Letters 1

Major issues need to be addressed


Jill Rodgers

At the *Journal of Diabetes Nursing*'s February conference, *Diabetes Nursing: Que Sera Sera?*, I was pleased to see the focus on representation and advancement of diabetes nursing. This focus was maintained through Maggie Watkinson's editorial and readers letters in the last issue of journal. However, there appear to be many major issues that are still not being dealt with by any of the existing diabetes nursing groups.

How would DSNs describe the core elements of their role, and how much variation is there? What should a patient expect when they see a DSN? What do others think the DSN role consists of — outside diabetes, there is very little understanding. Many DSNs have likened their roles to that of a nurse consultant, but do many understand what the differences are?

We currently have very little information about our effectiveness, and tend to count numbers of patients seen as evidence of how 'good' we are. Who is developing quality measures that we can use to assess our practice? Where are the courses helping us to develop the leadership, management and educational skills we need?

Although some progress is being made, I urge the leading diabetes nursing groups to address some of these fundamental issues. Otherwise, the inevitable question will recur — where is the leadership in diabetes nursing?

Jill Rodgers
Diabetes Specialist Nurse
North Hampshire Hospital, Basingstoke

Where is the time for leadership? Take a wider view on nursing issues


Rosemary Walker

In response to the above letter, perhaps the post of 'leader in diabetes nursing' should be full-time and have a job description including the qualities most commonly attributed to leaders — articulated by Sue Cradock (1999) at the first *Journal of Diabetes Nursing* conference, held in February 1999, *Diabetes Specialist Nursing — Where Now?* The post should be based in a well-appointed office with full-time administrative and PR support and of course remunerated to the tune of at least £50000. I strongly suspect that there would be no shortage of strong applicants who would be very effective — there could even be a system of secondment to the post, so that all people capable of undertaking the role could do so.

I say this because, as an extremely hard worker and a leadership candidate herself, Jill knows the challenges such positions bring — and they are all 'on top of the day job'. Add to this apparently simple two-job equation, a busy home, usually a family, a social life and personal, emotional and physical commitments and it's no wonder that some activities which should be undertaken are not! I don't think that there is any shortage of knowledge of what needs to be done. There is an extreme shortage of time to action them — on some days, I don't have time to blow my nose, let alone spend a luxurious hour planning a considerable research project into diabetes specialist nursing activity! The Diabetes Nursing Forum Committee has spent the last month trying to find a suitable date for our next meeting.

Most people are busy with their lives and don't want to take on more work — I've heard it said more than once that 'If I express my opinions publicly, I might have to join a committee and do even more work'. The people who do undertake national activity (in whichever organisation) do so excellently, by and large, and often at great personal expense. It is completely normal for human beings to leave things to other people, to criticise activities rather than compliment them and fail to respond to invitations to consultations (note, extremely poor turnouts at elections and responses to articles in journals). Hence, the present situation where a few people in leadership positions are seen as 'power hungry' or hogging the limelight. I have learnt that it is not possible to do everything that needs to be done, nor be in two places at once. The compromise is to do the best you can in the situation according to your philosophy.

Having said all of the above, to address Jill's point about core elements of the DSN role, consultant nurses, etc. I think we can do a great deal worse than to look at developments in the general healthcare world. For example, consultant nurse posts are being advertised and appointed and even though there are only two in diabetes, there are plenty of

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others for us to find out about. Making a Difference (Department of Health, 1999a) is being implemented and of course will have an impact on diabetes nursing. The Higher Level of Practice Pilot (UKCC, 1999) is, I believe, the way forward for finally defining advanced/specialist practice and I for one am finding it extremely exciting to be involved.

Agenda for Change (Department of Health, 1999b) is likely to have implications for us all and the Government's modernisation programme (Department of Health, 1997, 1998) could offer diabetes care great opportunities. If anyone does not know about the above initiatives, then it's time to look them up!

I think we need to stop thinking that we're a special case in nursing and get on with finding out and meeting the challenges in the wider world of health care — do you agree?

Rosemary Walker
DSN, Romford
Chair, RCN Diabetes Nursing Forum

Cradock S (1999) Conference reflections. *Journal of Diabetes Nursing* **3**(2): 39

Department of Health (1997) *The New NHS: Modern, Dependable.* HMSO, London

Department of Health (1998) *A First Class Service: Quality in the New NHS.* HMSO, London

Department of Health (1999a) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare.* HMSO, London

Department of Health (1999b) *Agenda for Change: Modernising the NHS Pay System.* HMSO, London

UKCC (1999) *A Higher Level of Practice. Report on the Consultation of the UKCC's Proposals for a Revised Regulatory Framework for Post-Registration Clinical Practice.* UKCC, London

Joint strategy would help to resolve long-standing issues


Sara Da Costa

Jill's insightful letter raises a number of issues, many of which have been unresolved for a considerable time. When the majority of DSN posts were created in the 1980s, there was little, if any, consideration of career development, role clarity or definition, or quality of nursing care (Da Costa, 2000). This lack of foresight is also evident with the profusion of clinical nursing posts that were recently developed in response to the reduction in junior doctors' hours (Doyal, 1998). Lack of vision and nursing seem to go hand in hand! However, it is never too late.

Jill identifies issues worthy of action and resolution; however, we must recognise that 20 years of neglect require more than a quick fix. I believe a strategy shared and owned by diabetes nursing organisations is the way forward. This will require communication and planning; prioritisation of projects with realistic objectives and timescales; and skilled management.

DSNs will also be needed to contribute in working parties which would need to be fully funded. Personnel and money are key to the success of any venture and need consideration at the outset. One of the UK Association's objectives is to advance diabetes nursing and we would obviously contribute to resolving the issues.

Sara Da Costa
Chair
UK Association of Diabetes Specialist Nurses

Da Costa (2000) Diabetes nursing: looking to the future, learning from the past. *British Journal of Nursing* **9**(5): 287–90

Doyal L (1998) Crossing professional boundaries. *Nursing Management* **5**(4) 8–10

Response from the editor


Maggie Watkinson

As Jill points out, there are many important issues about diabetes nursing which need to be resolved. It is sad that many of these have been around for a very long time.

However, time is problematic, as identified by both Sara and Rosemary. Perhaps one solution would be to ask those who have carried out work in relation to the issues identified to communicate it to the wider diabetes nursing world (i.e. publish their research!)

In relation to Jill's comment about leadership, management and education courses, it must be remembered that they already exist, albeit not specific to diabetes. We need to access these now to meet our learning needs.

I would hope too, that if the other issues are not already on the agendas of diabetes nursing groups, they soon will be. It occurs to me that a priority component is a collaborative research programme to address questions about the core elements of the role. Any takers?

Maggie Watkinson
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Letters 3

Inactivated flu vaccines *can* be given at the same time as BCG vaccines

Sarah-Louise Wainwright

I write after reading the article 'A simple influenza campaign for young people with diabetes' published in the *Journal of Diabetes Nursing* recently (Thornton, 2000). I refer to the paragraph under 'special considerations', stating that 'the influenza vaccine is an inactivated influenza virus'. The author then proceeds to state in the following paragraph that the 'influenza vaccine cannot be administered at the same time as school Bacillus Calmette-Geurin (BCG) vaccine as a minimum of three weeks should be allowed between the administration of two 'live' vaccines (DoH, 1996).

I would be grateful for the author's comments on these contradictory statements. I accept that 'live' vaccines should either be given at the same time or, as the author states, with a three week gap. I wonder, however, how this relates to inactivated flu virus and why this presents any problem at all with a child receiving a BCG vaccination at any time subsequent to vaccination with inactivated flu vaccine (other than site usage).

Sarah-Louise Wainwright
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Rainbow Medical Centre, St Helens.

Thornton H (2000) A simple influenza campaign for young people with diabetes. *Journal of Diabetes Nursing* **4**(1): 8-11

Policies must be agreed locally with school health services

Helen Thornton

Thank you for looking for clarification regarding administration of influenza vaccine at the same time as school BCG vaccine.

As stated in the article this was an unanticipated problem. At the time of the influenza campaign (1998-99), I contacted infection control and the school health services to ask why there was a problem. Their explanation was that the individual school nurse or doctor in attendance would ask the child if any other immunisations had been administered within the preceding three weeks. If any had and there was any suspicion that it could have been a live vaccine, the BCG would be deferred.

I do appreciate that influenza vaccines are now only available in inactivated form, but they have been available in a live form in the past. The responsibility for deciding whether or not a child may receive the school BCG lies with school health service and not the paediatric diabetes care team and is, therefore, beyond our control.

Within the article 'live' was placed in inverted commas to indicate that it could be open to interpretation, and I apologise for any confusion that this may have caused.

Locally, this issue of dual administration of the vaccines is subject to discussion because there are also practical difficulties surrounding site usage post-vaccination, as insulin should not be administered at the same site as BCG for three months, or until the BCG ulcer has healed.

In conclusion, influenza vaccines may be administered at the same time as school BCG vaccines if agreed locally.

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