

Community nursing: transforming health care



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Nurses who work in the community are facing significant challenges during this time of health reform and demands to make financial savings. While this is so for all nurses, regardless of their workplace, media and political attention is often focussed on hospital care, and community services remain less visible. As a result there is little understanding of what constitutes community nursing, the range of roles covered, and the principles that underpin the development of nursing services that are suitable to serve their communities well.

The work carried out by community nurses is described in the RCN publication, *Pillars of the community** which offers a set of principles to help ensure the development of high quality community nursing services. It applies to educators, commissioners, service planners, managers and frontline community nurses. The RCN maintains that, if each one of the principles described were properly implemented, people, ranging from newly born babies to children and young people, pregnant women and the elderly – would have access to world class community based nursing services.

Nurses who work in the community can be invisible to local people (apart from those who are receiving services) as well as the people who have the authority to decide how local NHS funding is spent. The RCN needs to constantly highlight the excellent work carried out by community nurses 52 weeks a year and seven days a week so that they have a chance of acquiring a similar profile to those nurses who do equally important, but different work in hospitals.

The RCN wants these case studies of excellent community nursing to inform, inspire and persuade people to scrutinise their current community nursing services and identify how they can be both expanded and enhanced – for the benefit of their local population.

During the last decade there has been a significant investment in hospital services with a corresponding increase in the number of hospital nurses and doctors. However over the same period the number of both district nurses and health visitors has fallen and the university based programmes for these disciplines have been drastically reduced.

The RCN believes strongly that a renewed investment in the community nursing workforce is essential to people's health and is also affordable. If the nation fails to invest in community nursing, the long-term costs of health care are likely to increase. These case studies not only illustrate how people's health and life styles can be improved from new baby to older adult, but how community nurses can also provide the most marvellous end of life care within people's homes.



Dr Peter Carter
Chief Executive & General Secretary
Royal College of Nursing

*** Reference**

Royal College of Nursing (2010) *Pillars of the community*, RCN: London.



Joining up mental health care

April Morris: Community Mental Health Nurse, working in an adult integrated community mental health and social care team, at South Staffordshire and Shropshire NHS Foundation Trust, England

For April Morris the best thing about working with adults with mental health problems in a community setting is the autonomy and responsibility it gives her as a nurse.

April's team works with adults with mental health problems that range from moderate and time-limited mental health episodes, to long-term and relapsing conditions. A senior nurse within the team, April also has an additional management responsibility for six community mental health nurses and two support workers.

"We engage with people experiencing moderate episodic conditions such as depression, anxiety, OCD (obsessive compulsive disorder), post-traumatic stress disorder and post-natal depression to individuals with severe and enduring conditions such as bi-polar disorder, schizophrenia, psychosis and other relapsing long-term mental health conditions," she explains.

April is very proud of the wide range of services her team can offer, and the fact that these benefit both service users and clinicians alike. "We can offer people the choice of seeing either a doctor or a nurse prescriber and my colleague holds nurse-led clinics," she says. "As well as helping to reduce clinic waits and ensure continuity of care for service users, our team's specialist nursing roles have proved clinically cost-effective and help ensure consultant workloads are prioritised."

Prioritising user needs is a key goal for her team, as April explains. "The trust has an active service-user involvement strategy and our service users are involved in developing their own care plans. What's more, it's standard practice

to involve service users in areas like recruitment – for example, recently we recruited some primary care mental health workers and a service user was part of the interview panel."

Engaging with the families and carers of service users is vital, and a large amount of the team's work relates to educating families, particularly when someone has an enduring illness such as schizophrenia. "Families are a key part of the care plan, as they are often in a position to see when someone may be becoming unwell, and can work with the team with detailed relapse management plans," says April.

April's team works closely with other agencies to provide high-quality care. "We have contact with health visitors and midwives in cases where mothers suffer from post-natal depression or where there may be safeguarding children issues," continues April. "We also take referrals from a wide variety of agencies including GPs, health visitors, district nurses, midwives and local authorities. People may also self-refer to us."

And in spite of all the pressures of time and competing deadlines April loves the work she does: "It's rewarding working with people who are disabled by their illness and seeing them recovering and functioning."



Enabling dignified end-of-life care

Candice Pellett: Case Manager District Nurse and Queen's Nurse working in an integrated community nursing team, Lincolnshire Community Health Services, England. Candice was also seconded two days a week with the Department of Health as the clinical nursing lead in the *Transforming Community Services* programme

South West Lincolnshire is setting high standards for end-of-life care by enabling 90 per cent – compared to the DH figure of 20 per cent – of those who wish to die at home to do so. Candice piloted an end-of-life care guide which she helped to produce while on secondment with the Department of Health.

“A lot of my work is palliative and end-of-life care,” explains Candice. “We do our best to allow people to die at home if they express a wish to do so.”

As a highly experienced case manager district nurse, Candice is very proud of the support the integrated team offers to patients and families. “They’re so knowledgeable and patients really feel supported,” she says. “We were filmed for BBC TV last year because our statistics of people dying at home are way above the national average. But what the film really picked up on was how passionate we are about getting medication in place before the patient needs it.”

Being ahead of the game is a key part of the team’s work as Candice explains. “I work with a great team of community nurses, Macmillan Nurses and GPs. If one of our patients expresses a wish to die at home we try to prepare in advance and not leave anything until the last minute. Every five weeks we meet to discuss the patients we believe to be in the last six to 12 months of their life, irrespective of condition. These patients are added to a supportive care electronic register and we use these meetings to discuss their condition, their

medication and their carers’ needs, where they wish to die, any recent hospital admissions as well as welfare concerns such as benefit entitlements.”

The e-register is maintained by Candice in the practice. And by being proactive in this way the team is able to anticipate potential problems and plan how to deal with them. What’s more, each patient receives a care plan that states their preferences and needs, including advance decisions to refuse treatment.

“We make contact with patients and support them as much as they want,” explains Candice. “When that patient becomes more dependent we go in and check what support is needed. For example, when a person wants to die at home they might need something like a profiling bed, pressure relieving mattress, hoist or a commode. Anything they would have in hospital we can get for them at home.”

“With the patient’s consent we often turn a dining room into a bedroom, so they don’t have stairs to contend with when their mobility decreases,” she continues. “We pull in support from whatever source is necessary to help the patient and their loved ones.”

Having set such a high standard in Lincolnshire, Candice worked with the Department of Health to pilot a guide on how to offer the same standard of care in other locations. As Candice says; “End-of-life nursing is my passion and it was fantastic to pilot this guide throughout England.”



Improving vascular care for long-term conditions

Evelyn Ryan: District Nurse Team Leader at Coatbridge Health Centre, Lanarkshire, Scotland

Leg-ulcers in the house-bound are almost a thing of the past in Coatbridge because a couple of district nurses identified a need to treat these patients and introduced nurse-led clinics which work with nine GP practices in the town and the surrounding area.

As Evelyn explains, the new nurse-led clinics have had a real impact. “Previously, nurses here were treating people conservatively at home, and their legs were never getting any better. But when we took a look at the research and saw that with special training we could improve the service – which ultimately led to the introduction of nurse-led vascular clinics. As a result, we now have less house-bound patients with leg ulcers.”

Working in a deprived area where alcohol and drug abuse is prevalent and there are a lot of smokers and people with heart disease, Evelyn’s team is keen to make the best use of available resources.

“We’ve just undergone a LEAN methodology programme to analyse our workloads, and the capacity we have to deliver a service. We now record all phone calls, and note both appropriate and inappropriate referrals. Each month the statistics are analysed and the results fed back to us. We’ve found this approach helps us to better plan our skill mix and workforce needs – and it gives us evidence to support our case.”

The programme has helped Evelyn’s team reduce the number of inappropriate referrals it receives, as she explains. “When we get GP referrals we now ask for more information so we can decide if it should really be a social work referral – for example the patient has no nursing needs but requires a home help.”

And while Evelyn’s team deals with children if they need post-operative intervention, the main focus is on patients with long-term conditions such as diabetes, heart disease, motor neurone disease and palliative and terminal care.

“As a team we’re very committed to keeping people at home and are very robust at doing our assessments,” confirms Evelyn. “Because people can become destabilised we have to reassess regularly to make sure we’re keeping an eye on everything to keep them from being re-admitted,” she says. “The introduction of our Anticipatory Care Plan will also allow us to work in partnership with our patients and ensure we acknowledge our patient’s wishes.”

The team also works very closely with social services to ensure a holistic patient approach. “We deal with a diverse population with all sorts of interventions, so we need to be able to look at complex situations and work with our social work colleagues to plan a care package together that enables a patient to stay at home with the proper support,” she explains.

As Evelyn confirms; “There’s a great deal of satisfaction in being able to keep a patient at home.”



Holistic care for vulnerable, young mums

Jacqueline McCracken: Community Service: Health Visitor, the New Parent Project, South Eastern Health and Social Care Trust, Northern Ireland

Jacqueline, along with her colleague Rita McPartland, both won the RCN Nurse of the Year Award 2010 for their groundbreaking project targeting vulnerable young women having their first baby.

Improving the health and emotional well-being of children is a key objective for the Social Care Trust in Northern Ireland, and as Jacqueline explains, the New Parent Project aims to target support at pregnant young women identified as vulnerable by the midwife. “We work with teenage mums and young women with identified mental health problems or little social support or in cases of suspected domestic violence issues.”

The women are referred to Rita and Jacqueline early in their pregnancy and the health visitors begin working with them at 20 weeks gestation. Following an initial family health needs assessment, Rita and Jacqueline work with mother and baby up to and after the birth.

“We first see them monthly until the baby is born, then weekly from the birth until the baby is eight weeks old, fortnightly until the baby is four months and finally monthly until the baby is nine months old.”

Alongside delivering a core health visiting programme, Jacqueline and Rita provide extra support tailored to the specific needs of the family. “Some might need help with housing or domestic violence issues, others may have mental health issues, and for those who have limited family contact we become that vital point of contact,” continues Jacqueline. “We also aim to link them up with other community service agencies like Sure Start or Barnados.”

As part of their role, Jacqueline and Rita provide education and parent skills coaching, as Jacqueline explains; “We do a lot of work with these young women on the impact of the baby’s early environmental experiences, how they develop emotionally, and how to pick up on communication cues and interact with babies. We also talk a lot about skin-to-skin contact, explaining that one of the first things the baby will do when laid on their mother is to search for mum’s face – the young women who’ve experienced this after we told them to expect it have been delighted when it happened!”

When it comes to meeting the needs of their client group the two health visitors have tried to be as innovative as possible, as Jacqueline describes; “We make ourselves available in the evenings, work around their school or college commitments, and contact them by mobile phone if that’s more convenient for them. And when we discovered some of the girls were having their babies in Belfast, but weren’t attending the ante-natal classes, we worked with community midwives to arrange for small classes to be delivered locally. These proved very rewarding for the girls”.

Rita and Jacqueline are looking forward to assessing how successful their interventions have been, as Jacqueline explains; “We’re the first to do this in Northern Ireland and our aim now will be to assess how the mothers feel about their bond with their babies. When we come to the end of our time with them we will be discharging them to the core health visiting team but we hope to have a care package in place with links to the community.”



Seamless care on your doorstep

Linda Penny: Lead Nurse Practitioner and Community Dermatology Nurse, Trevethin Health Centre, Aneurin Bevan Health Board, Wales

Linda is proud of the quality primary care service she provides for the local community in the Trevethin Health Centre in Pontypool, Wales.

The nurse practitioner-led health service at the centre began eight years ago and covers three of the most deprived wards in Wales. Since it's within walking distance, local patients often make Linda's practice their first port of call as the GP surgeries are a bus or car ride away.

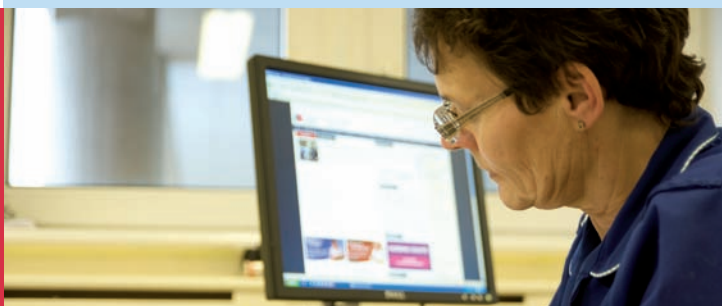
This ease of access is important, as Linda explains; "Our centre is at the top of a hill, while the GP practices are in a valley at the bottom. Because there is very low car ownership in this area most people depend on public transport, and it takes patients one or two buses to get to their GP. As we cover four GP practices, patients have the choice of going down to their GP or visiting us on their doorstep."

The health centre team works seamlessly with local GP practices and, as Linda confirms, has a good relationship with doctors; "The novel thing about our centre is that we hold patient medical records electronically, so it's as though we're working in the GP's surgery. And while we don't have GPs on site we have an agreement that if we're not sure about a patient we can talk to the GP or send a patient to the GP the same day."

Linda works with one other nurse practitioner and a health care assistant, providing a morning drop-in service and an appointment-only service in the afternoons. The team also operates two specialist clinics; a dermatology clinic and a weight management clinic.

Linda, who trained at the dermatology department of the local hospital, runs the dermatology clinic and explains how the service benefits local patients; "We found a high incidence of referrals to dermatology for patients with psoriasis, eczema and mild to moderate acne. Previously, people were referred to hospital for treatment which meant a long wait to be seen. Today the wait time is never more than two weeks, and because I'm an independent prescriber I can prescribe drugs."

This means the service is able to deliver a complete care package, as Linda explains. "What's nice about this service is that because we can prescribe we can complete the care and usually there's no need to refer our patients elsewhere – last year the practice saw 7,428 patients, and only 181 of those were referred to a GP."



Advancing custodial nursing

Lorraine Jackson: Custody Nurse Practitioner Area Manager, Metropolitan Police, Islington Police Station, Central London, England

Lorraine is enjoying her exciting role helping to create a new custody nursing service at the Metropolitan Police. The service currently has seven custody nurse practitioner teams working across London and by the close of 2012 will have a team in all 32 boroughs.

Lorraine outlines her team's responsibilities. "We carry out a lot of the work formerly done by forensic medical examiners (FMEs) and because we're based at the station 24-hours a day, we're able to see detainees without delay. Previously there could be long waits because FMEs often covered a large number of stations."

The team has some key priorities, as Lorraine explains; "The main thing we're concerned about with detainees is making sure they're safe to be detained in the police station. Everyone brought into custody goes through a risk assessment with the sergeant and if there are any health concerns – like alcohol or drug taking, or any obvious injuries or ongoing health care conditions, they will be referred to us."

The team of five nurses also gets involved in taking samples in suspected sexual assaults and blood samples of people arrested for driving offences. The team will also see officers if they've been injured on duty.

Lorraine stresses the team does not provide any form of advanced care. "While we can do emergency care – for example if someone has a heart attack – we would transfer to hospital as soon as possible, and people with major injuries should be taken straight to hospital."

The role of custody nurse practitioner is a new initiative for the Metropolitan Police. As additional teams are established, the role will continue to evolve and expand as Lorraine explains; "The next new responsibility to be added to the role is 'verifying life extinct', if we can go out and verify when someone is deceased in specific circumstances it saves either an ambulance going or having to wait for a local GP."

Although Lorraine heads up a team of five, each nurse is responsible for their own practice and works autonomously on shifts. "It is a hugely responsible role and the nurses must make their own clinical decisions based on their assessments," says Lorraine. "We will continue to have FMEs available to refer to if necessary but for the vast majority of the time there's not really any need to make such referrals."

Lorraine's role is to coordinate the services across multiple stations, ensuring officers and other community teams – like the community mental health teams – are aware of the services the custody nursing service offers.

Lorraine, who previously worked in both accident and emergency and the prison service, loves her new role. "I chose the job because I thought it combined all my previous experience – and it's nice to be involved at the start of a service so you can influence how things develop in the future. It's my ideal job really and I love working for the Met."



Educating for patient self management

Morag Barrell: District Nurse Case Manager, Midlothian Anticipatory Care Service, Scotland

Morag and her colleague Julie Churchill are trail blazing a new service that aims to support patients with long-term conditions, with a specific focus on chronic obstructive pulmonary disease (COPD).

“The service – which began in June 2009 – supports patient self-management and self-care and aims to reduce unplanned hospital admissions,” explains Morag. “The approach is working well with COPD patients and we hope to extend our service to people living with other long-term conditions.”

Morag outlines how they work with patients; “We get referrals from hospitals, specialist nurses, GPs and other agencies in the community. Following an initial assessment, we’ll arrange with a GP to have anticipatory medicines available in the patient’s house and support patients in having the confidence to manage their condition. Having us as a single point of contact can prove extremely helpful.”

The team makes pioneering use of telehealth monitoring to keep track of patients. “Patients test their oxygen levels daily, answer questions on sputum levels and medication, and update us if they’ve recently started their anticipatory medication. Patients can call and ask for extra support – in addition to any scheduled regular visit.”

The team is proving highly successful at reaching previously hidden patient groups. “We find that most of the people we assess are often not known to any other services,” continues Morag. “They may need psychological support and education to give them the confidence to manage – and this is where we come in. We also try to educate and support families so they don’t wait too late and then phone 999.”

Morag is proud of her team’s achievements; “We feel our service makes a real difference, helping people to develop the skills to manage at home – which in turn reduces the number of unplanned hospital admissions, all of which we find very satisfying.”



Revolutionising self management of long-term conditions

Sue Moody: Community Matron, and Chair of District Nursing Forum for West Sussex Health, England

Telehealth – the electronic exchange of personal health data from a patient at home to medical staff at hospital or in a clinic – has revolutionised the way Sue Moody and her team provide care for people with long-term conditions in West Sussex

Sue and her team mostly deal with older patients, helping them self-manage chronic illnesses such as diabetes, pulmonary, respiratory and cardiac diseases. The introduction of telehealth has helped reduce the number of hospital admissions and, as Sue explains, patients are much less likely to use emergency services.

“Patients monitor their vital signs – including their oxygen levels, blood pressure, blood sugar levels and weight – at home on a daily basis and the results are communicated directly to my computer via their telephone line,” she says. “I monitor their signs and if I’m not happy with a reading I might ask a patient to do them again in an hour. If after that second reading I’m still not happy, I go out and visit them.”

The programme began as a pilot two years ago, and now there are plans to extend the scheme across the trust.

“Our job is to help patients understand their conditions and the medicines they have to take,” confirms Sue. “We find that hospital admissions often result because patients haven’t understood how to manage their medications properly. We educate patients about their health and signpost them to the right services.”

As a community matron, a big part of Sue’s role is to work closely with other social care and voluntary services – including occupational health therapists,

physiotherapists and speech therapists.

“Fortunately the community nurse teams are based in the local hospital alongside the specialist nurses, the falls team and the intermediate care team which makes networking so much easier,” explains Sue. “While we are generalists, because of the broad spectrum of problems we come across, being able to network and work closely with many agencies makes the community job very satisfying.”

Sue also promotes a ‘whole team’ approach that ensures that when she’s away, the rest of her team know her patients and are able to support them in her absence.

Having completed a masters degree in advanced nurse practice, Sue is very keen on having the right supervision in place. She explains; “The ability to be able to critically evaluate your own practice is really helpful. We have a lot of autonomy and responsibility, so it’s good to be able to discuss different ways of doing things with peers and medical colleagues, so you don’t become tunnel visioned.”



Supporting families of children with autism

Sue Holtby: Specialist Health Visitor for Children with Disabilities, United Lincolnshire Hospitals NHS Trust, England

When Sue Holtby first started working for United Lincolnshire Hospitals NHS Trust, she expected to spend her time seeing children with genetic disorders and other neurological conditions, but found herself predominantly working with children with autism. Her new role is to provide county-wide training to school nurses and health visitors so they can support families with these children. Sue also contributes to working groups focusing on policies to develop services.

As Sue explains; “One of the principles of health visiting is to seek out health needs and meet those needs, and when I joined the trust 12 years ago I saw there was a growing number of parents needing support when they found their child was autistic. So that’s what I took up and developed.”

As Sue outlines, she undertakes direct interventions with parents. “In face-to-face contact with parents I help them to make sense of the diagnosis and put strategies in place to manage their child’s behaviour better. Sometimes we have parents transferred from other areas where they have just been given their diagnosis and told to get on with it. That doesn’t happen here.”

Sue also plays a key role in signposting parents to local support sources, such as children centres for the under-fives and parent support advisers.

With a waiting list of six to eight weeks, Sue offers two home visits to parents. “I think parents benefit from being seen in their own home, and ideally I like to visit alongside the family’s existing health visitor or school nurse as they have knowledge of the family before the diagnosis.”

With the support of a clinical psychologist, 13 years ago Sue set up a parent support group. Alongside providing telephone and email support for parents in the area and actively lobbying on issues that affect families, the group offers activities in school holidays and also organises lectures for parents and professionals from well-known international speakers on autism.”

Sue is deeply committed to her work within the community and is concerned that there is not enough time or staff to give the excellent service she would like to give, but does not let that hold her back. “Sometimes it’s all about doing things differently. For example, I’m currently part of a working group that is developing a gold standard autism pathway which we hope the clinical commissioning groups will sign up to, and which will give families with children with autism the support they need.”

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