# Two years into the diabetes specialist nurse role: What I know now

Sophie Daltry, Diabetes Specialist Nurse, Portsmouth

My initial spark of interest and intrigue for diabetes occurred when I attended one of the professional education modules on long-term complications associated with poor glycaemic control in both type 1 and type 2 diabetes. I was fascinated how this metabolic disease can have an overwhelming systemic effect on the body. I was impressed by the life-long follow up of such individuals and the vast array of involvement from the multidisciplinary team. From the early monitoring and detection of microvascular changes, such as those carried out by the retinal screening programme, to the screening for renal disease with a progression to dialysis, I was impressed with the great deal of care given to ensuring the best outcome for each individual with diabetes.

Prior to attending this study day, I understood diabetes rather simply; it was a blood glucose level that I would record, insulin that I would administer, or a medication I would give. I had very little understanding of the long-term complications that diabetes can cause or the psychological implication for the person dealing with a life-long diagnosis of diabetes. I was eager to learn more about this complicated condition.

Career wise, I had always thought that I would prefer to venture down the nurse specialist route rather than management on the wards. I was keen not to be tied down by paperwork and enjoyed the patient contact. The most enjoyable and rewarding part of my role on the wards was to feel I had made a difference, even if it was just a feeling that I had made one person's hospital stay a little more bearable and happier. Within my nursing role, I see myself as a caring, compassionate and patient person and with these qualities in mind I sought to progress my career by developing a clinical specialism. And, in April 2013, I was delighted to accept an offer to join the Portsmouth Inpatient Diabetes Team.

Starting a new job can be daunting and this move involved a complete change of role, environment and team. My first month or so I was supernumerary, which meant that I was able to have a structured induction programme, ranging from supervised inpatient visits to observing various clinics and structured education programmes. I was able to gradually gain the experience and knowledge to visit patients independently on the wards, with support from my colleagues at the end of the phone, if required.

As a DSN, I work predominately in the inpatient team, covering a 1000-bed acute hospital. On a day-to-day basis, I have a structured priority list for high risk areas, which I aim to visit daily. These include the Medical Assessment Unit, the Surgical Assessment Unit and vascular wards. I review people that have been admitted for a variety of diabetes reasons, from diabetic ketoacidosis to hypoglycaemia, as well as people admitted when diabetes is not the primary cause. I also review, diagnose and assess people admitted with new and unusual presentations of diabetes. All of these responsibilities mean daily challenges that leave me curious and I often have more questions than answers. Luckily, there is always a helpful colleague to ask. I have been extremely impressed with the wealth of knowledge and experience of the team members around me. Their experience has been invaluable in helping me to develop my consultation and investigatory skills.

## What I have learnt so far

A huge step for me was appreciating that the majority of diabetes care is given in the community; we only see a fragment of their care while in hospital. I have learnt that when I encounter people with diabetes who have been admitted to hospital, it is about engaging the individual and having a shared vision for diabetes care and education. Importantly, I have learnt

*"The DSN team consistently reflects and reviews how it is delivering services required and are constantly looking for ways to improve."*

to ensure that this vision is shared at each visit or communication we have with people with diabetes, throughout every step of their care (Funnell and Anderson, 2004).

Crucially, underpinning every interaction we have with people with diabetes is the idea that I must ensure they are equipped with the necessary skills and empowered to effectively manage the daily decisions for their diabetes and attain goals (Funnell and Anderson, 2004).

Furthermore, in my short time as a DSN, I have seen first-hand how individuals will be more motivated to obtain goals and stick to a structured monitoring plan if it is personalised. I have learnt to recognise at each review if there are any aspects of the individual's life that will affect their ability to self manage and achieve their goal (Leichter, 2005).

As the *National Service Framework* suggests (Department of Health, 2001), it is essential to ensure that those with diabetes are empowered with the necessary information and skills in order to improve their personal control of the everyday management of their diabetes, so that they can have an improved quality of life.

## Challenges

I see myself as a logical thinker and process-driven person. In diabetes care, however, there is not always a clean-cut answer; it is not always black and white and this can sometimes be frustrating. Over the past 2 years, however, I have grown to understand that in order to overcome this you must see beyond the grey to the individual, their needs and priorities for their diabetes.

One of the downsides of my job is that we often see people when they have reached a crisis with their diabetes. It is from a privileged and humble position that we may try to appreciate and understand their situation, and try to offer some advice and education to help improve their control of their diabetes and quality of life. Another challenging aspect of my role is responding to inpatient referrals that are of the "fix and mend" nature. It seems that ward staff often expect us to respond to a long-term problem, such as ongoing hyperglycaemia, and offer an immediate cure. In reality, this is not something we can always achieve. Often, the individual will have been struggling with this problem for some time and often a ward environment is not conducive to such problem solving. In this instance we would often invite the individual to attend the ward follow up clinic. This clinic reviews inpatients who have been recently discharged from hospital with a change made to their diabetes care, or have been admitted due to a complication of their diabetes.

Another key element of my role is in education of health professionals in the inpatient service. During a hospital admission, many people with diabetes report suboptimal experience and knowledge of hospital staff (National Diabetes Support Team, 2008). Indeed, due to the nature of their varied and complex roles, general nurses may lack the in-depth knowledge to be able to fully manage people whose control is unpredictable and more complex in nature (Andalo, 2012). This is an issue that we are attempting to resolve in Portsmouth with the link nurse education study day, which educates generalist nurses about diabetes care from admission to discharge (Herring et al, 2012). This programme aims to educate ward staff in an interactive manner that is relevant to ward areas and encourages ward staff to draw on scenarios from practice in order to improve diabetes inpatient care in a memorable and enjoyable way (Herring et al, 2012).

Looking to the future, I plan to further my career in diabetes nursing. I hope to improve my understanding of the daily challenges for people with diabetes and help individuals to navigate this complex condition. ■

Andalo D (2012) How to get ahead in diabetes specialist nursing. *The Guardian*, London. Available at: http://bit.ly/1l0bC1B (accessed 17.03.15)

Department of Health (2001) *National Service Framework for Diabetes: Standards*. Department of Health, London. Available at: http://bit.ly/19NaieV (accessed 17.03.15)

Funnell MM, Anderson R (2004) Empowerment and self- management of diabetes. *Clin Diabetes* **22**: 123–7

Herring R, Pengilley C, Hopkins H et al (2012) The "Piecing Together Diabetes" educational tool improves healthcare professional knowledge, confidence and quality of inpatient diabetes care. *Diabetes* **61**(Suppl 1): A171

Leichter SB (2005) Making outpatient care of diabetes more efficient: Analyzing noncompliance. *Clin Diabetes* **23**: 187–90

National Diabetes Support Team (2008) *Improving emergency and inpatient care for people with diabetes*. National Diabetes Support Team, Salford. Available at: http://bit.ly/1GhIIlo (accessed 17.03.15)