Why we need diabetes inpatient specialist nurses

Diabetes inpatient specialist nurses (DISNs) are essential for providing a good, patient-centred inpatient service for people with diabetes. With one in six inpatient beds now occupied by someone with diabetes, it is essential the workforce is trained in the complex needs of these patients, and this training role lies with the specialist team. Here, Emily Watts, Diabetes UK’s Inpatient Care Programme Manager, introduces three DISNs and makes a strong case for the role.

I would suggest that there are four key aspects to my role: being clinical; teaching; research and audit; and leadership. The above can’t really be separated. For example, I teach every day. Not always formally – like on our 3-day Think Glucose programme, or on the Junior Doctor Foundation programme – but every time I have contact with somebody with diabetes, their families and my colleagues. I can’t teach unless I am clinical, and my teaching is based on research and audit. By teaching (or let’s say sharing knowledge), I am in a leadership role – I want to inspire others, set a good example and challenge bad practice, but also ask ‘why’.

It has taken 17 years as a DSN to be clear on what my role entails. I still struggle to make others understand the role, however – because so many want to associate it with ‘tasks’. Yes, I receive referrals, attend ward rounds, give my ‘specialist’ opinion, hold patient forums – but one of the most irritating requests is ‘can you just pop and see’, as if I run a milk delivery round! But did I really associate leadership with the role 10 years ago, when I moved into the acute setting? No. It was part of my job description, but the definition of leadership was fuzzy.

As I have now been a DISN for so long, have an MSc in Diabetes and am an independent prescriber, I am often seen as the ‘voice’ of diabetes, and attend board, patient safety and improvement meetings to engage with others outside my immediate team. I believe I have a responsibility to put inpatient diabetes care on everybody’s agenda – from the Chief Executive to the housekeepers looking after those patients on the ward. Great ideas only work if everybody is involved and on board.

As nurses, we are given opportunities that we may not even realise – being a patient advocate, being the ‘link’ between other healthcare professionals and, importantly,
enabling others to achieve good standards of inpatient care. I have tapped in to other senior nurses’ experience and expertise – not necessarily in diabetes – because peer support is vital when in a leadership role. I have been introduced to ‘Action Learning,’ where I meet with colleagues from across diabetes care, including consultants, GPs, and other nurses to discuss challenges. This is so useful, as it can be practised within my daily work (I now ask ‘why’ instead of just saying ‘yes’).

Everybody has a role to play in improving and maintaining good patient care and there are always others to engage beyond our own teams. You need to have passion and drive to make a difference – and to lead, you have to engage, challenge and explore beyond what you already do.

My role was created thanks to a determined diabetes consultant who recognised that planned surgical patients weren’t being cared for. He fought for funding. There was always the need, and developing the role and service to achieve this responsibility and opportunity.

My DISN role is constantly evolving. Sometimes I felt as if I was making it up as I went along, but it was about identifying the needs, and developing the role and service to achieve those needs and putting that into place. There was always support from the diabetes consultant.

The nurse-led role needed to facilitate a cultural change in attitudes to how diabetes can affect the patient on their surgical pathway. It was about designing and developing the service to meet specified needs and support patients leading up to, and during, their inpatient stay. The role needed to be adaptable and I could autonomously make that change. Yes, I had a rolling caseload but I needed to do the work to enable me to develop and improve my role and the service.

Protocols were developed. Leading the service meant attending meetings and completing audits to demonstrate evidence to facilitate continual funding for my role and the service. I had to develop medication advice leaflets for patients and shared that information with other trusts. I developed templates needed for communication, such as a written diabetes plan. I also e-mailed surgical consultants to highlight any concerns (well received, as they made the clinical decision as to whether the operation went ahead) and also spoke to anaesthetists on the day of surgery. Of course, I did – and still have – a continuing rolling caseload of patients, which now has doubled since 2008–2009 to 700 new referrals a year. I now have an assistant again and, last year, another DISN was put in post. Both are invaluable.

I prioritise our workload on an hourly basis. We share knowledge on the ward. I teach junior doctors about correct insulin prescribing (you would be shocked at examples of bad practice) and insulin titration.

Completing my nurse prescribing course was the toughest six months, but also the most rewarding, as I can immediately implement a medication change. I also was involved in developing a self-administration of insulin protocol and its implementation. Put simply – I love my DISN job!

I have worked within the specialty of diabetes for seven years at Addenbrooke’s Hospital, part of Cambridge University Hospitals. Throughout this time a large part of my role has been as a DISN. In addition, for the last four years, 50 per cent of my role has been working in research.

Cambridge University Hospitals has approximately 1,000 inpatient beds over 52 wards. Over time, our inpatient service has evolved and we now have a dedicated inpatient team known as the Diabetes Outreach Team, which is made up of a DISN, diabetes specialist dietitians, a podiatrist and some inpatient-dedicated consultant time.

I have always had a passion for the delivery of safe, effective inpatient diabetes care. The NaDIA has been a very useful tool in assessing what is being achieved within inpatient diabetes management and highlights the need for improvement.

My time in research has also been a key area of interest for me and has given me valuable experience in all aspects of research – from development of a protocol through to publication. The combination of these interests led me to ask what we can do to improve inpatient diabetes care from an educator’s perspective. In September 2017, I commenced an MSc in Clinical Research at UEA, funded by the NIHR. This is a fantastic opportunity to explore the questions I have relating to the way we deliver inpatient diabetes services through designing my own research protocols. I also found out about the new Clinical Study Groups that have been put together by Diabetes UK and am now a member of the Clinical Study Group 4 – Acute Medicine.

The group allows diabetes specialists and people with diabetes from around the UK to come together and highlight areas where further research is required. This group, along with the expertise found within my clinical area, means I now have the support I need to further explore areas of potential improvement from the diabetes nurse perspective.

The support of an innovative management team has allowed me to develop my role as a DISN beyond delivering day-to-day care. It has allowed me to raise questions about how we work and feed these ideas back to the right people. The NHS and the needs of our patients are always evolving. Working on the front line gives nurses and other healthcare professionals a valuable perspective on how to improve service delivery. We are united by many of the challenges we face within inpatient diabetes management and, if you have an idea on how we can overcome these, I would encourage you to share it. You never know – it might just trigger an improvement in national diabetes inpatient management.