

CONFERENCE ABSTRACT

Processes of care performed by specialist nurses to support integrated diabetes management: Feedback to inform service delivery

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Introduction: In Ireland, there has been an increased investment in Clinical Nurse Specialists (CNS) in Diabetes Integrated Care, placed in the community to support the delivery of a new model of integrated diabetes care whereby patients with uncomplicated type 2 diabetes (T2DM) are managed in primary care, and patients with complicated T2DM are managed between primary and secondary care. We describe care processes relating to new (2013-2015) and existing community CNS to examine the implementation of the new model.

Methods: CNS recorded care processes for April–June 2016 including practices visited, practice visits, GPs interested in the service, service capacity, patient contacts, and cases discussed with a member of the multidisciplinary team (MDT) as an indicator of service integration. Data were recorded in Excel and submitted to the National Diabetes Programme manager. Results are reported by Whole Time Equivalent (WTE) (based on CNS returning data), and by Community Healthcare Organisations (CHO), nine regional networks of community-based services in Ireland.

Results: Of 27 CNS, 25 (93%) (23.36 WTE) returned data. Overall, 395 practices were visited (23.8 per WTE; median(range) per CHO, 47(10-88) per CHO), 533 practice visits were conducted (24.9 per WTE; 48 (10-111) per CHO). Most of the practices visited were attended regularly by the CNS (n=359, 91%), while 9% (n=36) were new practices visited for the first time in that quarter. Of the 22 CNSs who reported on service capacity, 68% (n=15) indicated they were not in a position to take on new practices. Among CNS reporting on GP engagement (n=20), 17 had ≥1 practice waiting to avail of the service. There were 2817 patient contacts (121 per WTE; 194(40-728) per CHO), primarily patients with complicated T2DM (n=1947, 69.1%), with few non-attenders (n=387, 12.1%). Overall, 339 patients (12%) were discussed with the MDT, 33(10-114) per CHO.

Discussion: CNS activity varied across CHOs, possibly reflecting differences in regional allocation of CNS, and how diabetes services are organised locally.

Conclusions: (key findings) Patient contacts were mainly complicated T2DM in keeping with the national model of care. CNS activity was concentrated in practices already accessing their service, with most reporting their service is at capacity.

Lessons learned: Despite GP interest in the service, most CNS are unable to take on new practices. The new diabetes 'cycle of care' national funding initiative, which will remunerate GPs for management of patients with uncomplicated T2DM, is expected to increase demand for CNS support in the community. Regional disparities in resourcing should be addressed, and CNS supported to work with new practices.

Limitations: Provision of patient and professional education, also part of the CNS role, was not captured. There are no baseline data against which to benchmark current activity. While outcomes of care are important, our initial focus has been on processes to develop a culture of data collection and monitoring.

Suggestions for future research: These data will form part of an audit and feedback cycle with CNS, to develop the data collection process, inform future service delivery, and work towards creating key performance indicators.

Keywords: nurse specialist; diabetes; integrated care
