

# Role of the hospital diabetes specialist nurse: perception vs reality

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## Introduction

The role of the diabetes specialist nurse (DSN) is diverse and open to a number of different interpretations. A definitive description remains elusive, although core elements of the role have been proposed in the RCN Diabetes Nursing Forum Working Party Report (1991). In this paper the authors describe some aspects of the role of the DSN working within a hospital setting and challenge some assumptions made by the Working Party about the responsibilities of the hospital DSN.

Although nurses have been involved in the education of people with diabetes for over 70 years (Joslin, 1924), the number of diabetes specialist nurses (DSNs) appointed in the UK only increased significantly following the introduction of U100 insulin in the early 1980s. These appointments were in response to the resulting volume of individuals with diabetes who required education in its use. Today, there are over 900 DSNs employed in the UK (British Diabetic Association, 1997).

Despite this rapid growth — or maybe because of it — the DSN's role remained undefined until the publication of *The Role of the Diabetes Specialist Nurse* by the RCN Diabetes Nursing Forum Working Party (1991). This document defined a DSN and outlined the core elements of the role. The DSN was defined as:

**'A nurse clinician, with extended knowledge and skills in diabetes management, as an educator, counsellor, manager, researcher, communicator and innovator held responsible for his/her actions.'**

This definition was based on Castledine's (1989) definition of a clinical nurse specialist, with additions specific to the role of the DSN. One of these was that the DSN should be based in the hospital or community, but could visit either depending on the need.

The document went on to outline the responsibilities of the DSN, acknowledging that one of these was to liaise 'with

hospital wards and department nurses, doctors and other staff regarding the care of patients with diabetes'. However, the provision of direct care to inpatients appeared to be excluded, since the intervention in hospital was limited to assessment of diabetes nursing needs, educational status and referral on to the community. This was supported by the document's omission of the hospital setting in its list of potential venues for 'giving advice and information' to those with newly diagnosed or long-standing diabetes.

This limited role of assessment and referral was reinforced by the document's stipulation that advice on insulin doses 'should not be given by the DSN to inpatients because there are many factors to be taken into consideration'. The document advises that any problems identified should be discussed with medical colleagues, even though such decisions will be made by DSNs in the community.

While we accept that patients in hospital have more acute and/or complex medical problems, we would argue that the DSN's contribution in hospital and community are equally valuable and that the hospital DSN's role now extends beyond the assessment of educational needs in hospital.

## Realities of the role of the hospital DSN

In an attempt to describe and evaluate the role of the hospital DSN, we have observed and recorded the interventions of the hospital DSN at The University Hospital

## ARTICLE POINTS

**1** The role of the hospital DSN is not limited to assessment and referral on to the community.

**2** Hospital DSNs do provide direct inpatient care.

**3** Hospital DSNs provide both education and advice on management.

**4** The RCN Working Party report needs to be reviewed and updated in line with current practice.

## KEY WORDS

- Diabetes specialist nurse
- Role definition
- Inpatient care

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**PAGE POINTS**

**1** Referrals to the hospital DSN can be made by any healthcare professional, patient or relative.

**2** All referrals are accepted and each patient is visited.

**3** Over a 1-year period, 772 patients at The University Hospital of Wales were referred to the hospital DSN.

**4** Just over half of the patients referred were existing insulin users.

**5** The majority of referrals were for patient education.

of Wales over a 1-year period. Following this period of observation we have been able to examine some aspects of the role.

The University Hospital of Wales is part of one of the largest trusts in the UK and currently admits approximately 100 adults with diabetes every week (Currie et al, 1996). The hospital DSN takes referrals from all wards that admit adults with diabetes. The children are referred to the paediatric DSN, whose remit covers both hospital and community.

Referrals can be made by any healthcare professional, patient or relative. Some referrals involve the intervention of both the hospital DSN and the diabetologist, but many patients are referred for hospital DSN intervention alone. All referrals are accepted and the individual is visited. A total of 772 patients were followed up in the hospital setting.

For the purpose of the study, the focus of DSN interventions was divided into education and management advice, which included treatment recommendations; it was recognised that there would be a degree of overlap between categories. The findings are summarised in *Figure 1*.

**Patients referred for DSN intervention**

Patients were grouped into categories with similar diabetes-related needs. The contribution of the diabetologist was also noted in order to demonstrate the extent

to which the hospital DSN works with or separate from the diabetologist.

**Patients with established insulin-treated diabetes (types 1 and 2)**

The largest group of patients (412) referred to the service were existing insulin users. The reasons for referral were primarily education (n=392). Other reasons included specific requests to the hospital DSN alone for advice about treatment and control management (n=20), especially where parental feeding was in place.

The diabetologist saw 52 of the 412 patients in this group. This was unsurprising as diabetes was the primary reason for admission in this group. The 20 individuals referred specifically for advice were referred initially to the hospital DSN alone.

**Patients with established type 2 diabetes**

A total of 155 people with established type 2 diabetes were referred to the service. Of these, 148 were referred primarily for education on various aspects of their care and treatment. These could be general requests for educational updates or specific requests related to the reason for admission, such as help in maintaining independence in blood glucose monitoring during admission for assessment and/or treatment of retinopathy. There were seven specific requests for management advice, e.g. advice about diabetes care perioperatively. Ninety of the 155 patients in this group were seen by a diabetologist.

**Patients with newly diagnosed type 2 diabetes**

One hundred and fifty-one people were diagnosed with type 2 diabetes during their admission to hospital, and were referred to the service. Of these, 115 were referred primarily for education. Each received an individually tailored educational package in the hospital, and those who showed an interest were invited to attend group education sessions after discharge for continuing education.

The remaining 36 were referred by healthcare professionals seeking management advice about the individual's care and treatment. The most common

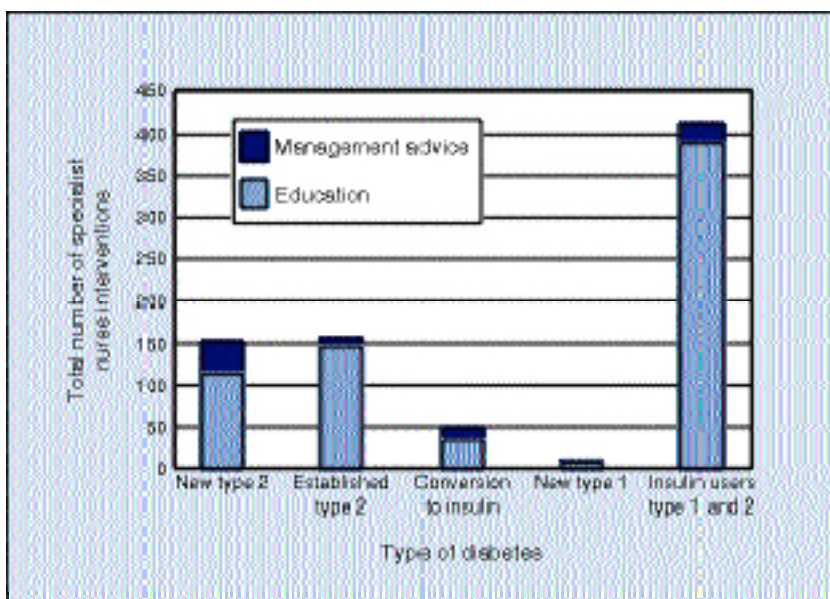


Figure 1. Breakdown of patients referred for specialist nurse interventions.

Publisher's note: This image is not available full resolution in the online version.

request for management advice was whether or not the patient required oral therapy.

Of the 151 patients referred to the hospital DSN, 10 were also seen by a diabetologist; six of these were at the request of the hospital DSN.

### Patients converting to insulin

Over the 1-year period, 47 individuals were referred to the hospital DSN for inpatient conversion to insulin. Thirteen were admitted primarily for conversion to insulin, and the remaining 34 were found to require insulin therapy during their admission.

Patients admitted primarily for conversion tended to be under the care of a diabetologist, who assessed them as unsuitable for conversion in the community as they frequently required other tests/treatment.

In this group, 35 of the referrals were primarily for education, and the remaining 12 were for management advice. Only three of the 34 incidentally converted to insulin were seen by a diabetologist as inpatients.

### Patients with newly diagnosed type I diabetes

Only one individual was referred with newly diagnosed type I diabetes. Six others were referred to the service as being type I, but on assessment were shown to have developed diabetes as a result of surgery and/or through the introduction of new medication. Five of the seven referrals were primarily for education.

The remaining two patients died shortly after surgery, but management advice and support was provided to both healthcare professionals and relatives if requested.

Six of the seven were seen by a diabetologist during their stay in hospital.

### Discussion

The findings indicate a demand for the services of the hospital DSN (772 patient referrals in 1 year). Education is a central part of diabetes care and without knowledge, individuals, for a variety of reasons, cannot make informed choices about their self-care. Empowerment of patients and 'allowing' them to manage aspects of their diabetes in the hospital wards requires the collaboration of all healthcare professionals, and the involvement of general nurses needs to be encouraged.

However, problems with the recruitment and retention of nurses have limited the extent of their involvement — in times of shortage, education is low in the list of priorities. Education needs to be more than information giving: it should be a two-way discussion in protected time, with an individual whom the patient has confidence in. The DSN has both the knowledge and the dedicated time to provide the patient with this education.

The findings also indicate that the DSN's role is not limited to education. Referrals often relate to managerial aspects of diabetes care, and the differing referral patterns suggest that they are different from the managerial advice sought from diabetologists. The hospital DSN is viewed as the individual to involve in practical managerial issues, whereas the diabetologist is viewed as the individual to involve if the managerial advice is of a purely medical nature. This aspect of the role is an important and essential function, as it contributes to the overall care and comfort of the patient during his/her hospital stay.

DSNs hold a unique position within the diabetes team, bridging the gap between medical management and the provision of day-to-day practical, realistic advice.

### Conclusion

The number of hospital DSNs is not known. Our findings suggest that, where they do exist, patients receive direct care and advice in hospital.

It is healthy that roles continue to evolve and change in response to changing healthcare needs. The Working Party document was a much-needed attempt to define the role of the DSN and has provided a benchmark for DSNs around the country. Perhaps it is now time to review the document, in the light of changing practice. ■

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### PAGE POINTS

1 Education is a central part of diabetes care, enabling patients to make informed choices about their self-care.

2 When there is a shortage of nurses, education of patients assumes a low priority.

3 General nurses need to become involved in patient education.

4 Referrals often relate to managerial aspects of diabetes care.

5 The hospital DSN is viewed as the person to consult for practical managerial advice.