



CASE STUDY

Alstonville Diabetes Group

Practice Name: Alstonville Clinic • **Location:** Alstonville, NSW • **MM:** 3

Context

Joni Mackenzie (RN, CDE) works at Alstonville Clinic, a general practice in the Northern Rivers region of New South Wales. With over 22 years' experience, Joni is passionate about making diabetes education accessible to her local community.

Healthy North Coast Primary Health Network (PHN) data shows that the rate of potentially preventable hospitalisations for diabetes complications in this region is significantly higher than other parts of New South Wales.

To address this, Joni applied to APNA's Building Nurse Capacity Program in 2024 to establish a diabetes nurse clinic. Joni's clinic aims to improve the availability and accessibility of primary health care diabetes education and management services in the Alstonville area.

A clear plan

Approximately 6% of Alstonville Clinic's patients have Type 2 diabetes. Alstonville's nurse clinic aims to provide a face-to-face, patient-centred, group education program that improves the health and wellbeing of residents living with diabetes. The clinic also aims to increase screening rates and early detection to reduce the risk of unplanned hospital admissions and societal disease burden.

Funding

Alongside funding from her participation in the Building Nurse Capacity Program (co-sponsored by Healthy North Coast Primary Health Network), Joni utilises MBS items 10951, 81105, 81100, 10997 (GP), 93201 and 93203.

Location and facilities

The Alstonville area experienced catastrophic flooding in 2022, which introduced new barriers to accessing diabetes care. Many locals were unable to travel to diabetes centres and faced long waiting times. Additionally, some buildings, including diabetes centres were destroyed by flood water.

In light of this, Joni operates the clinic from an annex behind the main Alstonville Clinic building, and has ensured plenty of available parking, including for mobility scooters. She made sure the clinic was easy for locals to get to and has found that this increased attendance to the diabetes groups.

Staffing and HR

Joni receives organisational support to run the clinic, including protected time, patient referrals from GPs, and administrative support with data collection. This team approach, along with Joni's strong connection to the local community, has been a key enabler of the group's success.

Best practice care

A multi-disciplinary approach was used in developing the group session content. Sessions featured guest speakers—including a podiatrist, optometrist, exercise physiologist, renal nurse, and dietitian—who shared their specialist expertise. In addition, patients received education on disease processes, medications,



We acknowledge the Widjabul/Wia-bal people of the Bundjalung Nation as the Traditional Custodians of the lands featured in this story and pay our respects to Elders past and present.

glucometer and lancet device use, continuous glucose monitoring, insulin therapy adjustments, healthy eating and weight management, exercise, renal and cardiovascular health, sick-day action plans, and mental wellbeing.

The interactive group setting provided the opportunity for peer learning, and as one participant noted:

“The group was very friendly and contributed to the sessions by asking wise questions. I learnt a lot from this.”

Patient engagement

Without Alstonville's Diabetes Educator Services, patients would need to travel to surrounding towns for care- adding financial strain and exposing them to long waiting lists, limited parking, and transport barriers that can significantly reduce access. Beyond the clinical benefits, the group sessions have also created a safe and supportive environment for community members to build social connections and reduce isolation, particularly among older patients. Even after the six-week program concluded, participants have continued to stay connected by sharing diabetic friendly recipes, meeting socially, and exercising together.

It can be difficult for residents of Alstonville to access specialist diabetes care, due to cost, long waiting lists,



parking and transport issues. These challenges have been exacerbated by the ongoing effects of devastating flooding in 2022 in the community, which has impacted local access to health services, as well as morale.

Supporting systems and processes

Newly diagnosed or existing patients are referred by GP for 45 minute appointment with lead nurse (CDE)



Lead nurse (CDE) screens patient for group education eligibility



Patient attends 6 weeks of group diabetes education sessions (1 hour per week)

Evaluation and improvement

Joni uses APNA's nurse clinic resources, as well as clinical evaluation to develop the content to best suit patient needs. Data collection has shown an increase in the number of Alstonville Clinic's patients with HbA1C, and blood pressure recorded. The clinic has also contributed to an increase in the number of patients with Type 2 diabetes who have a HbA1C reading of less than 7, indicating improvements in diabetes management. The data identifies an increase in the number of patients with Type 2 diabetes who have a chronic condition management plan in place: another indicator of improved, structured care.

Additionally, the clinic has recorded an increase in patients with Type 2 Diabetes signing up to use Libre 2 Sensors to manage their glucose levels.

By participating in education sessions on these topics, Joni feels that patients gain a deeper understanding of how to manage their diabetes, in a group that is community led, participant informed, and evidence based.



Scan the QR code to watch the video about [Alstonville Diabetes Group Nurse Clinic](#).



Scan the QR code to learn more about [APNA's Nurse Clinics](#).

APNA's Building Nurse Capacity Program is funded by the Australian Government Department of Health, Disability and Ageing under the Nursing in Primary Health Care Program.