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Survey of Diabetes Nurse Specialists in Ireland (Wave 2)

Consent Form

1. We want to gain a greater understanding of your role in diabetes care. This study is going to improve our understanding of how services are currently organised in Ireland. This information is important to inform plans for changes in diabetes management in the future.

Before proceeding with the survey, we ask that you please read the following and indicate your consent below.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I understand that I can withdraw from the study, without repercussions, at any time.

I understand that I can withdraw permission to use the data, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up of results.

I understand that anonymised data will be used in the report and any subsequent publications.

☐ I consent to participate in the National Survey of Diabetes Nurse Specialists in Ireland.

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Contact Information

2. Please provide the following information:

Name:

Address 1:

Address 2:

City/Town:

Email Address:

Mobile Number:

3. The survey will be followed by a qualitative study exploring Diabetes Nurse Specialists' experiences providing care in the Irish health system. If you do not wish to be contacted about this follow-up study please tick this box:

☐

Do not contact me

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Education & Employment

4. What is your job title?

5. Are you a:

- ☐ Community DNS
- ☐ Hospital DNS
- ☐ Both community and hospital DNS
- ☐ ANP (Primary Care)
- ☐ CNS (General Practice)
- ☐ Other (please specify below)

6. Where are you based? (Tick all that apply)

- ☐ Community
- ☐ General Practice
- ☐ Hospital
- ☐ Other (please specify below)

7. Do you work in:

- ☐ Adult services
- ☐ Paediatric services
- ☐ Maternity services
- ☐ Other (please specify below)

8. What is your catchment area?

9. What age group are you in?

☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 or older

10. Post basic qualification (please tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Masters in Diabetes | <input type="checkbox"/> Post Graduate Diploma in Diabetes |
| <input type="checkbox"/> Masters in Nursing Studies | <input type="checkbox"/> Certificate in Diabetes Nursing |
| <input type="checkbox"/> PhD (completed or undertaking) | <input type="checkbox"/> Certificate in Diabetes through E-learning (ICGP module) |
| <input type="checkbox"/> Diabetes counselling course | <input type="checkbox"/> Diabetes in Primary Care (NUIG/UCC module) |
| <input type="checkbox"/> Higher Diploma (HDip) in Diabetes Nursing | <input type="checkbox"/> Masters in Primary Care |
| <input type="checkbox"/> Other (please specify below) | |

11. Are you a Registered Nurse Prescriber (RNP)?

- ☐ Yes
- ☐ No

12. How many years experience do you have working as a DNS?

13. How many years experience do you have working in your current position?

14. What is the grade of your current position?

- ☐ Staff nurse
- ☐ Senior staff nurse
- ☐ Clinical Nurse Specialist
- ☐ Advanced Nurse Practitioner
- ☐ Clinical Nurse Manager
- ☐ Other (please specify below)

15. Do you know the whole time equivalent (WTE) of your position?

- ☐ Yes
- ☐ No

16. If yes, please estimate the WTE.

17. Who are you employed and funded by?

	Employed by	Funded by
HSE	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Ireland	<input type="checkbox"/>	<input type="checkbox"/>
Pharmaceutical company	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes initiative	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

18. How many hours per week do you spend working in each setting(s)?

Community	<input type="text"/>
General Practice	<input type="text"/>
Hospital	<input type="text"/>
Total hours per week	<input type="text"/>

19. How many hours per week do you spend working in each of these services?

Adult services	<input type="text"/>
Paediatric services	<input type="text"/>
Young person's clinic	<input type="text"/>
Diabetes in pregnancy	<input type="text"/>
In-patient services	<input type="text"/>
Out-patient services	<input type="text"/>
Community clinics	<input type="text"/>
GP practices	<input type="text"/>
Research/audit	<input type="text"/>
Administration	<input type="text"/>

20. Are you linked to a specific hospital?

☐ Yes

☐ No

If yes, which hospital(s)?

21. Is there a clinical governance lead for your service?

☐ Yes

☐ No

22. If yes, who is responsible for clinical governance?

☐ Consultant

☐ GP

☐ Other (please specify below)

23. Who is your manager?

☐ Hospital

☐ GP

☐ General manager for community

☐ Transformation Development Officer

☐ Director of Nursing

☐ Director of Public Health Nursing

☐ Other (please specify below)

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Providing Diabetes Care

24. Is there a written job description for your role?

- ☐ Yes
- ☐ No

25. What type of patients attend your service? (Tick all that apply)

- ☐ Type 1 diabetes
- ☐ Stable Type 2 diabetes
- ☐ Complicated Type 2 diabetes
- ☐ Gestational Diabetes
- ☐ Young adults with diabetes
- ☐ Pre-diabetes
- ☐ Other patient groups (please specify below)

26. Regarding diabetes, what are your specific roles in patient care? (tick all that apply)

	Type 1 diabetes	Type 2 diabetes	Other patient groups
Patient management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dose adjustment only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin/GLP1 initiation/education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Checking injection sites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypo Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

27. Are you involved in any of the following? (Tick all that apply)

	Type 1 diabetes	Type 2 diabetes	Other patient groups
Hypertension clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-conception discussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-patient diabetes care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment clinics prior to surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

28. What are your specific roles in education? (Tick all that apply)

	Type 1 diabetes	Type 2 diabetes	Other patient groups
Patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pump Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

29. Are you involved in any of the following aspects of lifestyle management? (Tick all that apply)

	Type 1 diabetes	Type 2 diabetes	Other patient group
Smoking cessation advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dietary advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical activity advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

30. Are care plans developed with patients?

☐ Yes

☐ No

31. Are you involved in providing foot care?

☐ Yes

☐ No

If yes, which screening tool do you use?

32. Do you register patients for RetinaScreen?

☐ Yes

☐ No

If no, who is responsible for this?

33. Do you have referral access to other services? (Tick all that apply)

☐ No

☐ Podiatrist

☐ Dietician

☐ Ophthalmologist

☐ Psychologist

☐ Social Worker

☐ Other (please specify below)

34. Do you advise patients with diabetes to self-monitor blood glucose levels?

☐ Yes

☐ No

If yes, which patients are advised to self-monitor?

35. Is there a local agreement between the hospital and primary care regarding how your DNS service operates?

☐ Yes

☐ No

If yes, please outline what has been agreed locally.

36. Do you have a liaison role with any of the following colleagues? (Tick all that apply)

☐ No

☐ GP

☐ Practice Nurse

☐ Hospital DNS (if applicable)

☐ Community DNS (if applicable)

☐ Consultant

☐ Other (please specify)

37. What does this liaison role involve?

38. Do you cover other roles not solely related to diabetes?

☐ Yes

☐ No

If yes, please specify

39. Are there other nurses engaged in the diabetes service in your area? (Tick all that apply)

- ☐ No
- ☐ Diabetes Nurse Facilitator
- ☐ Staff Nurses
- ☐ Practice Nurses
- ☐ Public Health Nurses
- ☐ Other (please specify below)

Clinics

40. Do you run a nurse-led diabetes clinic?

- ☐ No
- ☐ Yes, generalised clinics only
- ☐ Yes, specialised clinics only
- ☐ Both

What type of specialist clinic you do you lead?

41. How many nurse-led clinics do you run each week?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

42. On average, how many patients do you see per clinic?

- ☐ Less than 5
- ☐ 5
- ☐ 10
- ☐ 15
- ☐ 15 or more
- ☐ Not applicable

43. Do patients also see a consultant/GP?

- ☐ Yes, during the same visit
- ☐ Yes, at a later date
- ☐ No
- ☐ Not applicable

44. Where are these clinics held? (Tick all that apply)

- ☐ General Practice
- ☐ Primary care centre
- ☐ Community outreach clinic
- ☐ Hospital
- ☐ Out-patients clinic
- ☐ Not applicable
- ☐ Other (please specify below)

45. If you provide clinics in the community, are all GP practices eligible to access your service?

- ☐ Yes
- ☐ No
- ☐ Not applicable

If no, who is the service available to?

46. Who is generally available to support you in the diabetes clinic? (Tick all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Community DNS |
| <input type="checkbox"/> SpRs or equivalent | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Senior House Officer | <input type="checkbox"/> Dietician |
| <input type="checkbox"/> Intern | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Practice Nurse | <input type="checkbox"/> Health care assistant |
| <input type="checkbox"/> GP | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Hospital DNS | |
| <input type="checkbox"/> Other (please specify below) | |

47. Is there a waiting list for your service?

☐ Yes

☐ No

If yes, please estimate how long people wait to attend the service

48. In your opinion, what are the main reasons for the waiting list in your area?

49. Do you provide out-of-hours diabetes consultations?

☐ Yes

☐ No

50. If 'yes', when are the out-of-hours sessions held in your area? (please tick all that apply)

☐ At weekends

☐ In the evenings

☐ Other (please specify below)

51. Do you provide a drop-in service for patients?

☐ Yes

☐ No

52. Are any of the following telephone services available to patients? (Tick all that apply)

	Telephone support service	Messaging service
Yes, universal access for all patients	<input type="checkbox"/>	<input type="checkbox"/>
Urgent only	<input type="checkbox"/>	<input type="checkbox"/>
Specialist patient groups	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric	<input type="checkbox"/>	<input type="checkbox"/>
None available	<input type="checkbox"/>	<input type="checkbox"/>

53. When is the telephone support service available? (Tick all that apply)

- ☐ Weekday office hours
- ☐ Weekend office hours
- ☐ Weekday evenings
- ☐ 24hours- 7 days a week
- ☐ Not applicable

54. Which members of staff operate the telephone support service? (Tick all that apply)

- | | |
|---|---|
| <input type="checkbox"/> DNS | <input type="checkbox"/> Dietician |
| <input type="checkbox"/> Secretaries | <input type="checkbox"/> Practice Nurse |
| <input type="checkbox"/> Medical staff | <input type="checkbox"/> GP |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Podiatrist | |
| <input type="checkbox"/> Other (please specify below) | |

55. How quickly do patients get a response to messages?

56. Is there a discharge follow-up pathway from wards to diabetes out-patient care?

- ☐ Yes
- ☐ No
- ☐ Not known

57. Is there a discharge follow-up pathway to primary care for ward discharges?

- ☐ Yes
- ☐ No
- ☐ Not known

58. Do all people with diabetes admitted to hospital in your area have ready access to specialist diabetes team support?

- ☐ Yes
- ☐ No

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Education

59. Is a structured patient education programme available in your area for the following patient groups ?
(Tick all that apply)

- ☐ Type 1
- ☐ Type 2
- ☐ Paediatric
- ☐ Gestational Diabetes
- ☐ Prevention
- ☐ None available
- ☐ Other (please specify below)

60. If yes, which programmes are available in your area?(Tick all that apply)

- ☐ DESMOND
- ☐ XPERT
- ☐ CODE
- ☐ DAPHNE
- ☐ Walk Away from Diabetes
- ☐ Not applicable
- ☐ Other (please specify below)

61. Are you involved in providing education to any of the following professional groups?

- | | |
|---|---|
| <input type="checkbox"/> GP | <input type="checkbox"/> Allied health professionals |
| <input type="checkbox"/> Practice Nurse | <input type="checkbox"/> Medical staff in nursing homes |
| <input type="checkbox"/> Nursing staff in hospitals | <input type="checkbox"/> None of these groups |
| <input type="checkbox"/> Medical staff in hospitals | |

If yes, how is this education provided? (e.g. information only, one-to-one sessions, groups sessions)

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Recording Activity

62. Are any of the following records used? (Tick all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Paper record | <input type="checkbox"/> Shared care book |
| <input type="checkbox"/> Electronic patient health record | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Patient passport | |

63. If yes, who completes the record? (Tick all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Me | <input type="checkbox"/> GP |
| <input type="checkbox"/> Another DNS | <input type="checkbox"/> Practice Nurse |
| <input type="checkbox"/> Patient | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Consultant | |
| <input type="checkbox"/> Other (please specify below) | |

64. Please estimate the percentage of time (%) per month spent on each of these additional activities.

Telephone advice

Informal patient drop-in activity

In-patient contact

Running clinics

Multidisciplinary team activity/meetings

GP/Practice liaison

65. Are these activities recorded? (Please tick all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Telephone advice | <input type="checkbox"/> Multidisciplinary team meetings |
| <input type="checkbox"/> Informal patient drop-in activity | <input type="checkbox"/> GP/Practice liaison |
| <input type="checkbox"/> In-patient contact | <input type="checkbox"/> None recorded |
| <input type="checkbox"/> Number of clinics | |

66. Do you have protected time for continuing professional development?

☐ Yes ☐ No

67. Is there a protected budget for diabetes continuing professional development?

☐ Yes ☐ No

Survey of Diabetes Nurse Specialists in Ireland (Wave 2)

Opportunities & obstacles for diabetes care in Ireland

68. We value your insight into diabetes care. Please use the space provided to describe the main barriers and facilitators to delivering the diabetes service in your area.