Diabetes Specialist team and Community Nurses (CN's) working in partnership – How the creation of a 'Virtual Ward' led to improved patient outcomes and saved nursing time in North East Essex

Background: North East Essex (NEE) has a high prevalence of diabetes (5.9%) and an increasingly elderly population. These patients cannot always administer their own insulin due to cognitive or physical impairment, requiring CN support. Locally CN time for insulin administration is limited to 10 mins per visit. There are currently 188 patients across NEE requiring CN's to administer insulin daily- most of which are BD visits.

Aims of the Virtual Ward:

1. Improve overall diabetes control
2. Reduce the number of patients experiencing hypoglycaemia due to poor timing of insulin administration, thus improving patient safety,
3. Review suitability of medication regimes,
4. Educate CN's around insulin and diabetes care
5. Reduce the time spent on diabetes for the CN's

Methods:

North East Essex covers an area of 125 sq/miles, which has four community nurse localities. Each Community Nurse Team has a diabetes link nurse who is the diabetes lead for the team. The diabetes lead CN, DSN and Consultant (when appropriate) meet at each locality monthly, to review the caseload of patients, who meet the referral criteria below. Together by reviewing blood glucose levels, current medication (Polypharmacy), 8 care processes and co-morbidities we make a clinical decision about each patient's individualized day to day BG targets and HbA1c target and any changes in medication required.

The criteria for referral to virtual ward are:

- HbA1c < 53 mmols (hypo risk)
- HbA1c > 65 mmols
- Cognitive impairment > 69 mmols.
- Unable to self-administer insulin

Results: HbA1c outcomes:

Of those people starting with HbA1c <53 mmols (Hypo risk):

- Initial mean HbA1c 44 mmols
- 3 month mean follow up 62 mmols
- 6 month mean follow up 66 mmols

Of those people starting with Hba1c >65 mmols:

• Initial mean Hba1c 88 mmols

• 3 month mean follow up 74 mmols

• 6 month mean follow up 68 mmols

Community Nurse out-comes (one month):

• 78% of patients had medication changes, improving HbA1c and safety

• saving of 60 CN visits (allocated 10 minutes each) equivalent to 10 hours of CN time saved

• 8 people stopped insulin completely

Patient outcomes:

* Improved quality of life and safety

* Reduction in unnecessary medication

Summary: The Virtual Ward has gone from strength to strength in the last 18 months, and has had a long lasting improvement to patient care, safety and quality of service offered. 188 patients across NEE require the CN's for administration of insulin and the virtual ward has now reviewed 145 of them. Over the whole project this equates to-

- 112 Patients having improvements made to their diabetes medication regime
- 1,446 Community Nurse Visit's saved over the whole project equal to visits saved: or 241 hours saved.
- Staff feedback has been very positive

Lead Nurse for the project:

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With invaluable input, contributions and hard work from

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