinants of health, evidence-informed practice, and patient preference.
- Counsel patient on therapeutic option(s), including rationale, potential risks and benefits, adverse effects, required after care, and follow-up.
- Order required treatments (e.g., wound care, phlebotomy).
- Discuss and arrange follow-up.

IV.B.1.a)(4)(e) Perform invasive and non-invasive procedures: <sup>(Core)</sup>

- Inform patients about the procedure, including rationale, potential risks and benefits, adverse effects, and anticipated aftercare and follow-up.
- Obtain and document informed consent from the patient.
- Perform procedures using evidence-informed techniques as per regulations and scope of practice.
- Review clinical findings, aftercare and follow-up.

IV.B.1.a)(4)(f) Provide oversight of care across the continuum for patients with complex and/or chronic conditions. <sup>(Core)</sup>

IV.B.1.a)(4)(g) Follow up and provide ongoing management: <sup>(Core)</sup>

- Develop a systematic and timely process for monitoring patient progress.
- Evaluate response to plan of care in collaboration with the patient.
- Revise plan of care based on patient's response and preferences.

#### IV.B.1.a)(5) Collaboration, consultation, and referral

The competent, entry-level Nurse Specialist identifies when collaboration, consultation, and referral are necessary for safe, competent, and comprehensive patient-centered care.

IV.B.1.a)(5)(a) Establish collaborative relationships with healthcare providers and community-based services (e.g., school, police, child protection services, rehabilitation, home care). <sup>(Core)</sup>

IV.B.1.a)(5)(b) Provide recommendations or relevant treatment in response to consultation requests or incoming referrals. <sup>(Core)</sup>

IV.B.1.a)(5)(c) Identify need for consultation and/or referral (e.g., to confirm a diagnosis, to augment a plan of care, to assume care when a patient's health condition is beyond the nurse Specialist's individual competence or legal scope of practice). <sup>(Core)</sup>

IV.B.1.a)(5)(d) Initiate a consultation and/or referral, specifying relevant information (e.g., patient history, assessment findings, diagnosis) and expectations. <sup>(Core)</sup>

IV.B.1.a)(5)(e) Review consultation and/or referral recommendations with the patient and integrate into plan of care as appropriate. <sup>(Core)</sup>

#### IV.B.1.a)(6) Health promotion

The competent, entry-level Nurse Specialist uses evidence and collaborates with community partners and other healthcare providers to optimize the health of individuals, families, communities, and populations.

IV.B.1.a)(6)(a) Identify individual, family, community and/or population strengths and health needs to

collaboratively develop strategies to address issues.  
(Core)

IV.B.1.a)(6)(b) Analyze information from a variety of sources to determine population trends that have health implications. (Core)

IV.B.1.a)(6)(c) Select and implement evidence-informed strategies for health promotion and primary, secondary, and tertiary prevention. (Core)

IV.B.1.a)(6)(d) Evaluate outcomes of selected health promotion strategies and revise the plan accordingly. (Core)

#### IV.B.1.b) Quality improvement and research

The competent, entry-level Nurse Specialist uses evidence-informed practice, seeks to optimize patient care and health service delivery, and participates in research.

IV.B.1.b)(1) Identify, appraise, and apply research, practice guidelines, and current best practice. (Core)

IV.B.1.b)(2) Identify the need for improvements in health service delivery. (Core)

IV.B.1.b)(3) Analyze the implications (e.g., opportunity costs, unintended consequences) for the patient and/or the system of implementing changes in practice. (Core)

IV.B.1.b)(4) Implement planned improvements in healthcare and delivery structures and processes. (Core)

IV.B.1.b)(5) Participate in quality improvement and evaluation of patient care outcomes and health service delivery. (Core)

IV.B.1.b)(6) Identify and manage risks to individuals, families, populations, and the healthcare system to support quality improvement. (Core)

IV.B.1.b)(7) Report adverse events to patients and/or appropriate authorities, in keeping with relevant legislation and organizational policies. (Core)

IV.B.1.b)(8) Analyze factors that contribute to the occurrence of adverse events and near misses and develop strategies to mitigate risks. (Core)

IV.B.1.b)(9) Participate in research. <sup>(Core)</sup>

IV.B.1.b)(10) Contribute to the evaluation of the impact of nurse Specialist practice on patient outcomes and healthcare delivery. <sup>(Core)</sup>

#### IV.B.1.c) Leadership

The competent entry-level nurse specialist demonstrates leadership by using the nurse specialist role to improve patient care and facilitate system.

IV.B.1.c)(1) Promote the benefits of the nurse specialist role in patient care to other healthcare providers and stakeholders (e.g., employers, social and public service sectors, the public, legislators, policymakers). <sup>(Core)</sup>

IV.B.1.c)(2) Implement strategies to integrate and optimize the nurse specialist role within healthcare teams and systems to improve patient care. <sup>(Core)</sup>

IV.B.1.c)(3) Coordinate interprofessional teams in the provision of patient care. <sup>(Core)</sup>

IV.B.1.c)(4) Create opportunities to learn with, from, and about other healthcare providers to optimize patient care. <sup>(Core)</sup>

IV.B.1.c)(5) Contribute to team members' and other healthcare providers' knowledge, clinical skills, and patient care (e.g., by responding to clinical questions, sharing evidence). <sup>(Core)</sup>

IV.B.1.c)(6) Identify gaps and/or opportunities to improve processes and practices, and provide evidence informed recommendations for change. <sup>(Core)</sup>

IV.B.1.c)(7) Utilize theories of and skill in communication, negotiation, conflict resolution, coalition building, and change management. <sup>(Core)</sup>

IV.B.1.c)(8) Identify the need and advocate for policy development to enhance patient care. <sup>(Core)</sup>

IV.B.1.c)(9) Participate in program planning and development to optimize patient care. <sup>(Core)</sup>

#### IV.B.1.d) Education

The competent, entry-level nurse specialist integrates formal and informal education into practice. This includes but is not limited to educating self, patients, the community, and members of the healthcare team.

IV.B.1.d)(1) Patient, community, and healthcare team education

IV.B.1.d)(1)(a) Assess and prioritize learning needs of intended recipients. <sup>(Core)</sup>

IV.B.1.d)(1)(b) Apply relevant, theory-based, and evidence informed content when providing education. <sup>(Core)</sup>

IV.B.1.d)(1)(c) Utilize applicable learning theories, develop education plans, and select appropriate delivery methods, considering available resources (e.g., human, material, financial). <sup>(Core)</sup>

IV.B.1.d)(1)(d) Disseminate knowledge using appropriate delivery methods (e.g., pamphlets, visual aids, presentations, publications). <sup>(Core)</sup>

IV.B.1.d)(1)(e) Recognize the need for and plan outcome measurements (e.g., obtaining patient feedback, conducting pre- and post-surveys). <sup>(Core)</sup>

IV.B.1.d)(2) Continuing competence

IV.B.1.d)(2)(a) Engage in self-reflection to determine continuing education competence needs. <sup>(Core)</sup>

IV.B.1.d)(2)(b) Engage in ongoing professional development. <sup>(Core)</sup>

IV.B.1.d)(2)(c) Seek mentorship opportunities to support one's professional development. <sup>(Core)</sup>

IV.B.2. Diabetes Nurse Specialist Competencies

IV.B.2.a) Professional, Ethical and Legal Practice

IV.B.2.a)(1) Professional Practice

IV.B.2.a)(1)(a) Maintain licensure, certifications (e.g., RN, CDCES), and ongoing professional development. <sup>(Core)</sup>

IV.B.2.a)(1)(b) Adhere to evidence-based practice guidelines (e.g., ADA Standards of Care). <sup>(Core)</sup>

IV.B.2.a)(1)(c) Demonstrate responsibility and accountability in all aspects of diabetes care. <sup>(Core)</sup>

IV.B.2.a)(1)(d) Mentor new nurses and contribute to team knowledge-sharing. <sup>(Core)</sup>

IV.B.2.a)(1)(e) Reflect on personal practice and accept feedback to improve performance. <sup>(Core)</sup>

IV.B.2.a)(1)(f) Participate in professional organizations and advocacy efforts (e.g., ADCES, ADA). <sup>(Core)</sup>

IV.B.2.a)(1)(g) Engage families and caregivers in care planning and education for holistic diabetes management. <sup>(Core)</sup>

IV.B.2.a)(1)(h) Utilize motivational interviewing and behavioral counseling strategies to support lifestyle modification. <sup>(Core)</sup>

IV.B.2.a)(1)(i) Include diabetes-specific assessments (blood glucose trends, HbA1c, insulin regimen, complications)

IV.B.2.a)(1)(j) Include lifestyle counseling for diabetes: nutrition, exercise, and self-monitoring of blood glucose. <sup>(Core)</sup>

IV.B.2.a)(1)(k) Ensure collaboration with dietitians, endocrinologists, pharmacists, and diabetes educators to optimize patient-centered diabetes care. <sup>(Core)</sup>

IV.B.2.a)(1)(l) Implement community-based diabetes education initiatives to raise awareness and promote lifestyle interventions. <sup>(Core)</sup>

IV.B.2.a)(1)(m) Mentor and guide junior nurses and residents in research, quality improvement, and evidence-based practice to enhance program capacity. <sup>(Core)</sup>

IV.B.2.a)(1)(n) Lead initiatives to improve diabetes care outcomes through protocol development, guideline implementation, and interprofessional collaboration

IV.B.2.a)(1)(o) Provide structured diabetes self-management education (DSME) and support for patients, families and caregivers to enhance adherence and glycemic control. <sup>(Core)</sup>

#### IV.B.2.a)(2) Ethical Practice

IV.B.2.a)(2)(a) Uphold patient confidentiality and HIPAA compliance at all times. <sup>(Core)</sup>

IV.B.2.a)(2)(b) Recognize and address ethical dilemmas in diabetes management (e.g., withholding treatment, consent for CGM use). <sup>(Core)</sup>

IV.B.2.a)(2)(c) Advocate for equitable diabetes care regardless of race, income, or insurance status. <sup>(Core)</sup>

IV.B.2.a)(2)(d) Provide non-judgmental care for patients with complications or poor glycemic control or adherence challenges. <sup>(Core)</sup>

IV.B.2.a)(2)(e) Practice informed communication and active listening. <sup>(Core)</sup>

#### IV.B.2.a)(3) Legal Practice

IV.B.2.a)(3)(a) Document care appropriately and accurately within electronic medical records. <sup>(Core)</sup>

IV.B.2.a)(3)(b) Follow institutional policies and national laws related to nursing scope of practice and delegation. <sup>(Core)</sup>

IV.B.2.a)(3)(c) Comply with billing and coding standards for diabetes self-management education and support (DSMES). <sup>(Core)</sup>

IV.B.2.a)(3)(d) Understand legal responsibilities in medication administration, especially with high-alert drugs like insulin. <sup>(Core)</sup>

#### IV.B.2.b) Care Provision and Management

##### IV.B.2.b)(1) Health promotion

IV.B.2.b)(1)(a) Educate patients on lifestyle interventions: nutrition, physical activity, smoking cessation. <sup>(Core)</sup>

IV.B.2.b)(1)(b) Use motivational interviewing techniques to guide behavior change. <sup>(Core)</sup>

IV.B.2.b)(1)(c) Educate patients and families using evidence-based materials. <sup>(Core)</sup>

IV.B.2.b)(1)(d) Use population health strategies to reduce diabetes risk factors (screenings, outreach, education). <sup>(Core)</sup>

IV.B.2.b)(1)(e) Promote self-management skills and education tailored to individual goals, beliefs, and culture in all settings (inpatient, outpatient, community). <sup>(Core)</sup>

IV.B.2.b)(1)(f) Facilitate access to diabetes prevention programs and community resources. <sup>(Core)</sup>

#### IV.B.2.b)(2) Assessment

IV.B.2.b)(2)(a) Conduct comprehensive diabetes assessments: blood glucose trends, A1C, lipids, renal function, foot checks, psychosocial risks and lifestyle factors. <sup>(Core)</sup>

IV.B.2.b)(2)(b) Understand diabetes pathophysiology, diagnosis, progression, and classifications (Type 1, Type 2, gestational, LADA, MODY). <sup>(Core)</sup>

IV.B.2.b)(2)(c) Assess and interpret lab data (A1C, lipid profile, eGFR, urine microalbumin, continuous glucose monitoring data, etc.). <sup>(Core)</sup>

IV.B.2.b)(2)(d) Identify barriers (financial, social, emotional) and help resolve them. <sup>(Core)</sup>

IV.B.2.b)(2)(e) Recognize social determinants of health and their impact on outcomes. <sup>(Core)</sup>

IV.B.2.b)(2)(f) Evaluate readiness to change, health literacy, cultural influences, and social determinants of health. <sup>(Core)</sup>

IV.B.2.b)(2)(g) Use screening tools for depression, distress, or food insecurity where appropriate. <sup>(Core)</sup>

IV.B.2.b)(2)(h) Assess knowledge gaps in self-care (e.g., insulin administration, carb counting hypoglycemia management, and technology use (CGM, insulin pumps)). <sup>(Core)</sup>

#### IV.B.2.b)(3) Planning

IV.B.2.b)(3)(a) Collaboratively develop individualized diabetes care and education plans based on assessments. <sup>(Core)</sup>

IV.B.2.b)(3)(b) Use shared decision-making strategies by setting SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals with the patient. <sup>(Core)</sup>

IV.B.2.b)(3)(c) Include plans for follow-up, technology use (e.g., CGM), and community support. <sup>(Core)</sup>

IV.B.2.b)(3)(d) Coordinate with multidisciplinary team (e.g., dietitians, endocrinologists, social workers). <sup>(Core)</sup>

IV.B.2.b)(3)(d) Apply pharmacological principles: insulin types, oral medications, GLP-1s, etc. <sup>(Core)</sup>

IV.B.2.b)(3)(d) Provide specialized support for pediatric, adolescent, elderly, and pregnant patients. <sup>(Core)</sup>

IV.B.2.b)(3)(d) Integrate current guidelines (e.g., ADA Standards of Care, AACE, ISPAD for pediatrics). <sup>(Core)</sup>

#### IV.B.2.b)(4) Implementation

IV.B.2.b)(4)(a) Deliver structured diabetes self-management education (DSME) using validated curriculums. <sup>(Core)</sup>

IV.B.2.b)(4)(b) Initiate or adjust diabetes technologies (CGM, insulin pumps, smart insulin pens, apps). <sup>(Core)</sup>

IV.B.2.b)(4)(c) Guide insulin self-titration protocols and hypoglycemia prevention strategies. <sup>(Core)</sup>

IV.B.2.b)(4)(d) Support behavior changes using motivational interviewing and shared decision-making. <sup>(Core)</sup>

IV.B.2.b)(4)(e) Adjust care plans based on patient status (renal impairment, pregnancy, pediatrics, elderly). <sup>(Core)</sup>

IV.B.2.b)(4)(f) Collaborate with healthcare providers for medication titration and monitoring. <sup>(Core)</sup>

IV.B.2.b)(4)(g) Coordinate care across providers and settings (hospital to home, outpatient to specialist). <sup>(Core)</sup>

IV.B.2.b)(4)(h) Identify community and organizational resources for patient referral (e.g., DSMES programs, financial aid, nutrition services support groups). <sup>(Core)</sup>

#### IV.B.2.b)(5) Evaluation

IV.B.2.b)(5)(a) Monitor patient progress against individualized goals (e.g., A1C, quality of life, self-management). <sup>(Core)</sup>

IV.B.2.b)(5)(b) Use data to measure outcomes and inform changes. <sup>(Core)</sup>

IV.B.2.b)(5)(c) Address psychosocial aspects of diabetes (stress, depression, stigma). <sup>(Core)</sup>

IV.B.2.b)(5)(d) Evaluate the effectiveness of interventions and revise care plans as needed. <sup>(Core)</sup>

IV.B.2.b)(5)(e) Utilize patient feedback and data (e.g., glucose logs, wearable tech outputs) to inform ongoing care. <sup>(Core)</sup>

IV.B.2.b)(5)(f) Track and report clinical outcomes as part of residency learning objectives. <sup>(Core)</sup>

#### IV.B.2.b)(6) Therapeutic Communication and Relationships

IV.B.2.b)(6)(a) Build trusting relationships using empathy and active listening. <sup>(Core)</sup>

IV.B.2.b)(6)(b) Practice trauma-informed and culturally competent communication strategies. <sup>(Core)</sup>

IV.B.2.b)(6)(c) Use teach-back and plain language techniques to confirm understanding. <sup>(Core)</sup>

IV.B.2.b)(6)(d) Respect patients' values, preferences, and lived experiences in all care discussions. <sup>(Core)</sup>

#### IV.B.2.c) Quality of Practice

#### IV.B.2.c)(1) Quality improvement

IV.B.2.c)(1)(a) Identify clinical practice gaps or system inefficiencies in diabetes care delivery. <sup>(Core)</sup>

IV.B.2.c)(1)(b) Lead or contribute to QI projects (e.g., reducing DKA readmissions, improving CGM use enhancing insulin titration protocols, or reducing hypoglycemia events.). <sup>(Core)</sup>

IV.B.2.c)(1)(c) Use data-driven tools (PDSA cycles, root cause analysis and benchmarking) to design, implement and measure improvements. <sup>(Core)</sup>

IV.B.2.c)(1)(d) Share findings through presentations, poster sessions, internal reports and publications. <sup>(Core)</sup>

#### IV.B.2.c)(2) Continuing Education

IV.B.2.c)(2)(a) Engage in diabetes-specific learning opportunities (webinars, certifications, conferences). <sup>(Core)</sup>

IV.B.2.c)(2)(b) Stay current with diabetes innovations (medications, devices, standards). <sup>(Core)</sup>

IV.B.2.c)(2)(c) Pursue higher-level training or credentials (e.g., CDCES, master's programs, fellowships). <sup>(Core)</sup>

IV.B.2.c)(2)(d) Reflect on learning needs and document a personal development plan annually. <sup>(Core)</sup>

#### IV.B.2.d) Management and Leadership

IV.B.2.d)(1) Coordinate care across settings and disciplines to ensure continuity. <sup>(Core)</sup>

IV.B.2.d)(2) Model leadership behavior in precepting, team meetings, and patient advocacy. <sup>(Core)</sup>

IV.B.2.d)(3) Manage time effectively and prioritize patient needs in high-acuity settings. <sup>(Core)</sup>

IV.B.2.d)(4) Participate in leadership councils or interprofessional committees related to diabetes care. <sup>(Core)</sup>

#### IV.B.2.e) Research

IV.B.2.e)(1) Critically appraise new literature and apply findings to nursing practice. <sup>(Core)</sup>

IV.B.2.e)(2) Translate diabetes research into patient education and care strategies. <sup>(Core)</sup>

IV.B.2.e)(3) Support or lead nursing-led research projects related to diabetes. <sup>(Core)</sup>

IV.B.2.e)(4) Contribute to a culture of inquiry by asking clinical questions and seeking answers through evidence. <sup>(Core)</sup>

### **IV.C. Curriculum Organization and Resident Experiences**

The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. <sup>(Core)</sup>

IV.C.1. Assignment of rotations must be structured with sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. <sup>(Core)</sup>

IV.C.2. Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. <sup>(Core)</sup>

IV.C.3. Educational curricula must include the following key components: <sup>(Core)</sup>

IV.C.3.a) Didactics <sup>(Core)</sup>

IV.C.3.b) Direct patient care (at least ~1,000 hours) <sup>(Core)</sup>

IV.C.3.c) Diverse rotation exposure: <sup>(Core)</sup>

- inpatient management
- obstetrics
- pediatrics
- wound care
- endocrinology or metabolic specialty rotations

IV.C.3.d) Technology training (insulin pumps, CGM) <sup>(Core)</sup>

IV.C.3.e) Scholarly activity (QI/research) <sup>(Core)</sup>

IV.C.3.f) Community engagement. <sup>(Core)</sup>

IV.C.3.g) Simulation Training: structured scenarios for emergencies. <sup>(Core)</sup>

IV.C.4. The structure of weekly resident clinical experiences must blend clinic sessions, didactic sessions, research, and on-call responsibilities. (Core)

IV.C.5. Curriculum elements (didactic and clinical) must be designed and implemented in progressive stages according to educational needs: (Core)

IV.C.5.a) Foundational

Core Focus: pathophysiology, pharmacology, lifestyle interventions, diabetes technologies, psychosocial care, guidelines. (Core)

IV.C.5.b) Clinical Rotations

Core Focus: inpatient/outpatient diabetes care (ensure a mix of populations: T1D, T2D, complications) plus specialty rotations (e.g., wound care, OB, pediatrics). (Core)

IV.C.5.c) Hands-On Skills and Simulation

Core Focus: insulin management, CGM/pump use, DKA/hypoglycemia scenarios, motivational interviewing. (Core)

IV.C.5.d) Professional Development

Core Focus: leadership, communication, evidence-based practice, reflective exercises. (Core)

IV.C.5.e) Scholarly/Quality Improvement Projects

Core Focus: project-based learning, QI, research or evidence-based initiatives, presented internally or externally. (Core)

IV.C.5.f) Community/Interprofessional Engagement

Core Focus: outreach (e.g., camps, screening clinics), and collaboration across care teams. (Core)

IV.C.5.g) Assessment and Feedback

Core Focus: ongoing formative assessments, preceptor feedback, mentorship, plus formal evaluation checkpoints. Use competency-based assessments, self-reflection, and multi-source feedback. (Core)

## **IV.D. Scholarship**

Scholarly activities must include discovery, integration, application, and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities in a group peers and faculty consistent with its mission(s) and aims. <sup>(Core)</sup>

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. <sup>(Core)</sup>

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. <sup>(Core)</sup>

#### IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: <sup>(Core)</sup>

- Research in education, patient care, or population health
- case-presentations
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, or case reports
- Creation of curricula, didactic educational activities, or electronic educational materials
- Contribution to professional committees, or educational organizations
- Innovations in education (e.g., use of simulation, technology integration, digital platforms)

#### IV.D.3. Resident Scholarly Activity

IV.D.3.a) While in the program, residents must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, webinars, or service on professional committees. <sup>(Core)</sup>

IV.D.3.b) Residents must participate in scholarly projects. <sup>(Core)</sup>

IV.D.3.b)(1) Residents must complete a scholarly project relevant to the specialty which was conducted under supervision of a faculty member. <sup>(Core)</sup>

IV.D.3.b)(2) The project shall be presented in a local, national or international specialty conference. <sup>(Core)</sup>

IV.D.3.b)(3) The proof of project presentation in a nursing/medical conference, will be part of the resident's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. <sup>(Core)</sup>

## **V. Evaluation**

Evaluation of residents is central to ensuring progressive development toward independent practice. Programs must use a structured, transparent, and multi-source evaluation system that incorporates both formative and summative assessments, aligned with program goals, professional competencies, and NIHS requirements.

### **V.A. Resident Evaluation**

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work.
- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

A planned, defined and implemented system of resident assessment must be in place with clearly defined methods and identified level of the expected outcomes. <sup>(Core)</sup>

#### **V.A.1. Formative evaluation**

There must be a system of formative documented evaluation of resident's performance at the completion of the rotation and assignments. <sup>(Core)</sup>

V.A.1.a) The formative evaluator must:

V.A.1.a)(1) Assess residents' performance based on the seven professional practice standards namely person-centered care, ethical and legal practice, communication and collaboration, research and evidence-based practice, community and public health, leadership and management, and informatics and technology. <sup>(Core)</sup>

V.A.1.a)(2) Include a review of case volume to ascertain comprehensive coverage. <sup>(Core)</sup>

V.A.1.a)(3) Use formal in-service cognitive exams to monitor knowledge when appropriate. <sup>(Core)</sup>

V.A.1.a)(4) Use multiplicity in resident evaluation (e.g. faculty, self, peer evaluation. online and simulation). <sup>(Core)</sup>

V.A.1.a)(5) Document progressive resident performance improvement. <sup>(Core)</sup>

V.A.1.a)(6) Provide residents with a documented semi-annual evaluation on performance with feedback to guide their learning plans. <sup>(Core)</sup>

#### V.A.2. Summative evaluation

There must be a system of documented summative evaluation of resident performance at the end of the rotation/year/program to verify that the resident demonstrated sufficient competence to enter practice without supervision. <sup>(Core)</sup>

V.A.2.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. <sup>(Core)</sup>

V.A.2.a)(1) More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation. <sup>(Core)</sup>

V.A.2.b) Evaluation must be documented at the completion of the assignment. <sup>(Core)</sup>

V.A.2.c) The program must provide an objective performance evaluation based on the Competencies, and must: <sup>(Core)</sup>

V.A.2.c)(1) use multiple evaluators (e.g., faculty members, peers, self, and other professional staff members) <sup>(Core)</sup>

V.A.2.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive

resident performance and improvement toward unsupervised practice. <sup>(Core)</sup>

V.A.2.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.2.d)(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress <sup>(Core)</sup>

V.A.2.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. <sup>(Detail)</sup>

V.A.2.d)(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; <sup>(Core)</sup>

V.A.2.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. <sup>(Core)</sup>

Residents who are experiencing difficulties with achieving progress may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.2.d)(4) The evaluations of a resident's performance must be accessible for review by the resident. <sup>(Core)</sup>

### V.A.3. Final Evaluation

V.A.3.a) The program director must provide a final documented evaluation for each resident upon completion of the program. <sup>(Core)</sup>

V.A.3.a)(1) The diabetes nurse specialist specific competencies, and when applicable the specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. <sup>(Core)</sup>

V.A.3.a)(2) The final evaluation must:

V.A.3.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; <sup>(Core)</sup>

V.A.3.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; <sup>(Core)</sup>

V.A.3.a)(2)(c) consider recommendations from the Clinical Competency Committee; <sup>(Core)</sup>

V.A.3.a)(2)(d) be shared with the resident upon completion of the program. <sup>(Core)</sup>

V.A.3.a)(3) NIHS will conduct both written and Clinical Exam before issuing the certificate. <sup>(Core)</sup>

V.A.4. A Clinical Competency Committee must be appointed by the program director. <sup>(Core)</sup>

V.A.4.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. <sup>(Core)</sup>

V.A.4.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. <sup>(Core)</sup>

V.A.4.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. <sup>(Core)</sup>

V.A.4.b) The Clinical Competency Committee must:

V.A.4.b)(1) review all residents evaluation at least semi-annually; <sup>(Core)</sup>

V.A.4.b)(2) determine each resident's progress on achievement of the specialty-specific competencies; <sup>(Core)</sup>

V.A.4.b)(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress, promotion, remediation, or dismissal; <sup>(Core)</sup>

V.A.4.b)(4) meet at least quarterly, keep minutes of their meetings and report to the Program Director. <sup>(Core)</sup>

V.A.4.b)(5) Contribute to a fair, transparent, and well-documented process, ensuring due process for residents under remediation or disciplinary review. <sup>(Core)</sup>

## **V.B. Faculty Evaluation**

V.B.1. The program must have a structured, transparent process to evaluate each faculty member's performance as it relates to the educational program at least annually. <sup>(Core)</sup>

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. <sup>(Core)</sup>

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. <sup>(Core)</sup>

V.B.2. Faculty members must receive documented feedback on their evaluations at least annually. <sup>(Core)</sup>

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. <sup>(Core)</sup>

V.B.4. The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. <sup>(Core)</sup>

## **V.C. Program Evaluation and Improvement**

The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. <sup>(Core)</sup>

V.C.1. The performance of residents and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in written form to be discussed with all program faculty and residents as a part of continuous improvement plans. <sup>(Core)</sup>

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least two or more residents from different years. <sup>(Core)</sup>

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; <sup>(Core)</sup>

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; <sup>(Core)</sup>

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; <sup>(Core)</sup>

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. <sup>(Core)</sup>

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; <sup>(Core)</sup>

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); <sup>(Core)</sup>

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; <sup>(Core)</sup>

V.C.1.c)(4) the quality and safety of patient care; <sup>(Core)</sup>

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; <sup>(Core)</sup>

V.C.1.c)(5)(e) scholarly activity; <sup>(Core)</sup>

V.C.1.c)(5)(f) resident and faculty surveys; <sup>(Core)</sup>

V.C.1.c)(5)(g) written evaluations of the program. <sup>(Core)</sup>

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(c) board pass and certification rates; <sup>(Core)</sup>

V.C.1.c)(6)(d) graduates' performance. <sup>(Core)</sup>

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; <sup>(Core)</sup>

V.C.1.c)(7)(b) professional development. <sup>(Core)</sup>

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. <sup>(Core)</sup>

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents; <sup>(Core)</sup>

V.C.1.e)(2) be submitted to the DIO. <sup>(Core)</sup>

V.C.1.d) A process must be in place to incorporate stakeholder perspectives and feedback, ensuring that confidentiality is maintained.

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. <sup>(Core)</sup>

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. <sup>(Core)</sup>

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. <sup>(Core)</sup>

V.C.3. The goal of NIHS-accredited education is to train nurses who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. <sup>(Core)</sup>

V.C.4. Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board to obtain the Board Certification. <sup>(Core)</sup>

## **VI. The Learning and Working Environment**

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in safety and quality of care
- Excellence in safety and quality of care
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment;
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery.
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team.

### **VI.A. Patient Safety, Quality Improvement, Supervision and Accountability**

VI.A.1. Patient Safety and Quality Improvement

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

#### VI.A.1.a) Patient Safety

##### VI.A.1.a)(1) Culture of Safety

VI.A.1.a)(1)(a) The program, its faculty and residents, must actively participate in patient safety systems and contribute to a culture of safety. <sup>(Core)</sup>

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. <sup>(Core)</sup>

VI.A.1.a)(1)(c) Residents must receive orientation and periodic refreshers on institutional patient safety protocols. <sup>(Core)</sup>

##### VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. <sup>(Core)</sup>

##### VI.A.1.a)(3) Patient Safety Events

VI.A.1.a)(3)(a) Residents, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; <sup>(Core)</sup>
- know how to report patient safety events, including near misses, at the clinical site; <sup>(Core)</sup>
- be provided with summary information on their institution's patient safety reports. <sup>(Core)</sup>

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. <sup>(Core)</sup>

##### VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. <sup>(Core)</sup>

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. <sup>(Detail)</sup>

#### VI.A.1.b) Quality Improvement

##### VI.A.1.b)(1) Education in Quality Improvement

VI.A.1.b)(1)(a) A system must be in place for internal quality improvements. <sup>(Core)</sup>

VI.A.1.b)(1)(b) Documentation and reporting systems must be in place, including the production of guidelines, manuals, and reports. <sup>(Core)</sup>

VI.A.1.b)(1)(c) Residents and faculty must be involved in quality improvement processes as part of interprofessional teams. The results must be used to improve the program. <sup>(Core)</sup>

#### VI.A.2. Supervision and Accountability

VI.A.2.a) Supervision in the setting of nursing education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice and establishes a foundation for continued professional growth. <sup>(Core)</sup>

VI.A.2.b) Supervision may be exercised through a variety of methods. Care provided by the residents shall be adequately supervised by the appropriate availability of the supervising faculty member. <sup>(Core)</sup>

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. <sup>(Core)</sup>

VI.A.2.b)(2) The program must define when the physical presence of a supervising nurse is required. <sup>(Core)</sup>

#### VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: <sup>(Core)</sup>

VI.A.2.c)(1) Direct Supervision: the supervisor is physically present with the resident during the key portions of the patient interaction. <sup>(Core)</sup>

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. <sup>(Core)</sup>

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. <sup>(Core)</sup>

VI.A.2.c)(2) Indirect Supervision: the supervisor is not providing physical or concurrent visual or audio supervision but is immediately available to the residents for guidance and is available to provide appropriate direct supervision. <sup>(Core)</sup>

VI.A.2.c)(3) Oversight: the supervisor is available to provide review of procedures/encounters with feedback provided after care is delivered. <sup>(Core)</sup>

VI.A.2.d) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). <sup>(Core)</sup>

VI.A.2.d)(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. <sup>(Outcome)</sup>

VI.A.2.e) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care, authority and responsibility. <sup>(Core)</sup>

## **VI.B. Fatigue Mitigation**

VI.B.1. Programs must:

VI.B.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; <sup>(Core)</sup>

VI.B.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; <sup>(Core)</sup>

VI.B.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. <sup>(Detail)</sup>

VI.B.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. <sup>(Core)</sup>

## **VI.C. Clinical Responsibilities, Teamwork, and Transitions of Care**

### VI.C.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on educational level, patient safety, resident ability, severity, and complexity of patient illness/condition. <sup>(Core)</sup>

### VI.C.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. <sup>(Core)</sup>

### VI.C.3. Transitions of Care

VI.C.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. <sup>(Core)</sup>

VI.C.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. <sup>(Core)</sup>

VI.C.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. <sup>(Outcome)</sup>

VI.C.3.d) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. <sup>(Core)</sup>

## **VI.D. Clinical Experience and Education**

### **VI.D.1. Maximum Hours of Clinical and Educational Work per Week**

Clinical and educational work hours must be limited to no more than 48 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. <sup>(Core)</sup>.

VI.D.1.a) No more than 20% of total program contact hours may be devoted to theory. <sup>(Core)</sup>.

VI.D.1.b) A minimum of 80% of total program contact hours must comprise direct clinical practice or supervised simulation activities that meet clinical learning outcomes. <sup>(Core)</sup>.

### **VI.D.2. Mandatory Time Free of Clinical Work and Education**

VI.D.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. <sup>(Core)</sup>

VI.D.2.b) Residents should have eight hours off between scheduled clinical work and education periods. <sup>(Detail)</sup>

VI.D.2.b)(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 48-hour and the one-day-off-in-seven requirements. <sup>(Detail)</sup>

VI.D.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). <sup>(Core)</sup>

### **VI.D.3. Maximum Clinical Work and Education Period Length**

VI.F.3.a) Clinical and educational work periods for residents must not exceed 12 hours of continuous scheduled clinical assignments. <sup>(Core)</sup>

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education. <sup>(Core)</sup>

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a resident during this time.  
(Core)

#### VI.F.5. Moonlight

Residents are not permitted to moonlight. (Core)

\*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical/nursing educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical/nursing education.

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## **Acknowledgement**

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