Don't leave it all to the DSN!

Jill Hill
Retired DSN, Shropshire Community Health NHS Trust, and Co-Chair of TREND-UK

This letter was received in response to Debbie Hick's editorial in our June issue: Hicks D (2016) Where have all the DSNs gone? *Journal of Diabetes Nursing* **20**: 198

As a recently retired DSN, I share Debbie Hick's concern in June's editorial about the scarcity of DSNs and who will replace me! However, I think focusing on DSNs is just part of the story and we need to be concerned about all aspects of diabetes nursing.

No matter which pathway a nurse takes in his or her career, he or she will be caring for people with diabetes. We need to be sure that every nurse has the appropriate skills and assessed competence to give the right care, no matter where they work.

The *Integrated Career and Competency Framework for Diabetes Nursing* (TREND-UK, 2015) is a good starting point for identifying the skills required appropriate to the environment and level at which the nurse is working. Usually, the DSN only gets involved when diabetes gets complex. Keeping people well, by ensuring they have regular reviews, ensuring risk factors for complications are identified and acted upon promptly, and supporting self-management by all nurses would have a beneficial impact on the numbers of DSNs required.

Most people with diabetes never see a DSN. Practice nurses deliver the majority of routine diabetes care. We learnt from the "legacy effect" of the UK Prospective Diabetes Study (Holman et al, 2008) that tight glycaemic control in the early years soon after diagnosis of type 2 diabetes has long-term benefits. This critical time is when the person with diabetes is supported by the practice nurse, not a DSN. It is essential, therefore, that the practice nurse is suitably skilled to provide this support, to achieve those long-term benefits. Some practice nurses have very advanced diabetes nursing skills, including insulin initiation and supporting people with type 1 diabetes (a TREND-UK associate, Jane Diggle, is one such example of a highly skilled diabetes nurse).

It is my experience, however, that practice nurses vary in their experience, qualifications and competence and so the routine care given to these patients may vary considerably. Although it is unrealistic for all practice nurses to have advanced skills in diabetes, inconsistency in standards of care, and nurse education and training is unacceptable.

The older person with diabetes often gets their care from community nurses and those working in nursing and care homes. Diabetes in older people is likely to be coupled with other comorbidities such as dementia, advanced cardiovascular disease or conditions requiring steroids making the management of the condition complex (Kirkman et al, 2012). However, the nurses working in these environments are usually generalists with no formal diabetes training and who may indeed struggle to get education opportunities. Yet, these nurses are expected to care for people with very complicated diabetes who are at high risk of unplanned hospital admissions (Anderson, 2014).

Approximately 15% of hospital beds at any given time are occupied by people with diabetes so all nurses, no matter in which area of secondary care they are working, will be caring

for people with the condition. Many sites have poor access to inpatient DSN support, so it is critical that the generalist nurse has good diabetes management knowledge.

Diabetes UK published a position statement outlining concerns about the quality of care for people with diabetes in hospital, based on the findings of the National Diabetes Inpatient Audit (NaDIA; Health & Social Care Information Centre, 2012). In the week that the audit took place, 63 individuals developed diabetic ketoacidosis after being admitted to hospital, 20% of those audited had at least one episode of mild hypoglycaemia and 9% had an episode of severe hypoglycaemia (Diabetes UK, 2014). Although these concerns cannot all be attributed to poor diabetes nursing care, it is still a contributing factor.

So yes, it is a worry that DSN posts are not being filled. However, in an ideal world, every nurse would have a good working knowledge about the management of diabetes. Diabetes training and the assessment of competence should be mandatory and linked to revalidation, because the cost of not doing things properly is proving costly both to the individual and to the NHS. ■

Anderson P (2014) Managing diabetes in nursing and care homes. *Nursing Times* **110**: 20–1

Diabetes UK (2014) *In-patient care for people with diabetes in England*. Diabetes UK, London. Available at: http://bit.ly/299jEp2 (accessed 30.06.16)

Health & Social Care Information Centre (2012) *National Diabetes Inpatient Audit (NaDIA) - 2011*. HSCIC. Available at: http://bit.ly/29fG2PT (accessed 30.06.16)

Holman RR, Paul SK, Bethel MA et al (2008) 10-year follow-up of intensive glucose control in type 2 diabetes. *N Eng J Med* **359**: 1577–89

Kirkman MS, Jones Briscoe V, Clark N et al (2014) Diabetes in older adults. *Diabetes Care* **35**: 2650–64

TREND-UK (2015) *An integrated career and competency framework for diabetes nursing* (4th edition). TREND-UK. Available at: www.trend-uk.org (accessed 30.06.16)