

# Diabetes specialist nursing: a vision for the future

Maggie Watkinson

## ARTICLE POINTS

**1** DSNs face many changes over the next decade and it is vital that they begin now to adapt their practice to meet the challenges of the future.

**2** Issues such as the blurring of nursing/medical boundaries, the need to embrace evidence-based practice, and the growing importance of education must be confronted.

**3** Diabetes nurses also need to acquire sound research skills and to use journals more to communicate their findings.

**4** If diabetes nurses do not take it upon themselves to shape their future, others will attempt to do it for them.

## KEY WORDS

- Diabetes specialist nursing
- Future role
- Changes

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## Introduction

**Whatever the future holds for diabetes specialist nursing, one thing that seems reasonably certain is that things will change, and the rate of change will increase. This article explores some of these changes and describes how diabetes specialist nurses (DSNs) could meet the challenges they are likely to face in areas such as education, research and role definition.**

**O**ne of the fundamental changes to diabetes nursing in the future may involve the emphasis on different aspects of DSN roles. Currently patient care is the main focus; other sub-roles, such as the well known ones of educator, change agent, researcher and consultant (RCN, 1988; Storr, 1988) tend to take second place to the more urgent requirement to meet patients' needs.

However, if DSNs continue to practise as at present, they will be ignoring the realities that are looming. By the year 2010 the global population of people with diabetes is predicted to be double the number it is now, albeit with the biggest rise in developing countries (Gruber et al, 1997). Even so, there will be an increase in numbers in the developed world as well — partly as a result of the new diagnostic criteria for diabetes developed by the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus (1997), which may be implemented in the UK.

### DSNs need to change their practice

With this imminent rise, DSNs need to change the way they practise. Many areas of the country do not have the recommended number of diabetes nurses now, and in the financial reality of the NHS it is unlikely that numbers will more than double over the next 12 years!

As well as the increasing prevalence of diabetes there are other transformations in health care which need to be considered. The first, and possibly the most important,



*Do DSNs at present strike the right balance between education and clinical practice?*

results from Government policy. The White Paper, *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997) continues to emphasise the importance of primary and community health care while calling for partnership with the secondary sector, in order to develop integrated care. Diabetes obviously has a good track record in this regard, but those diabetes nurses employed in the secondary sector, in particular, will need to make sure they are not being short sighted, and continue to deepen and strengthen relationships with primary care in the future.

Although quality of care has been always been important, there is an increased emphasis on this in the White Paper and there will be a new statutory duty for quality in trusts. Other initiatives that diabetes nurses will need to get to grips with include: national standards and

guidelines, National Service Frameworks, a National Institute for Clinical Effectiveness, clinical governance to ensure standards are met and a Commission for Health Improvement.

### **Blurring of nursing/medical boundaries**

Another change relevant to diabetes nursing is the blurring of boundaries between nursing and medicine. Nurses are taking on tasks that have traditionally been within the remit of doctors; the obvious example in diabetes is that of insulin prescribing. Nurse practitioner roles, whereby nurses perform physical examinations and history taking as part of their work, are increasing, particularly in general practice and in A&E departments, and there are now diabetes nurse practitioners.

There are, of course, other diabetes nursing roles too, such as facilitators, link nurses, diabetes care nurses and liaison nurses. Although not all of these are specialist nurses, this plethora and diversity of roles within diabetes nursing is to be welcomed and provides the opportunity to meet the needs of local situations.

### **Facing the challenge of evidence-based practice**

Evidence-based practice represents another challenge for diabetes nurses. Practising evidence-based nursing is not just about utilising the research evidence available. In making clinical decisions nurses have to assess the value of the research in the context of the individual patient as well as integrating their clinical expertise, the patient's preferences and an awareness of resource implications (DiCenso et al, 1998).

Nurses are particularly good at focusing on the needs of individual patients but the area which must be addressed urgently is the issue of research. Many diabetes nursing teams are auditing or evaluating the effectiveness of their services in a variety of ways and this seems to be an appropriate place to start developing diabetes nursing research expertise. As yet, however, there is not a huge amount of this evidence in the literature.

### **How to address the issues**

This vision for the future includes a change in the significance of the role of educator. Although direct patient care and expertise in clinical nursing must remain at the core of our being as diabetes nurses, and we need to continue to see people with diabetes who have special problems, the importance of education and training is greater than ever before.

The educator role for some diabetes nurses has to become the most crucial element of their function, and collectively diabetes nurses must spend proportionately much more time in educating their colleagues, to enable them to give a high quality nursing service to all those individuals not requiring specialist input.

This notion is of course not new. The British Diabetic Association (BDA) has identified the need for the provision of effective education and states that this is vital for the delivery of high quality diabetes care (BDA, 1996). With specific reference to nurses, the BDA suggests that the involvement of diabetes care teams in education needs to start from the very beginning of their learning experiences.

Although we do not have the luxury of a whole diabetes module, my own role as a lecturer/practitioner was designed to help meet this need. Our undergraduate students are taught both the theory and practice of diabetes care by 'real life' diabetes nurses; this helps to eliminate the theory/practice gap and seems to stimulate students' interest. Perhaps one measure of the success of this strategy is the number of diabetes-oriented dissertations undertaken by our nursing students — next year 10% of the students plan to investigate some aspect of diabetes.

Pre-registration students are obviously not the only learners who need to be educated by diabetes nurses. There are already many unaccredited practice and community nurse courses, study days for hospital nurses and link nurse schemes as well as a burgeoning number of courses, ENB or otherwise, which attract the increasingly important academic 'brownie' points. These initiatives are all to be welcomed; indeed even more are desirable.

However, in the future, training events

### **PAGE POINTS**

**1** In making clinical decisions nurses have to assess the value of research in the context of the individual patient.

**2** The educator role for some diabetes nurses has to become the most crucial element of their function.

**3** Training events need to be evaluated in the future to discover whether they have changed practice for the better.

**PAGE POINTS**

**1** More diabetes nurses need to acquire sound research skills.

**2** There is also a need for nurses to communicate their research findings more widely, particularly via appropriate journals.

**3** *Diabetes specialist nurse* will become a generic term describing nurses who work wholly in diabetes care but who may have different titles depending on the nature of the job they perform.

must be evaluated. Assessing the amount of knowledge acquired by learners and whether or not they enjoyed the course are important aspects of evaluation, but what is really necessary is to discover whether they have changed their practice for the better as a result. Unless this kind of evaluation is undertaken, evidence that the time spent in education has had the desired effect, and is cost effective, will not be acquired.

As well as educating colleagues, diabetes nurses also need to address their own educational requirements (BDA,1996). In relation to the education role it is proposed that all diabetes nurses with a formal teaching commitment need a formal teaching qualification. The reason for this is that attendance at such a course should help to ensure that individuals have the opportunity to acquire the skills for the job. For example, the BDA's (1996) document on training and development in diabetes care suggests that open learning packages should be developed, and experiential, active learning methods should be used wherever possible in diabetes teaching.

Meeting these demands, producing high quality learning packages, confidently and competently managing workshops, and evaluating the effectiveness of educational strategies requires individuals who have had opportunities to practise and refine these skills in the relative safety of a formal learning environment. Although some of the qualities of good educators are probably inherent in their personalities, they cannot but be improved by having a suitable tool box.

**The need for sound research skills**

Other tools needed by more diabetes nurses include sound research skills. It is not anticipated that diabetes nurses will be doing randomised clinical trials immediately; however, using evaluation methodologies, for example, as a starting point, will help judge not only the effectiveness of teaching, but also help to assess the effectiveness of our interactions with patients. As with teaching skills this will necessitate further education.

It is also necessary to communicate

the results more widely, for example in symposia, and on a broader scale via journals — diabetes nurses need to become prolific authors. It can only be beneficial for nurses to share the trials, tribulations and learning that are experienced in order to provide mutual support and encouragement to others as well as stimulating new ideas.

The document *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997) gives diabetes nurses many opportunities. The Government has acknowledged the value of nurses and seems to appreciate the development in nursing roles. For example, it is noted that

**'...expert nurses are taking on a leadership role, mentoring and educating nurses and other staff, managing care, developing nurse led clinics and district wide services.'** (p46)

It also appears to have noticed the initiatives that many nurses have already begun in relation to cross-boundary working. These points may almost have been written about DSNs. However, diabetes nurses must not be complacent; their future depends on building on this platform. For example, the innovation and creation with regard to diabetes nursing roles needs to continue. In relation to titles, it is envisaged that in time the designation *diabetes specialist nurse* will become a generic term which broadly describes a group of nurses, each of whom works wholly in diabetes care, but who may have different titles depending on the specific nature of the job performed.

Although the first generation of diabetes nurses is on the whole still going strong, it is essential that myopia about succession planning does not occur. Skill mix within each local diabetes nursing team needs to be organised within the limits of financial constraints, to ensure that the most clinically and cost-effective arrangement is achieved and that the necessary specific posts are in place. Each individual nurse then needs to be developed according to their wishes, abilities and the requirements of their role. However, it is essential that senior nurses are not parochial and only consider the immediate needs of their own localities.

### Strong nursing leadership

This vision for the future relies on strong nursing leadership; the leaders of the various diabetes nursing organisations which now exist, working in partnership together, and with the statutory bodies, need to develop a strategic plan to ensure that there are enough diabetes nurses adequately prepared for the future. Training and education are vital for this process of growing new diabetes nurses; with a nationally derived plan this can be delivered in a cohesive and economical fashion as suggested by the BDA (1996).

Some readers may believe this vision is being pictured through rose-coloured spectacles! It is acknowledged that there are difficulties in considering the future when individuals are heavily involved in the maelstrom of everyday practice. Meeting daily targets occasionally seems to be an achievement in itself, let alone needing to consider the future. It is also likely that diabetes nurses will have periods of doubt about their abilities to meet the new challenges ahead, especially considering the thick and fast pace at which these arrive. These are therefore the times when diabetes nurses need to support each other.

Resource issues are also relevant; although the BDA (1996) has called for more resources to meet the needs for increased education, for example, to simply ask for them seldom works. There are no visionary answers for this problem apart from diabetes nurses continuing to endeavour to prove their worth.

### Conclusion

In order for diabetes nurses to make the world a better place for people with

diabetes, they collectively need to keep their eyes open to see what is around them. Having some dreamers in their midst to develop imaginative ideas and insights is necessary; the leaders of diabetes nursing must develop their strategic thinking abilities and evolve into shrewd and proactive planners in order to take control of the future.

If diabetes nurses do not grasp the opportunities for the future in this manner it is likely that others will endeavour to plan their destiny for them. There is a huge agenda for change but diabetes nurses will surely rise to the challenge. It may help to remember that 'where there is no vision people perish' (Proverbs 29:18). ■

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### PAGE POINTS

1 Meeting daily targets can sometimes seem difficult enough without having to worry about the future.

2 Diabetes nurses need to support each other in order to confront the issues ahead.

3 Diabetes nurses need to continue to prove their worth and remember that if they choose not to face up to these issues, others will try to plan their destiny for them.