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Management of the primary care nursing consultation for the control of patients with type 2 diabetes mellitus

Type 2 diabetes mellitus (T2DM) is one of the main challenges for Primary Care in the 21st century. It is a progressive and chronic disease, closely linked to lifestyle factors, and it requires a comprehensive and continuous approach. Diabetes care is teamwork involving health professionals, the family, and, above all, the person living with diabetes.

ROLE OF NURSING IN PRIMARY CARE

The basic care unit for managing the patient with diabetes is composed of the physician and the nurse. Both must participate in a coordinated manner in achieving goals and organizing activities. However, the Primary Care nurse becomes a key figure in the follow-up of T2DM. Their work is not limited to clinical monitoring, but also includes diabetes education, support in disease self-management, and coordination with the rest of the healthc are team. The nurse provides a personalized approach that integrates each patient's preferences, values, and social circumstances.

The patient with diabetes should clearly perceive the concept of a team, in which each professional has assigned responsibilities to ensure comprehensive care.

CONSULTATION MANAGEMENT

Organizing the nursing consultation allows for structured scheduling of visits and follow-up. In the initial phase after diagnosis, frequent contact is recommended to adjust treatment and reinforce health education. Over time, visit frequency is adapted according to the level of control and clinical situation of each person.

During the consultation, the nurse assesses physical health, lifestyle habits, and emotional well-being. Coordination with family medicine and other specialists ensures an integrated, multidisciplinary approach.

KEY INTERVENTIONS

Primary Care nurses lead several essential interventions:

- Structured and progressive diabetes education.
- Promotion of healthy lifestyle habits: balanced diet, regular physical activity, and smoking cessation.
- Glucose monitoring and control of cardiovascular risk factors.
- Prevention of complications through periodic examinations (diabetic foot, retinopathy, nephropathy).
- Emotional and motivational support, fostering patient autonomy.

Example of the content of a Primary Care nursing consultation

History Taking

- Hypoglycemia (number and circumstances).
- Symptoms of hyperglycemia (polyuria, polydipsia).
- Assessment of medication adverse effects.
- Review of neuropathy signs/symptoms.
- Review of peripheral arterial disease signs/symptoms.
- Foot examination and self-care ability.
- Review of cardiovascular risk factors.
- Assessment of emotional and psychological needs related to diabetes.

Adherence Assessment

- Diet.
- Exercise.
- Pharmacological treatment.
- Foot hygiene and care.
- Therapeutic goals (treatment and education).

Physical Examination

- Weight, body mass index (BMI), waist circumference.
- Foot examination.
- Blood pressure review.
- Insulin injection site assessment.

Evaluation of Outcomes and Self-Monitoring

- Metabolic control: glycated hemoglobin. »

THE PRIMARY CARE NURSE IS THE CENTRAL FIGURE IN SUPPORTING DIABETES SELF-MANAGEMENT

A WELL-ORGANIZED NURSING CONSULTATION IMPROVES PATIENT QUALITY OF LIFE AND OPTIMIZES HEALTHCARE RESOURCES

PHASE OF THE CONSULTATION	KEY NURSING ACTIONS	CLINICAL OBJECTIVE
1. Diagnosis / initiation	– Welcome and targeted history taking. – Initial assessment of lifestyle habits. – Basic educational program.	Establish a therapeutic bond; initiate structured education.
2. Intensive follow-up (first 6–12 months)	– Frequent reviews (monthly/bimonthly). – Monitoring of blood glucose and HbA1c. – Evaluation of adherence and self-monitoring/injection technique. – Educational reinforcement.	Adjust treatment, improve adherence, prevent hypoglycemia.
3. Stable follow-up	– Visits every 3–6 months depending on control. – Evaluation of diabetic foot, BP, weight/BMI, CV risk factors. – Annual screening for complications (retina, nephropathy).	Maintain metabolic control and prevent complications.
4. Evaluation of results	– Review of individual goals. – AGP / CGM report review. – Emotional and motivational assessment.	Promote autonomy and sustainable self-care.
5. Special populations (older/frail adults)	– Comprehensive geriatric assessment. – Adaptation of glycemic goals (less stringent). – Involvement of the main caregiver.	Improve quality of life; avoid hypoglycemia and falls.
6. Annual comprehensive review	– Multidisciplinary comprehensive assessment. – Update of the care plan. – Coordination with family medicine and specialists.	Ensure a safe and comprehensive approach.

TABLE 1. Simplified Algorithm of the Nursing Consultation in T2DM in Primary Care
AGP, *ambulatory glucose profile;* ***CV,*** *cardiovascular;* ***BMI****, body mass index;* ***CGM,*** *continuous glucose monitoring;* ***BP,*** *blood pressure.*

- Frequency and technique of self-monitoring.
- Injection technique.
- Hypoglycemia records.
- Continuous glucose monitoring (CGM) review, AGP report interpretation.

Diabetes Education

- Initial education program.
- Cardiovascular risk factors; smoking, alcohol, etc.
- Nutrition: Mediterranean diet.
- Use of new technologies.
- Annual reinforcement interventions.

USE OF TECHNOLOGY AND DIGITAL SUPPORT

New technologies provide tools that facilitate T2DM monitoring and self-management. CGM systems, mobile apps, and digital coaching allow for closer and more personalized control. The nurse must guide patients in the use of these tools, ensuring they match their needs and capabilities.

CARE OF OLDER AND FRAIL PATIENTS

In older and frail individuals, consultation management must prioritize quality of life and prevention of complications. Comprehensive geriatric assessment, nutritional support, and fall prevention become essential. In this group, therapeutic goals must be individualized and realistic, avoiding interventions that may pose additional risks.

» ✓ ANNUAL CHECK-UP FOR PEOPLE WITH TYPE 2 DIABETES

Medical and nursing visits

- ☐ Review of **treatment plan** (medication, insulin if applicable).
- ☐ Assessment of **hypoglycemia symptoms** and side effects.
- ☐ Measurement of **weight, BMI, and abdominal circumference**.
- ☐ **Blood pressure** control.

Foot care

- ☐ Full **foot** examination (sensation, pulses, skin and nails).
- ☐ Daily **self-care** recommendations.

Eye health

- ☐ Funduscopic exam for **diabetic retinopathy**.
- ☐ Vision and eyeglass review if needed.

Laboratory tests

- ☐ HbA1c: every 3–6 months.
- ☐ Lipid profile (cholesterol and triglycerides).
- ☐ Renal function (creatinine, glomerular filtration rate, microalbuminuria).

Heart and blood vessels

- ☐ Review of cardiovascular risk factors (cholesterol, blood pressure, smoking).
- ☐ ECG if there is heart disease or symptoms.

Well-being and quality of life

- ☐ Questions about mood and memory.
- ☐ Review of physical activity and exercise routines.
- ☐ Dietary counseling tailored to the patient's situation.

Technology and self-care

- ☐ Review of glucose meter or CGM use.
- ☐ Reinforcement of diabetes education.
- ☐ Adjust goals and answer questions about new technologies. D

CONCLUSIONS

- The nursing consultation is a strategic pillar in the management of T2DM.
- Structured, personalized management improves adherence and self-control.
- Diabetes education and motivation are fundamental.
- Technology should be incorporated progressively and appropriately.
- Interprofessional coordination ensures a comprehensive and effective approach.

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