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Implementation of an integrated model of care for diabetes nursing in county Donegal

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IMPLEMENTATION OF AN INTEGRATED MODEL OF CARE FOR DIABETES NURSING IN COUNTY DONEGAL

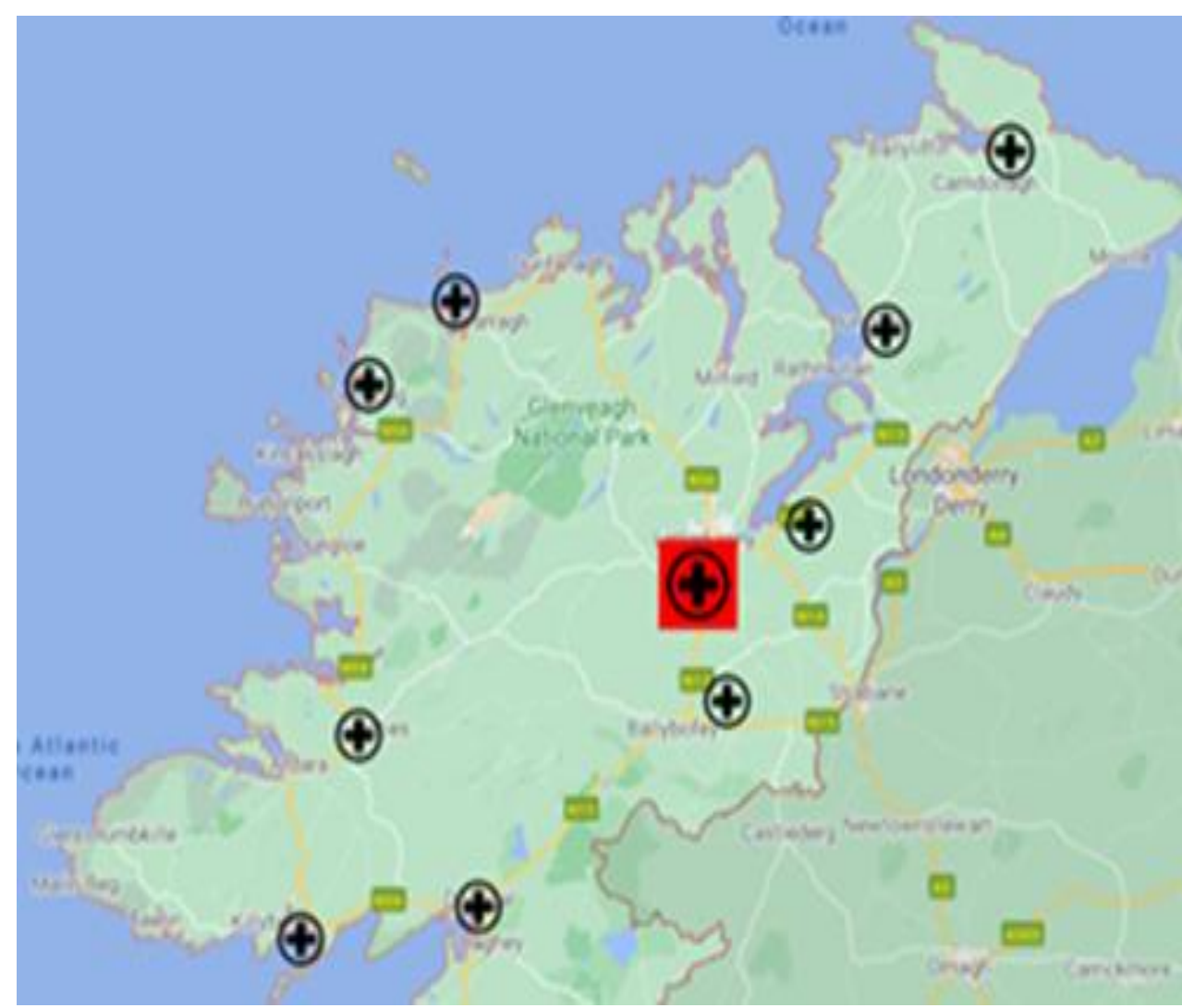
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Introduction

The Enhanced Community Care (ECC) programme is currently transforming the way healthcare is being delivered nationally, shifting the focus away from acute hospitals towards a new model of specialist integrated care in the community for patients with chronic diseases.

The integrated diabetes nursing service in Donegal has transitioned from general practice-based clinics to chronic disease management (CDM) hubs and outlying 'spoke' clinics in the county to increase equity and accessibility for patients with Type 2 Diabetes.

CO DONEGAL HUB AND SPOKE CLINICS



Engagement:

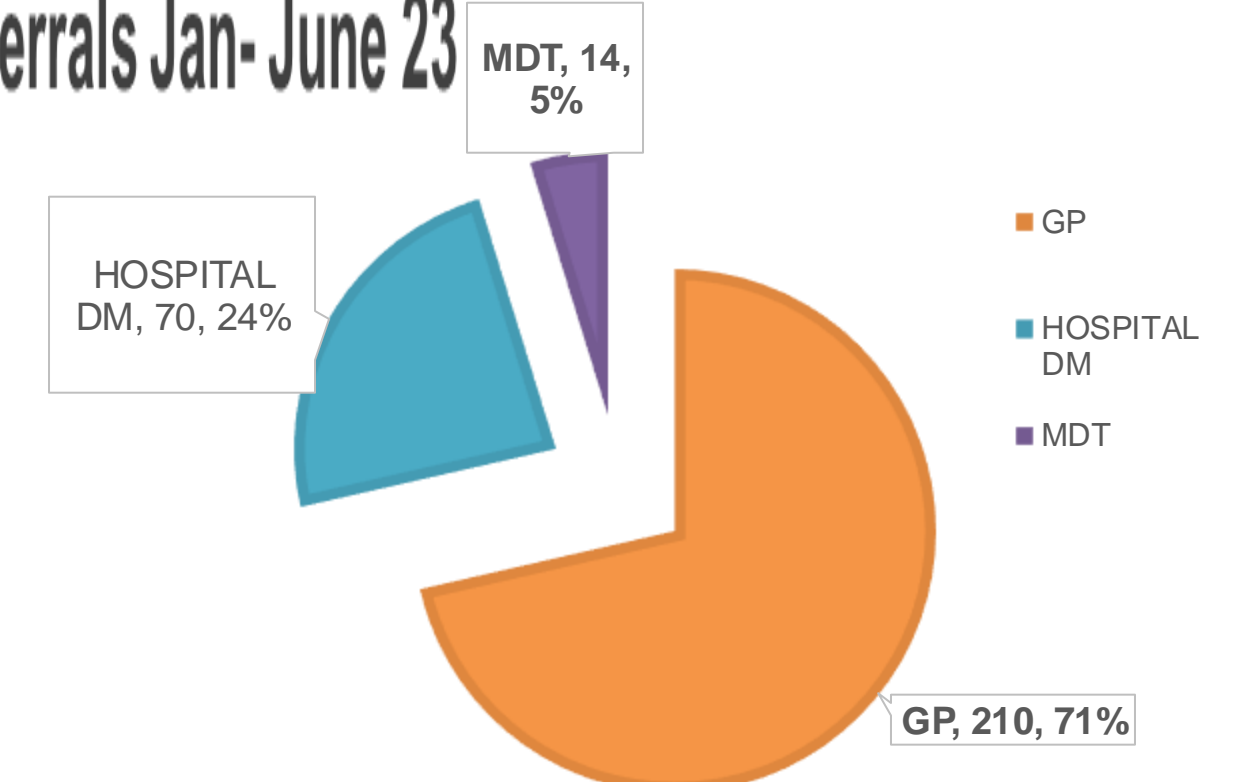
- Meetings with GPs and GP Nurses
- Gradual transition from General Practice to CDM Hubs
- CNS Diabetes per 50,000 population – aligned to community health networks
- Referral criteria via healthlink from GP to CNS
- Support of Consultant Endocrinologist and diabetes team at Letterkenny University Hospital
- Development of ANP Diabetes service
- ANP service targeting hospital waiting lists
- Diabetes Implementation Group

Clinical Nurse Specialist Service

1st January- 30th June 23	CNS DIABETES SERVICE
CLINIC APPOINTMENTS FACE TO FACE	457
HOME VISITS	55
VIRTUAL REVIEWS	636

- 90 patients discharged to GP Jan-June 23
- 10 community clinic locations
- Referral to appointment time avg. 20 days
- High patient satisfaction

CNS Referrals Jan-June 23



RANP Diabetes Service

1st January- 30th June 23	ANP DIABETES SERVICE
CLINIC APPOINTMENTS FACE TO FACE	364
VIRTUAL REVIEWS	133
Number of pts discharged to GP	57
Number of pts managed with Consultant Endocrinologist	28

- Waiting lists reviewed –
- Caseload: Low risk pts identified. High risk pts requiring rapid access
- 153 patients with Type 2 diabetes removed or diverted from secondary care waiting lists Jan-June 23. 57 pts discharged back to GP
- Rapid access for ANP review
- 8 community clinic locations
- Waiting time reduced from 3 years to 1 month

Outcomes

- 196 UNSCHEDULED PATIENT INTERVENTIONS (Jan-June 23) RESULTING IN REDUCED ED ATTENDANCE AND HOSPITAL AVOIDANCE
- CLINICS IN PATIENTS OWN LOCALITY
- JOINT VISITS ARRANGED FOR MDT REVIEW OR WITH OTHER CDM SERVICE WHERE POSSIBLE
- UP TO 150KMS SAVED PER PATIENT PER VISIT



National Clinical Programme for Diabetes (2022) Resource Document to support the Community Specialist Diabetes Teams: A working document
HSE (2020) National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020 – 2025
HSE Integrated Model of Care for People with Type 2 Diabetes Mellitus 2024