The Queen's Nursing Institute

Transition to District Nursing Service

Contents

Section B - Working in the community nursing setting

Chapter 4 - Patient focus

The aim of this Chapter is to:

- Define Long Term Conditions and their impact on the patient

- Consider the role of the community nurse when caring for patients with Long Term Conditions and Palliative care

- Develop an understanding of integrated approaches to care in the community setting and the resources and networks available for this group

Long Term Conditions

As a community nurse you will come into daily contact with many patients that are living with one or more Long Term Conditions (LTC). The issue (LTC's) has been at the top of the government's health agenda for many years and now takes up 70% of the health service budget. The NHS Five Year Forward View (2014) notes that managing long term conditions is now a central task for the NHS and makes the case for improved personalised care and support for people with LTCs and their carers. Within the NHS Five Year Forward View it has been acknowledged that there needs to be some major changes within health care systems and delivery of care in order to address the LTC agenda. LTC's are now a central task for the NHS; requiring a partnership with patients over the long term rather than providing single episodes of care. It is generally agreed that services need to be integrated combining NHS, GP and social care services as a way of improving care. NHS (2014) Five Year View www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The NHS Five Year Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. In relation to LTC's management, NHS England have worked to develop three 'service components' or 'handbooks' to provide practical support for good long-term conditions management. They draw on the latest research, best practice and case studies:

1. Case finding and risk stratification – identifying cohorts of people with LTCs that are most vulnerable and/or will benefit most from tailored care and support. Using case finding and risk stratification: a key service component for personalised care and support planning (2015) www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14- FINAL.pdf

2. Next Steps for Risk Stratification in the NHS (2015) – recent discussion paper on Case finding and risk stratification handbook. www.england.nhs.uk/wp-content/uploads/2015/01/nxt-steps-risk-strat-glewis.pdf

3. Personalised care and support planning – enabling commissioners and health care practitioners to deliver personalised care. NHS England and Coalition for Collaborative Care - Action for Long Term Condition (2015) Personalised Care and Support Planning Handbook - the journey to person - centred care.

'LTCs have been at the top of the government's health agenda for many years and now takes up 70% of the health service budget.'

www.england.nhs.uk/wp-content/uploads/2015/01/pcsp-guid-exec-summ.pdf

Whole Systems Approaches to care

The traditional divides between primary care, community services and hospitals has been viewed as a barrier to delivering personalised and coordinated care. The NHS Five Year Forward View advocates partnership working over the long term, rather than providing single, unconnected 'episodes' of care.

The NHS Five Year Forward View acknowledges that England is too diverse for a single model of care to be applicable everywhere and that in different parts of the country needs will be different. It is also acknowledged and particularly pertaining to the role of the district nurse that the most important change will be to expand and strengthen primary and 'out of hospital' care:

'Give GP-led Clinical Commissioning Groups (CCG's) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.'

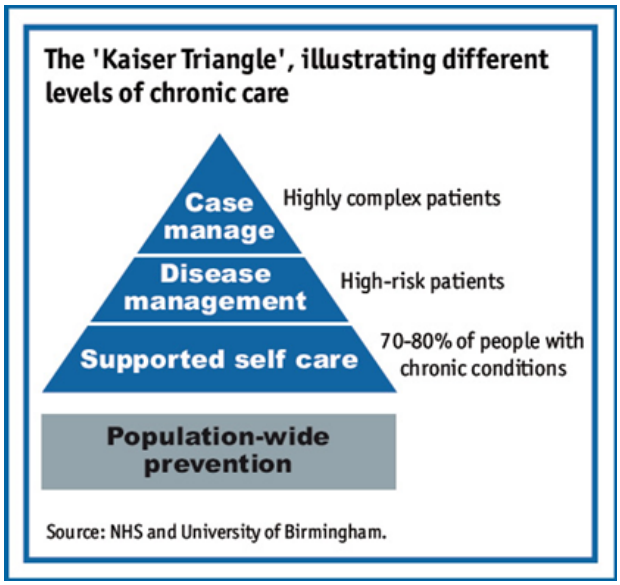
'Expand as fast as possible the numbers of GPs in training while training more community nurses and other primary care staff.'
NHS Five Year Forward View (2014),page 18.

In 2015 the government invited individual NHS organisations and partnerships to apply to become 'vanguards' for the new care models programme, as one of the steps to delivering the NHS Five Year Forward View. In particular, there were some integrated primary and acute care systems that concentrated on multi-speciality community providers (MCPs). These MCPs would become the focal point for a far wider range of care needed by patients registered with a GP. The vision is that these 'vanguards' will act as blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

Exercise

As part of you learning for this Chapter find out more about vanguard sites and also whether you are working in one.
www.england.nhs.uk/ourwork/futurenhs/new-care-models

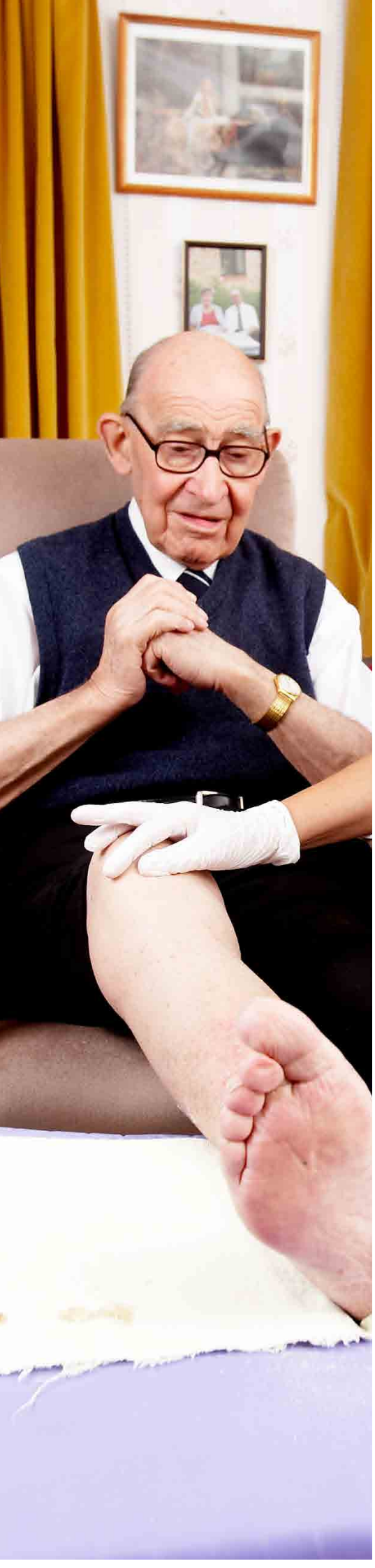
Health policy in the UK has tended to be shaped to an extent by American policy on long term conditions and no explanation of this policy would be complete without reference to the Kaiser Permenante triangle (DH 2005a).



This model acknowledges that people affected or potentially affected by LTCs have differing and complex needs. Level one refers to 70-80% of the population that self-manage their own condition and may require advice on health promotion. Level two are those with a disease-specific unstable long term condition; this is the level at which community nurses are mostly likely to be involved. Level three are those with highly complex multiple conditions that require intense case management and these patients are usually cared for by a community matron or equivalent case management worker.

The ACEVO (Association of Chief Executives of Voluntary Organisations) Taskforce on Prevention in Health was established in 2012 to examine ways to encourage a shift in focus and investment towards preventative health and care provision. They produced a report that called for a fundamental change in behaviour and culture throughout the health and social care system: a 'Prevention Revolution'. It sets out a number of key recommendations aimed at creating the conditions for change to occur. Throughout the report the emphasis is on the role that the voluntary and community sector must play in promoting innovation and transformation throughout health and social care.

The report can be accessed at:
https://www.acevo.org.uk/sites/default/files/documents/Prevention_Revolution_ACEVO_Report_Mar2013.pdf



Action: consider what voluntary and social care services there are in your area and how you might work together to improve health outcomes for your practice population.

Living with a Long Term Condition

For some people being diagnosed with an LTC can be devastating and there is a feeling that their life will change significantly. Patients may have already lived with the uncertainty of symptoms including pain, discomfort, disability and the anxiety of not knowing what is wrong with them. Features of a LTC include symptoms that have become intrusive, have gone on for longer than six months, multiple pathology and requiring medical intervention.

In order to assist these patients you will be involved in care planning in order to address the range of needs that these patients present with. You will be required to take into account their personal, psychological, health, family, social, economic, ethnic and cultural circumstances. It will be vital for you to understand the need for individualised care planning in order to provide quality care to all your patients. Assessment is a core skill of the qualified district nurse and you will have the opportunity to learn and develop some of these skills whilst working alongside these specialist practitioners. It will be part of your role to facilitate this person centred approach to care and assist in some of the decisions made to optimise patient care.

Person - centred care has become one of the major goals of health policy and recent system reform. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. Visit the Health Foundation Inspiring Improvement website for more information www.health.org.uk

Another aspect of LTCs is the notion of self - care where patients take responsibility for themselves to stay well and maintain their wellbeing by being informed about their LTC. As a community nurse your role here will be about health education and promotion. You will be involved in sign posting patients to the most appropriate source of information to assist them in making the right choices for them. Skills for Health (2015) Common Core Principles to support self - care

ACTIVITY

Think about some of the patients you may have on your caseload. In what ways might you promote self-care?

- Think about how you could educate them about health related issues
- How could you direct them to more information and what would be the best source of information for them taking into account the person
- Can you think of where you could access resources to help you to inform them better?

‘Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you.’

Here is a list of some of the types of LTCs

- **Cardiovascular/ circulatory conditions:** venous/ arterial leg ulcers, coronary artery disease, hypertension, congestive heart failure, valve or arterial occlusive disease.

- **Respiratory conditions:** asthma, cystic fibrosis, occupational respiratory diseases, chronic obstructive pulmonary disease.

- **Neurological conditions:** Parkinson’s, Alzheimer’s, multiple sclerosis, motor neurone disease.

- **Immune and haematological conditions:** HIV, hepatitis, haemophilia, sickle cell, thalassaemia, rheumatoid arthritis, systemic lupus erythomatosus, iron deficiency anaemia.

- **Cancers:** lung, colorectal, head and neck, breast, cervical, bladder etc. leukaemia.

- **Gastrointestinal conditions:** irritable bowel syndrome, inflammatory bowel disease, cirrhosis, chronic pancreatitis, hiatus hernia, constipation, faecal incontinence.

- **Endocrine conditions:** diabetes mellitus, hyperthyroidism, hypothyroidism.

- **Renal and urological conditions:** chronic renal failure, neurogenic bladder, urinary incontinence.

- **Gynaecological conditions:** endometriosis, fibroids, infertility.

- **Frailty** results from the ageing process in which multiple body systems gradually lose their in-built reserves

- **Musculoskeletal conditions:** osteoporosis, osteoarthritis, chronic back pain, scoliosis.

- **Dementia**

- **Spinal conditions**

Below are links to voluntary organisation representing people with Long Term Conditions. This is not an exhaustive list.

- www.alzheimers.org.uk
- www.diabetes.org.uk
- www.bhf.org.uk
- www.blf.org.uk
- www.mndassociation.org
- www.macmillan.org.uk
- www.mind.org.uk
- www.ageuk.org
- www.mssociety.org.uk

Practicalities of nursing people LTCs

There are some fundamental clinical skills that are required when caring for people with LTCs and these will be addressed in Chapter Five. It is also important to assess your own current knowledge and abilities regarding certain conditions, either as they appear on the caseload or if you have a particular interest in an illness or condition. Some local organisations may be a valuable source for this type of information, as they will be current and up to date on treatments and initiatives relating to the national guidelines and strategies.

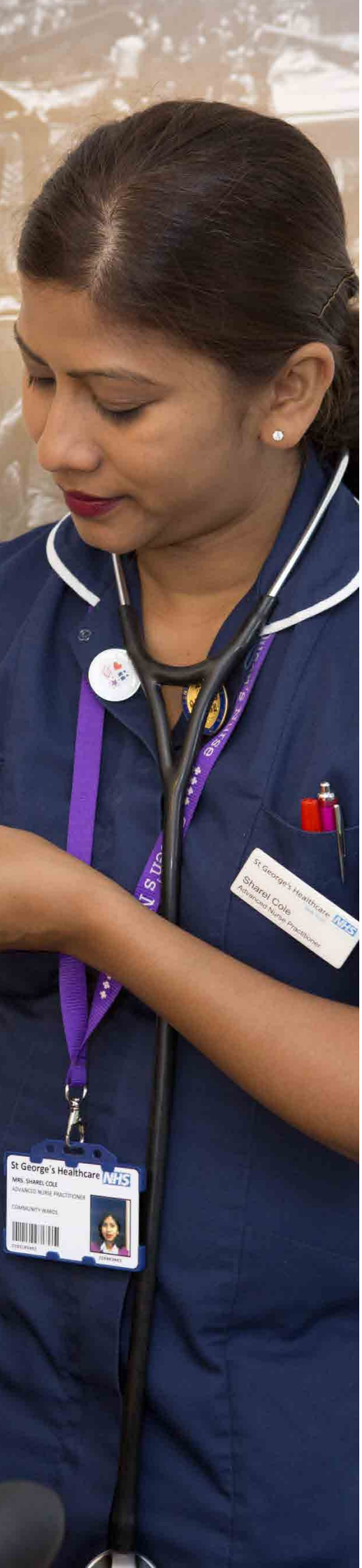
Advocacy

As a community nurse you will have to establish a personal authority and assertiveness in order to influence other health and social care professionals, colleagues and patients to promote care. Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you. The goal of this assertive behaviour in this context is to stand up for patient’s rights and act as an advocate. Being assertive does not always mean you get what you want, but it can help you achieve a compromise. You will need to develop a deeper degree of self-awareness, self-belief in your ability to convey information with confidence and conviction.

Assertiveness is considered to be an essential skill for a nurse, and in the community setting assertive behaviour can assist in promoting multi-professional relationships.

‘Being Assertive means being able to stand up for your own or other people’s rights in a calm and positive way, without being either aggressive, or passively accepting ‘wrong.’
Begley C and Glacken M (2004): Irish nursing students’ changing levels of assertiveness during their pre-registration programme. Nurse Education Today Vol 24 – 501-510

‘You need to learn the art of acting, of appearing confident even if inside you are scared… most important is learning to be confident.’
Stewart (1989 page 11)



Here are a few articles that you may find useful when considering how to boost your confidence.

- http://transitionsinnursing.com/9-ways-to-boost-your-confidence-as-a-nurse/
- http://www.nursingtimes.net/nursing-practice/clinical-zones/management/boost-your-confidence-to-reach-the-stars/5044830.article
- http://www.nursingtimes.net/nursing-practice/career-development/boost-your-confidence-and-get-noticed/5039336.article

End of Life Care

As a community nurse you will get involved with the care of patients at the end of their life. The term 'End of Life Care' (EoLC) is relatively new and includes wider aspects of care of the dying e.g. supportive, palliative and terminal care and could go on for the last years, months or weeks of life. The DH (2008) developed an End of Life Strategy: promoting high quality care for adults at the end of their life to incorporate these wider aspects of dying:
End of Life Strategy:www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

When caring for people at the end of their lives in the home setting, it will be really important for you to understand some of the different approaches to care and how these are implemented. The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising the care for patients nearing the end of life delivered by generalist providers. It is concerned with helping people to live well until the end of life and includes care in the final year of life for people with any end stage illness in any setting. GSF improves the quality, coordination and organisation of care in primary care, care homes and acute hospitals. This enables more patients to receive the type of care they want, in their preferred place, with greater cost efficiency through reduced hospitalisation. www.goldstandardsframework.org.uk

Advanced Care Planning

Healthcare policy recognises the importance of engaging people in making decisions related to the management of their health. Advance care planning (ACP) offers a framework for decision making on end-of-life care. District nurses are in the ideal position to facilitate ACP, as they have the opportunity to build relationships with the people they are caring for over a period of time.

This is a useful article that explores the role of the district nurse in facilitating individualised care planning:
Boot M (2016): Exploring the district nurse role in facilitating individualised care planning British Journal of Community Nursing, Vol 3 No 3.

Additional Resources

In the last few years, EOL care has made some great strides forward in particular following the End of Life Care Strategy (2008) and as a result there has been a re-focus and the publication of some key reports:
Leadership Alliance for the Care of Dying People (2014): One Chance to Get it Right - Improving People's experience of care in the last few days and hours of life.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

National Palliative and End of Life Care Partnership (2015) Ambitions for palliative and end of life care. A framework for local action 2015-2020 (online). Available at: http://endoflifecareambitions.org.uk
Nice Guidelines – Caring of dying adults in the last days of life (2015) www.nice.org.uk/guidance/ng31

Dementia Care

There are around 750,000 people living with Dementia in the UK. It affects around two thirds of women, mainly due to the fact that women live longer than men. The number of people with dementia are expected to double in the next 30 years. Having dementia does not automatically mean that one has to go into a care home or hospital. Two–thirds of people with dementia live in the community. With the right support people diagnosed with Dementia can remain at home if they wish to.

'For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.'
NHS (2014) Five Year View

The government launched a campaign called Dementia Challenge in March 2012, an unprecedented programme to fight dementia. Three years on there have been significant improvements in health and care, creating dementia friendly communities and better research into the condition.

By 2020 the aim is for England to be:

- The best country in the world for dementia care and support for people with dementia, their carers and family to live
- The best place in the world to undertake research into dementia and other neuro-degenerative diseases

Prime Minister's challenge on dementia 2020:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/414344/pm-dementia2020.pdf

As a community nurse you will undoubtedly come into contact with patients and carers with Dementia.

The symptoms of dementia occur in three domains:

- Difficulties with activities of daily living- e.g. personal care
- Behavioural and psychiatric problems e.g. personality and emotional changes
- Cognitive dysfunction that may affect speech, language, memory and orientation.

Also access www.cks.nhs.uk/home - .This is a good source of information on a range of common condition managed in primary care.

There are many groups and charities set up to support people living with this condition:
www.nhs.uk/Conditions/dementia-guide/Pages/dementia-carers.aspx

Watch David Cameron talk about Dementia Friends:www.youtube.com/watch?v=mXryu-1-9xw&feature=youtu.be-
www.dementiacare.org.uk
Dementia (2014) Opportunity for Change, Alzheimer's Society www.alzheimers.org.uk

Sources of Support

Support mechanisms have already been discussed within this resource and this is just another quick reminder of the importance of accessing support if needed. Caring for patients with LTCs and at the End of Life is mentally and physically draining at times and you need to be aware that the effects can take hold of you when you least expect it. Remember that your colleagues in the team are experienced in this kind of caring and can be a 'listening ear' when it all gets too much for you. Handover can be a good time to air your thoughts and feelings about a patient's condition, also clinical supervision (if you can access it) is another forum to share with colleagues any challenges you are facing when providing care.

Here are some resources to access regarding stress and wellbeing:

- RCN (2005) Managing your stress – A Guide for Nurses www2.rcn.org.uk/__data/assets/pdf_file/0008/78515/001484.pdf
- RCN (2013) Beyond breaking point? A survey report of RCN members on health, wellbeing and stress https://www2.rcn.org.uk/__data/assets/pdf_file/0005/541778/004448.pdf
- Burke M (2013) Managing work- related stress in the district nursing workplace British Journal of Community Nursing Nov:18 (11) 535-538

Reflection trigger point- what would you do if?

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. We are aware that the solutions to these triggers may vary from Trust to Trust according to local policy and procedure. We are also aware that there may be no 'right or wrong' answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

- You are visiting a patient with COPD who has a chest infection. The patient is so unwell that they have had to stay in bed. They have no immediate relatives. How will you prevent this patient from being admitted to hospital?

- A patient phones for provision of continence pads, but upon visiting you find a situation where the patient has many more needs but does not recognise them. You want to help but you do not wish to encroach too heavily upon their lifestyle.

- Caring for a patient in an end of life situation and the patient and family have not realised the extent and the imminence of the death.

- ' … a patient has a blood glucose of 3.2 mmols and very little food in the cupboard and lives alone, what actions would you take as you have been allocated to give their insulin? '

Quotes from nurses when asked what is important to them:

'Enabling people to choose to die at home and provide a standard of care that supports both patient and family in the comfort of their own home.'

' … managing distressing symptoms in the home setting to enable the patient to remain at home to die and their choice of place of death has been met…'

'I like getting to know patients over a long period of time and being able to focus on their needs without distractions.'

‘I like getting to know patients over a long period of time and being able to focus on their needs without distractions.’

Chapter Summary

This Chapter has raised some awareness of the vast topic of LTCs and End of Life. It has introduced the concept of self-care and the importance for people to feel supported to make decisions despite their condition. As a community nurse the challenges posed by caring for this growing group of people is never ending and will require a real understanding of partnership working when addressing the needs of those experiencing the effects of an LTC.

Web Resources

- www.goldstandardsframework.nhs.uk/TheGSFToolkit
- www.depression-primarycare.co.uk
- www.nice.org.uk The National Institute for Health and Care Excellence
- www.helpthehospices.org.uk Help the Hospices
- www.dyingmatters.org
- www.nationalcouncilpalliativecare