Qni The Queen's Nursing Institute

Transition to District Nursing Service

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Section A - Thinking about working in the community

Chapter 1 - What is community nursing?

The aim of this chapter is to:

- Provide you with a brief overview of the history of community nursing in the UK.

- Consider historical attitudes of community nursing and how these feelings may still resonate in community nursing today

- Outline the different roles and responsibilities of professionals in the community setting

- Consider what skills you may need to work in the community nursing setting

The term 'community' encompasses a whole range of different meanings and viewpoints. The essence of community is therefore difficult to capture within a single definition.

Historical Perspectives

District nursing as an organised movement began when William Rathbone (1819-1902), the Liverpool merchant and philanthropist, employed Mary Robinson to nurse his wife at home during her final illness. In May 1859, after his wife died, he decided to try to extend the service started with Mary Robinson, but soon found that there was a lack of trained nurses and that nurse training was disorganised and very variable in quality. In 1860 he wrote to Florence Nightingale, who advised him to start a nurse training school and home for nurses attached to the Royal Infirmary in Liverpool and with typical Victorian organisation and energy this was built by May 1863.

For district nursing purposes, the city was divided into 18 'districts', each being a group of parishes. Each district was under the charge of a Lady Superintendent drawn from wealthy families who were expected to underwrite the costs of the scheme and provide accommodation for nurses.

The public attitude towards district nurses has always been positive due to the nature of the care that they perform. They have always been trusted and welcomed into the home and have been referred to in the past as the " I'll see what I can do" or the "tea and sympathy" nurse. Community nurses have had to be creative in the way in which they practice and deliver care in the home setting. They are renowned for being able to 'think on their feet' to adapt to situations and be resourceful in unpredictable surrounding and situations. The QNI was established in 1887 to co-ordinate training nationally.

Definition of District Nurse

It is important here to define what is meant by a District Nurse. A District Nurse is a qualified and registered nurse that has undertaken further training and education to become a specialist community practitioner. This community specialist practitioner qualification (SPQ)

can be taken at degree or Masters level and the current programmes comprise 50% theory and 50% practice and concentrate on four areas:

NMC (2001) Standards for Specialist Education and Practice (NMC London):

- clinical nursing practice
- care and programme management
- clinical practice development
- clinical practice leadership.

The QNI have has long advocated for the education of district District nurses Nurses to ensure that community nursing team leaders develop the specialist skills and knowledge to enable them to lead the service. The QNI/QNI Scotland have together developed new standards as a result of a long-standing project to build and enhance the NMC Standards, but not to replace them.

The QNI and QNIS recommend that the new standards are adopted by all education providers currently offering the Specialist Practitioner – District Nurse programme in the UK, and the QNI have welcomed the positive response from universities regarding the incorporation of the standards into their programmes.

QNI/QNIS (2015) Voluntary Standards for District Nurse education and Practice
http://www.qni.org.uk/for_nurses/policy_and_practice/district_nurse_standards

The Queen's Nursing Institute (QNI) published the results of the 2020 Vision Five Years On Survey on the future of District Nursing in 2014, which presented evidence that the Specialist Practitioner Qualification (SPQ) in District Nursing was critical to effective team leadership and caseload management (QNI, 2014a).

A subsequent report to investigate the value of the SPQ in more depth has reinforced the message that this specialist programme is essential to support the nurse to develop the unique skills and knowledge required to lead and manage a team of multi-skilled

Role of district nurse

PATIENT FOCUS
- Therapeutic relationships
- Patient advocate
- Carers support
- Self-management
- Evaluation and review

MANAGEMENT
- Organisational skills
- Caseload
- Care management
- Emotional labour
- Resources
- Business acumen

COLLABORATIVE
- Inter-professional working
- Complex care co-ordinator
- Referral
- Written and verbal skills
- Technology

DISTRICT NURSE

EDUCATION & KNOWLEDGE
- Graduate/Masters level workforce
- National and local policy
- Needs assessment
- Strategy
- Evidence based
- LTCs
- Health promotion/Improvement

SKILLS
- Holistic assessment
- Clinical decision making
- Clinical skills
- Communication
- Curative
- Maintenance
- Palliative

LEADERSHIP
- Role identity
- Team Leader/Staff Management
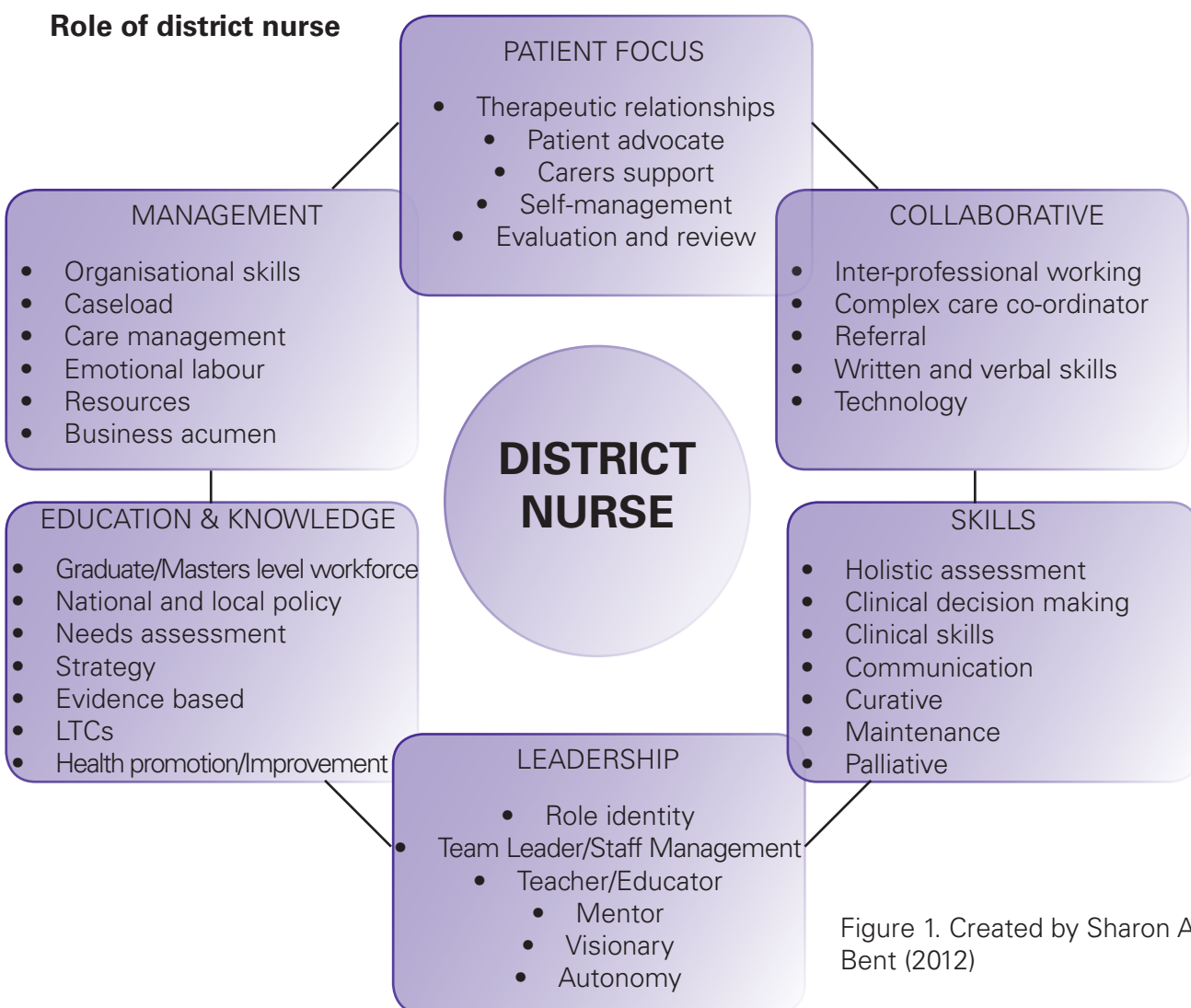- Teacher/Educator
- Mentor
- Visionary
- Autonomy

Figure 1. Created by Sharon Aldridge-Bent (2012)

professionals to deliver excellent nursing care to people in their homes and local communities (QNI, 2015). http://www.qni.org.uk/for_nurses/policy_and_practice/district_nursing_spq

The indisputable value of District Nursing in indisputable and this was also acknowledged by an RCN survey of district and community nurses published in 2014, which provided a unique view into the community nursing workforce.

RCN (2014) Survey of district and community nurses in 2013- Report to the RCN
www.rcn.org.uk/about-us/policy-briefings/pol-1414

Community staff nurses can be funded onto to undertake a Ddistrict Nnurse specialist practitioner programme via their employing trust. Applicants with the relevant registration and experience can also apply for sponsorship via their employing organisation. AlthoughHowever, as funding support becomes harder to access, self funding occurs is likely to occur in some instances.

Today District Nnurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members. As well as providing direct patient care, district District nurses Nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives.

District nurses also play a vital role in keeping hospital admissions and readmissions to a minimum and ensuring that patients can return to their own homes as soon as possible. The complexity of district District nursing Nursing care is highlighted by the work of the QNI (2011), including examples of engagement with the assessment of complex needs, risk assessment, leadership and management, application of specialist knowledge and skills, with the ability to work collaboratively across organisations. The key skills required for the district District nurse Nurse are demonstrated in Figure 1

The role of the District Nurse
The qualified District Nurse is professionally responsible and accountable for the quality of care that they provide and is well also qualified to assess the needs of individuals and their carers. District Nurses also lead and manage a multi-skilled team of nurses and are skilled to work collaboratively with a multiplicity of agencies (statutory, voluntary and private) in order to deliver care to a defined population. The reality of the level of responsibility and accountability in the qualified nurse is depicted overleaf.

'District nurses also play a vital role in keeping hospital admissions and readmissions to a minimum.'
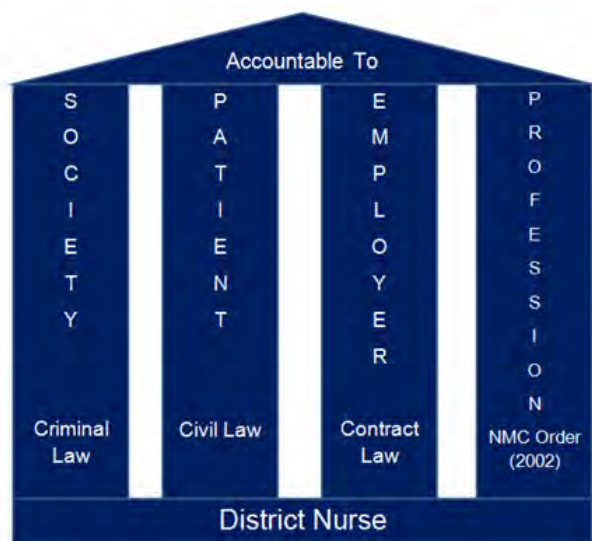
RCN (2010) Pillars of Community

The Future
The Health and Social Care Act (2012) saw the introduction of Clinical Commissioning Groups led by GPs responsible for the commissioning and delivery of health care. As a result many GP practices are working closely together to redesign primary care services and consider how the MDT might work in different ways.
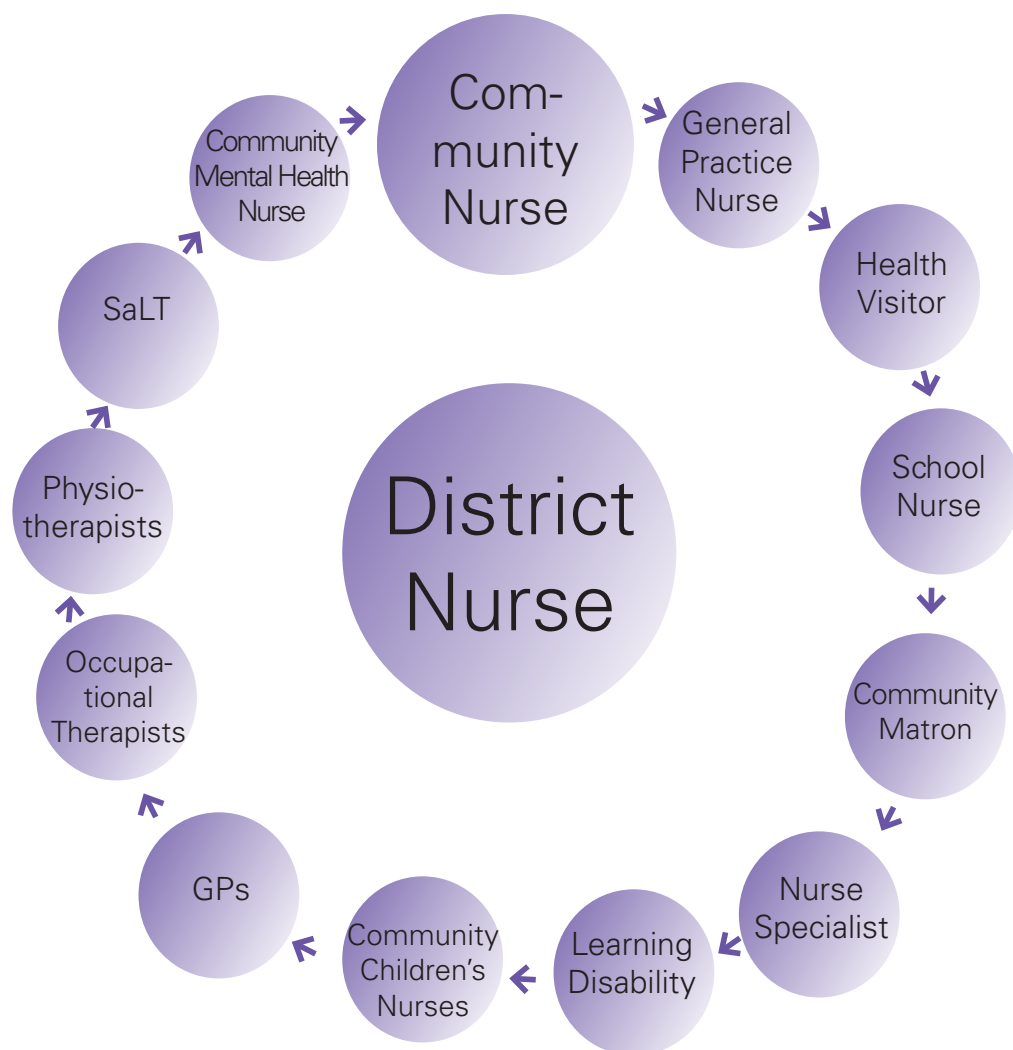
Different roles in the community
District Nurses work with a wide range of health and social care professionals to delivery care across the lifespan. Trying to identify and establish all the different roles will may seem quite daunting to begin with. Here is a brief overview of the roles to get you started.

Practice Nurses - work within GP surgeries and assess, screen and treat patients from across the lifespan. They run clinics for patients with Long Term Conditions such as asthma, heart disease and diabetes. They also offer health promotion advice in areas such as contraception, weight loss, smoking cessation and travel immunisations.

They can be known as case managers or caseload managers and are highly experienced senior nurses that work with patients with complex health problems (DH 2004). They provide a single point of care to support provide care for patient and prevent hospital admissions.

Health Visitors - also known as a specialist community public health nurse (SCPHN) Health visitors work with families with children under the age of 5 years of age. They support families and children in issues such as growth and development, post- natal depression, breastfeeding and weaning, domestic violence and bereavement. They also play a role in safeguarding and protecting children from harm.

Figure 1 Created by Sharon Aldridge-Bent (2012)

Community Children's Nurses - provide holistic care to sick children by providing nursing care in the community setting, empowering and enabling the child, family/carers' to become more competent in the management of the child's condition, thereby reducing the need for hospital admissions or enabling early discharge. The Community Children's Nurses provide nursing care to children and young people with a life limiting, life threatening condition, complex disability, long term conditions such as asthma, eczema or allergies as well as palliative and end of life care.

Community Matrons
Community matrons are usually deemed to be working as advanced nurse practitioners. These highly-skilled nurses have a variety of tasks and responsibilities, including: carrying out treatment, prescribing medicines, or refer patients to an appropriate specialist. Plan and provide skilled and competent care that meets patients' health and social care needs, involving other members of the healthcare team as appropriate.

Community Mental Health Nurses
A community mental health nurse (CMHN), also sometimes known as a community psychiatric nurse, is a registered nurse with specialist training in mental health. Some CMHNs are attached to GP surgeries, or community mental health centers, while others work in psychiatric units. CMHNs have a wide range of expertise and offer advice and support to people with long-term mental health conditions, and administer medication. Some CMHNs specialise in treating certain people, such as children, older people, or people with a drug or alcohol addiction.

General Practitioners (GPs) - provide a complete spectrum of care within the local community: dealing with problems that often combine physical, psychological and social components. Most GPs are independent contractors to the NHS. This independence means that in most cases, they are responsible for providing adequate premises from which to practice and for employing their own staff.

General Practice Nurses or Practice Nurses
General Practice nurses work in GP surgeries as part of a primary care team that is likely to include doctors, nurses, dietitians and pharmacists. Practice nurses assess, screen, treat and educate all sections of the community, from babies to older people. In smaller practices, they may be the sole nurse, whereas in larger surgeries, they may share duties with practice nurse colleagues.

Learning Disability Nurses - provide specialist healthcare to those with a range of learning disabilities. They also offer support to their families. Learning disability nursing is provided in settings such as adult education, residential and community centers, as well as in patients' homes, workplaces and schools.

Occupational Therapists - work with people of all ages to help them overcome the effects of disability caused by physical or psychological illness, ageing or accident. The profession offers enormous opportunities for career development and endless variety.

Physiotherapists - A physiotherapist's core skills include manual therapy, therapeutic exercise and the application of electro-physical modalities. They also have an appreciation of psychological, cultural and social factors influencing their clients. More physiotherapists work in

'The relationship between the public and health professionals is also changing.'

the community and a growing number are employed by GPs. Treatment and advice for patients and carers take place in their own homes, nursing homes, day centres, schools and health centres.

Rapid Response or Integrated Care Teams – are multidisciplinary health and social care teams made up of physiotherapists, occupational therapists, support workers and nurses. The service aims to prevent unnecessary patient admission to hospital. These teams provide short-term support and rehabilitation in the home.

Pharmacists - are experts in medicines and work to ensure the safe supply and use of medicines by the public. Pharmacists register with the General Pharmaceutical Council (GPhC) following completion of a four-year Master of Pharmacy degree from a UK school of pharmacy. They then work for at least a year under the supervision of an experienced and qualified pharmacist, either in a hospital or community pharmacy such as a supermarket or high street pharmacy. Around 70% of pharmacists work in the community preparing and dispensing prescription and non-prescription medicines in premises on local high streets.

School Nurse
School nurses work closely with pupils, parents, carers and teachers, offering support and advice on a range of issues from obesity to sexual health. They play a vital role in children's development, carrying out immunisation and screening programmes, managing medical conditions and acting as a point of contact on child protection issues.

Specialist Nurses
There are many specialist nurse working in the community setting and they play a key role in the management of patient care. Working closely with doctors and other members of the multidisciplinary team, they educate and support patients, relatives and carers from a variety of specialties eg Tissue Viability, Palliative Care, Diabetes, Parkinson's, Continence Advisors and Coronary Heart Disease.

Speech and Language Therapists (SaLT)
They assess and treat speech, language and communication problems in people of all ages to help them better communicate. They'll also work with people who have eating and swallowing problems.

New and developing roles in Primary Care
The primary and community care services now face major challenges; with an increasing workload, an ageing population, and increasingly complex medical problems being diagnosed and managed in the community. The relationship between the public and health professionals is also changing – with an increasing focus on giving people information and involving them in decisions about their care.

Whilst it is recognised that there is considerable potential in developing these new roles, the governance of these new staff members will be of critical importance in ensuring the quality and safety of their work. This is a particular issue where the GP practice is the employer, when GPs need clarification of the training and governance of these new staff members. Federations of GP practices have a particular role in supporting general practices in this area.

To read more about workforce development in the community read:
Primary Care Workforce Commission – The Future of Primary Care creating dreams for tomorrow
www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf

Physicians Associates
New clinical and support staff roles in general practice Physician Associates (previously called physician assistants) provide generalist clinical care in general practice, typically seeing people with acute minor illness. They have two years training, most after a basic science degree. This training follows the model of a medical qualification (for example, taking histories, performing examinations, making diagnoses, interpreting tests).

Health Care Assistants (HCAs)
Increasing use is being made of healthcare assistants in carrying out health assessments, performing routine tests, helping people monitor their conditions and carrying out administrative tasks in the community setting.

The Shape of Caring review (2015) chaired by Lord Willis outlines its intention to improve the capabilities of Health and Social Care Assistants and for Health Education England (HEE) to promote structured career development for these increasingly important members of the workforce. The introduction of the Care Certificate to be completed by all new HCAs

during their induction is the first step. The Care Certificate is a first level introduction to the fundamentals of care and consists of 15 standards that are assessed 'in house' during the first 12 weeks of employment.

Below are links to the Shape of Caring Review and to further information on the Care Certificate:
• http://hee.nhs.uk/wp-content/blogs.dir/321/ files/2015/03/2348-Shape-of-caring-reviewFINAL.pdf
• www.skillsforcare.org.uk/Standards/Carewww.skillsforcare.org.uk/Standards/CareCertificate/Care-Certificate.asp x

Health and Social Care Co-ordinator and Primary Care Navigator (PCN) roles

The purpose of both of these the roles is to work as part of a multidisciplinary health care professional team in GP surgeries, taking referrals for patients that have social issues that may be affecting their overall health and wellbeing. The purpose of the PCN is to refer or signpost the patients to relevant services/agencies that are available in the community, with the aim of reducing GP attendances and visits to A & E. Whilst the Health and Social Care co-ordinator role will perform similar duties but may establish and carry a caseload with longer input with patients.

Exercise

What personal skills are required to work in the community? In some instances a SWOT analysis is a good way to establish insight into your own abilities. Take a sheet of paper and divide it into four cells and label them 'strengths' 'weaknesses', 'opportunities' and 'threats'. Under each heading within each cell write down as many things that you can think of that relate to your role as a nurse. You can then ask yourself 'What are the threats that the weaknesses expose us to?' and 'What opportunities arise because of your strengths?'. By doing a swot SWOT analysis it allows you to become critical of and to reflect upon your own behaviour. This can sometimes be a step towards changing and developing as a result both personally and professionally.

Diagnostic self-assessed identification of leaning needs for community based practice:

STRENGTHS	WEAKNESSES
OPPORTUNITIES	THREATS

'It feels more like a partnership of decision-making between patient and the nurse.'

Example of a completed SWOT:

STRENGTHS	WEAKNESSES
Excellent clinical skills Good communication skills Enthusiastic Like being able to make decisions	Have not worked in the community before Lack confidence Worried about additional skills needed Not confident to teach others Lack of knowledge of a wide range of Long Term Conditions Lack of clinical skills
OPPORTUNITIES	THREATS
Working in a team Change in career pathway Support from my mentor Opportunity to do the course	Not sure if community nursing is for me Working on my own Safety Making the right decisions

Having completed your SWOT it should will be clear that you possess many transferable skills from your present position that can be used in a different setting. It may also allow you to realise that working in the community is not for you, or perhaps there are areas you need to develop before deciding upon a move.

In a recent QNI (2013) community survey, 58% of all nurses identified lack of clinical skills as one of their main concerns when starting a career in the community.

'When I first moved to the community I wasn't aware that I would have so much to learn. I thought that the skills I had as a qualified nurse would be all I needed- Oh how wrong I was!'

Now consider what additional clinical skills do I need to work in the community? Make a list of them here:

Additional clinical skills needed may include:
Examples:
- Medicines management in the community setting- e.g. use of controlled drugs
- Intravenous therapy and central venous access devices – including peripherally inserted central catheter (PICCs)
- Nutritional Support – including Percutaneous Endoscopic Gastrostomy (PEG) feeding
- Wound and leg ulcer assessment and management including: use of Doppler, wound products, compression bandaging. Vacuum Assisted Closure (VAC) Urinary catheterisation and management e.g. suprapubic, intermittent and male catheterisation
- Bowel management
- Ear irrigation
- Venepuncture

This list is not exhaustive.

Quotes

'…Seeing patients in their own environment and getting to know them and enabling patients to remain in their own home. I am able to make clinical decisions independently and the work is varied…'

'..It feels much more like a partnership of decision making between patient and the nurse. I feel able to work more autonomously than when I worked in hospital. It is much easier to holistically assess a patient in their own home and try to find strategies for care that will work for the patient in the home setting based on their individual needs and home set up…'

'Always remember you are a guest in someone's home, pick up on prompts such as photos, pets etc. to strike up a conversation and put the person at ease and you will soon build a rapport and the patient will gain confidence in your ability.'

Chapter Summary

This Chapter has looked at the history of District Nursing in the UK and some of the public attitudes towards community nurses. It has identified the distinct role of the qualified District Nurse and the importance of developing a clear understanding of all the other health care professionals that provide care to people in the home.

It has challenged you to consider if community nursing is for you and also to think about your own clinical skills and what additional skills you may need to work in the community.

Web Resources

www.adne.co.uk – Association of District Nurse Educators
www.qni.org.uk – The Queen's Nursing Institute
www.nhscareers.nhs.uk NHS Careers
www.bupa.co.uk/buildingthecase BUPA Resource

Nice – transition from a patient's persepective
https://www.nice.org.uk/guidance/ng27/resources/transition-between-
inpatient-hospital-settings-and-community-or-care-home-settings-for-
adults-with-social-care-needs-1837336935877

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Section A - Thinking about working in the community

Chapter 2 - Making the transition from hospital to community

The aim of this Chapter is to:

- Develop an understanding of the community setting as a work environment

- Identify the support available to you as a community nurse and whilst undertaking this resource

- Introduce 'Reflection' as a learning tool and consider some models of reflection

- Start to think about how you would like to record your reflections whilst doing this online resource

When making the transition from hospital to the community there are many practical aspects that need to be taken into consideration. The environment and location will be very different. It may take some time to familiarise yourself with the geographical area and one way of doing this maybe by spending some time either walking, cycling or driving around to get your bearings and to consider some of the below:

Housing
- What type of housing is in the area?
- Is there a mix of tenure (e.g. private, rented, social housing)?
- What condition are the houses in?

Environment
- Cleanliness of the streets
- Evidence of vandalism
- Parks and green spaces

Facilities
- Primary Schools?
- Secondary Schools?
- Are there local shops?
- Is there a pharmacist?
- Is there a supermarket nearby?
- Post Office?
- Where is the nearest GP Surgery?
- What District General Hospital serves this area?
- Residential Homes?
- Elderly Day centres?
- Community Centre and Library?
- Location of Local Social Services, chiropody, physiotherapy? etc

Transport
- What public transport is available?
- Are there frequent services?
- What else can you tell about the area?
- By doing this fact finding exercise you will develop a wider

> 'It is important that this shift in the balance of the patient-nurse relationship is not underestimated.'

understanding of the community in which you are going to be working and this local knowledge will be invaluable when delivering care to your patients.

Links to Primary Care

A District Nurse will have a good understanding of the wider context of Primary Care services and the importance of developing relationships across organisational boundaries. The vision outlined in the NHS Five Year Forward View is about the future for the primary care workforce including general practices, community nursing and pharmacies closely working together to provide a range of services in collaboration with secondary care, social care and voluntary organisations.

Primary Care Workforce Commission – The Future of Primary Care creating dreams for tomorrow www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf

Home visiting

A major change will be the fact that when visiting patients, you will be a guest in their home and you will be there by invitation. You will also be exposed to the way in which your patients choose to live their own lives, which may influence your relationship with them and also how you can deliver care effectively. People's homes are not set up or designed for the purpose of delivering health care and the challenge sometimes will be how you do this safely and effectively without invading a person's home life. It will not be your role to make judgements on the way in which people choose to live their lives. It will require you to apply the same anti-discriminatory practice and behaviour that you would have practiced in other settings.

It is important that this shift in the balance of the patient-nurse relationship is not underestimated. You will need to develop skills in managing relationships with patients and carers and ensuring that these relationships are positive. This may be achieved by contacting patients as early as possible, spending time to understand their individual needs and build a trusting relationship. It will also be about how you advocate for the patients you care for. This relationship is unique and will require you to maintain a professional relationship that protects both you and the patient.

Many nurses new to the community also highlight the isolation they can experience as a lone worker, having come from a ward environment where there is always someone to talk to and to access for advice. It will be important that you identify your sources of support very early on so that the feeling of isolation can be minimised. It is good practice to identify a support contact person whilst working.

Managing the work

Another challenge will be to manage your time effectively, when trying to ensure that you fulfil all of your allocated visits. Whilst wanting to spend time building up a relationship with a patient and their carer (which is vital) you will also need to keep to a schedule and balance the time spent with all of your patients. Over time the experienced district nurse can hone the skill of presenting themselves as having enough time to see to all her patient's needs, whilst underneath planning for the next visit on his/her list. However, increased workload has been shown to adversely impact the quality of attention that district nurses can give to their patients, which can lead to dissatisfaction and guilt. This guilt at times can manifest and you may be able to pick up on a 'culture' of nurses that fail to take regular breaks and work way beyond their employed hours in order to 'get through' their allocated work. It will be imperative for you to manage your personal workload so that at all times you take regular breaks and try not to get drawn into this culture. Also to bear in mind how incredibly rewarding working in the community can be if you remember to 'look after yourself'.

Acuity tools and Dependency scoring

One way in which workload is being address is by the introduction of acuity tools and dependency scoring of workload, which is something you will come across. Patient acuity refers to the severity of a patient's medical condition. A higher acuity would indicate a more serious condition or likelihood of deterioration, RCN (2010). In the community setting, the emphasis on deterioration is even greater, as patients with many long term conditions require a higher skill level of nursing. Two patients of the same acuity may exhibit the same level of complexity; however, they may still require different levels of nursing input according to factors such as their physical condition, mobility and mental capacity. This is known as 'patient dependency on nursing'. Dependency, therefore, is the cost driver of the nursing resource consumed.

Exercise
As part of your learning for this Chapter find out what scoring tools are being used

within your area and develop a clear understanding of how the work is allocated. Do the same for the shift patterns within your area.

Stress and burnout

As in any area of nursing these days, stress can be a factor and in community nursing teams this can lead to nurses taking time away from work. Factors such as emotional demands, staffing problems, work pressure, responsibilities and expectations, social issues, poor management and safety concerns can be linked with psychological distress and emotional exhaustion. Other reasons leading to stress may include lack of replacement staff and the inability to take leave for personal, medical or professional development. Having an awareness of stress will assist you when trying to develop some resilience to these pressures and how to cope with this transition.

District Nursing Team

The district nursing team will be key in assisting you to make the transition and at times will feel like a 'lifeline' in assisting you to make changes and to address some of the above stresses. The role of the qualified district nurse is that of developing and motivating staff within the team and supporting other team members. As a team leader, it will be down to this person to ensure that you feel supported to perform your role and to give you individual support if needed.

Community working is built on the foundations of good effective partnership and team working and excellent communication. One area that you can access support will be during any type of patient handover meetings, whether this is with the district nursing team or the wider multi-disciplinary team (MDT) that you might have, where you can share your experiences of delivering care and in particular any interpersonal aspects of the caring relationship.

What support is available in the community?

Whilst completing this resource it is advised that you identify a mentor that can support you whilst going through this online resource. Your mentor must be a qualified nurse and mentor who has had experience of working in the community setting.

The main role of your mentor will be to assist with your development, both in terms of making the transition to the community setting and identifying any additional support you may need.

Ideally you should try and meet with your mentor weekly to reflect upon your weeks learning and to get an experienced community nurses perspective on the challenges you may face.

If doing the e-reflective journal it is also good to invite your mentor into your journal so that your progress can be discussed.

Preceptorship

If you are a newly qualified nurse the NMC strongly recommends that all 'new registrants' have a period of preceptorship on commencing employment; NMC (2008).

The role of the 'preceptor' is to:
• Facilitate and support the transition of a new registrant.
• Facilitate the application of new knowledge and skills.

- Raise awareness of the standards and competencies set that the new registrant is required to achieve and support to achieve these.
- To providing constructive feedback on performance.

This is a crucial area of support, as the first year in practice is often a stressful time. The learning that has occurred at university in order to develop a level of knowledge and proficiency, produces highly motivated and professional individuals. However, it is acknowledged that the realistic nature of practice, with all its resource issues and other frustrations can lead to a demoralised nurse very quickly. A good preceptor will be someone who will support the consolidation of knowledge and skills, be a listening ear and be positive in their approach to ensure that there is a low attrition (drop-out) rate.

For more information access:
DH (2010) Preceptorship Framework- for newly qualified registered nurses, midwives and allied health professionals
http://www.nhsemployers.org/your-workforce/plan/education-and-training/preceptorships-for-newly-qualified-staff

Clinical Supervision
In some areas you may have regular clinical supervision sessions. Clinical supervision in the workplace was introduced as a way of using reflective practice and shared experiences as a part of continuing professional development (CPD). It has the support of the NMC and fits well in the clinical governance framework, whilst helping to ensure better and improving nursing practice.

The RCN have developed guidance on clinical supervision:
http://www.rcn.org.uk/__data/assets/pdf_file/0007/78523/001549.pdf

Introduction of the Reflective Journal
Whilst completing this resource we recommend that you use reflection as a tool to assist your learning. To reflect means to evaluate, consider carefully, weigh up, ponder, contemplate or think purposefully about something. The effect of doing this is to heighten your awareness of what it is you are thinking about.

Writing a Reflective Journal
If you decide to hand write your journal then we suggest that you record your thoughts and feelings about the way you are using the learning gained

from the resource in your daily professional practice. Consider using a hard backed notebook that you can take with you on a daily basis to record your experiences.

We would also like you to consider using an e-journal by clicking on the link below and developing a more permanent professional journal that can be used beyond this resource, as a way of recording your learning and development journey.
https://exchange.bcuc.ac.uk/exchweb/bin/redir.asp?URL=https://sites.google.com/site/appstepbystepuserguide2011/creating-your-portfolio-using-google-sites

In both instances it will be crucial that you share your journal with your mentor so that the experience does not become a 'solitary' exercise and you gain from the reflective conversation and receive feedback form your colleagues and mentor.

Confidentiality
Confidentiality and data protection are very important aspects of professional practice. It is very important that any written work concerning practice is anonymous. Real names of individuals and organisations must not be used. Please also access your own Trust's policy on Confidentiality and be aware of the Department of Health and Professional bodies' policies.

Department of Health (2003) NHS Code of Practice: Confidentiality.
Nursing and Midwifery Council, (2015) The Code: Professional standards of practice and behaviour for nurses and midwives
'As a nurse or midwife, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.' NMC (2015) page 6

Reflection (guided dialogue)
In all professional roles, it is important to reflect upon a situation whether it is deemed as positive or negative. Reflection is seen as a theory of critical thinking and is a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice (Boud et al., 1985). Invariably it is human nature to reflect upon an occurrence when 'something has gone wrong' (Taylor, 2006). Reflective practice advocates that we should also reflect upon good practice as a way of enhancing and reinforcing this practice and also

as a quality control mechanism. There are many models of reflection that can be used to assist in reflecting upon practice. Models may be viewed as academic exercises that at times are poorly implemented and poorly understood by practitioners (Quinn, 2008). The model that is used is not as important as long as a process occurs; Johns (1992) model of reflection is commonly applied, the basics of which are:

The process of reflection:
* Experience
* Perception
* Making Sense
* Principles
* Application

Reflection then becomes more than just a thoughtful practice; it becomes a process of turning thoughtful practice into a potential learning situation (Johns, 1996). The learning that occurs must be in some way utilised, and if it is viewed that practices or behaviours must be changed then how these changes occur needs to be considered: *'Reflection without action is wishful thinking.'* Freire (1972) cited in Ghaye (2011).

Here are some examples of reflective models that may assist you to reflect:

In the 'reflective cycle' (Graham Gibbs, 1992), there are six steps to aid reflective practice:

Gibbs Reflective Cycle
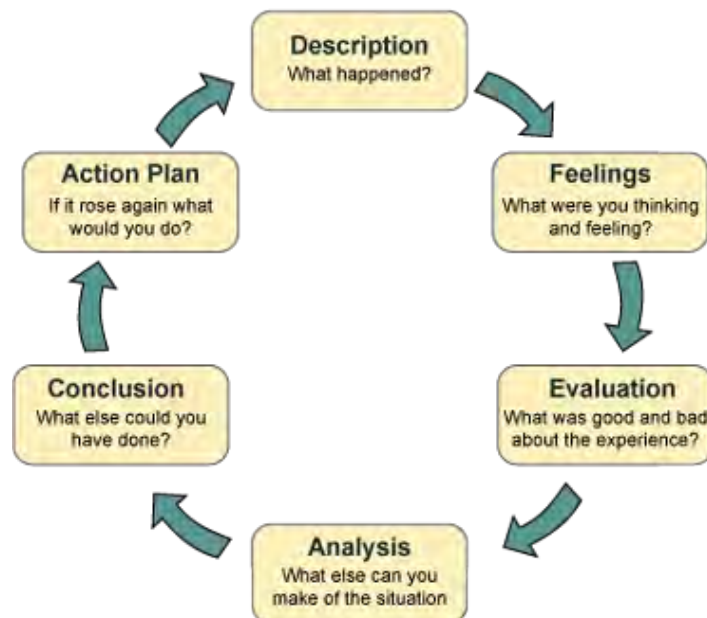
* Description: First you describe what happened in an event or situation
* Feelings: Then you identify your responses to the experience, for example 'What did I think and feel?'
* Evaluation: You can also identify what was good and bad about the event or situation.
* Analysis: The 'Feelings' and 'Evaluation' steps help you to make sense of the experience.
* Conclusions: With all this information you are now in a position to ask, 'What have I learned from the experience?'

'It feels more like a partnership of decision-making between patient and the nurse/'

- **Action plan:** Finally, you can plan for the future, modifying your actions, on the basis of your reflections.

Here is a practice example of reflection using Gibbs
Description: First you describe what happened in an event or situation

I went to visit a patient to administer an insulin injection. We have access to her home as she is unable to come to the front door. Upon arrival I found her lying on the floor in a semi- conscious state. I had to perform an initial assessment on her to work out whether she would need to go to hospital. I had to rouse her and work out whether this was a collapse as a result of a diabetic coma. She was able to respond to my questions and it soon became apparent that her blood sugars were low.

- **Feelings:** Then you identify your responses to the experience, for example 'What did I think and feel?'

I felt scared as I was alone with the patient with no one to call. I was worried about whether or not I would know what to do and how to treat her. I felt an initial panic come over me and my heart was pounding in my chest as I frantically searched for her glucose.

- **Evaluation:** You can also identify what was good and bad about the event or situation

The good aspect was that I made the right judgment about her condition and felt in control medically. I acted quickly and gave her some glucose that she had in the cupboard and stayed with her until she felt strong enough to get up from the floor and I could assess her condition further.
The worrying aspect was the amount of time it took me to find her glucose tablets as I had no prior knowledge of where they were and she was unable to tell me fully.

- **Analysis:** The 'Feelings' and 'Evaluation' steps help you to make sense of the experience

I felt happy that I had the ability to rely on my knowledge of Diabetes at that moment and also that the patient trusted me to do the right thing. I also felt empowered as I had prevented her from going into hospital for something that was manageable in this instance. I was very mindful of the amount of time I was spending with this patient and that I needed to be getting on with my list, especially as I had another Diabetic patient to see.

- **Conclusions:** With all this information you are now in a position to ask 'What have I learned

from the experience?'
I have learnt to trust my clinical judgements more and to realise that I can rely on my own ability in this type of situation

- **Action plan:** Finally, you can plan for the future, modifying your actions, on the basis of your reflections.

In the future I would will always make sure that I know where all my Diabetic patients keep their emergency glucose tablets.

Johari Window

1 Known self	2 Hidden self
Things we know about ourselves and others know about us	Things we know about ourselves that others do not know
3 Blind self	4 Unknown self
Things that others know about us that we do not know	Things that neither we nor others know about us

The Johari window model explores in depth parts of ourselves that we may not as yet recognised. The challenge is to explore and understand a little bit more about ourselves through a window framework:

1. Known self - these are things that you know about yourself and that you may consciously present to others.

2. Hidden self - these are things that you know about yourself but you choose to hide from others .

3. Blind self - these are things about you that others can see but are unknown to you.

4. Unknown self - these are feelings and abilities that you are not aware of and which others have not seen.

By considering the four domains it should provide assist you to identify what is known by you, what is known by others and what is yet to be discovered. It can assist to get feedback on performance and increase self-awareness of your own practice.

Here is the same practice example of reflection using the Johari Window:
I went to visit a patient to administer an insulin

injection. We have access to her home as she is unable to come to the front door. Upon arrival I found her lying on the floor in a semi-conscious state. I had to perform an initial assessment on her to work out whether she would need to go to hospital. I had to rouse her and work out whether this was a collapse as a result of a diabetic coma. She was able to respond to my questions and it soon became apparent that her blood sugars were low.

1. **Known self - these are things that you know about yourself and that you may consciously present to others**

'I felt happy that I had the ability to rely on my knowledge of Diabetes at that moment and also that the patient trusted me to do the right thing. I also felt empowered as I had prevented her from going into hospital for something that was manageable in this instance. I was very mindful of the amount of time I was spending with this patient and that I needed to be getting on with my list, especially as I had another Diabetic patient to see.'

2. **Hidden self - these are things that you know about yourself but you choose to hide from others**

'I felt scared as I was alone with the patient with no one to call. I was worried about whether or not I would know what to do and how to treat her. I felt an initial panic come over me and my heart was pounding in my chest as I frantically searched for her glucose.'

3. **Blind self - these are things about you that others can see but are unknown to you**

'When reporting back to my senior nurse the anxieties I had about this patient and how I acted, I was somewhat surprised at the amount of faith she had in my ability to cope. She stated that she could see how I had developed over previous months and knew that this type of situation 'would not faze me'. '

4. **Unknown self- these are feelings and abilities that you are not aware of and which others have not seen.**

'As I grow in experience I feel that I am working towards being a leader in caring for patients in the home setting.'

How to write reflectively

'It is often difficult for professionals to say or write about what they know and how they use their knowledge.'[1]

Questions to use when writing reflectively:
- Where did the event take place?
- Who was involved?
- What actually happened?
- How you were involved?
- What your feelings were at the time?
- What contribution did you make?
- What happened after the situation?
- What did you learn from this experience?
    - New knowledge
    - New skills
    - Professional development
    - Personal development

1. Thompson, N. and Pascal, J (2012) 'Developing critically reflective practice' Reflective Practice 13:2:311-325

'Nursing can be unpredictable and the patient choice at the end of the day is final.'

Tips on how to maximise learning time:
- Think of every experience as a learning one- 'talk as you go', externalise all your thoughts sharing tacit knowledge.

- Capture all learning opportunities however minor.

- Try to promote professional conversations with the mentor.

- Develop 'case studies' that maybe used to promote understanding.

- Try to have a short 'review' and evaluation session at the end of each day.

Example of a reflective account

Following the confidentiality policy the patient is going to anonymously known as John.

'John was referred to the district nursing service by the General Practitioner, due to recently feeling unwell and a diagnosis of cellulitis. I was asked by the District Nurse to visit this patient following her recent assessment of his care.

I first of all realised the importance of building a good relationship with John and I willingly took the opportunity to build a good relationship with John and his wife.

When I visited, unfortunately John had taken to his bed due to feeling lethargic and the pain he was experiencing from his legs. It soon became very clear he was only getting up to go to the toilet and achieve hygiene needs. I had great concerns about John and the risk of developing pressure sores due to his immobility at present. It was here I used the Waterlow scoring system to identify the risks so that I had a benchmark to report back to the District Nurse. Luckily all John's pressure areas were intact however from previous experience I was well aware how quickly they can deteriorate. This led me onto discussing the need for pressure relieving equipment to prevent future damage. John declined any equipment as he felt he would be back out of bed very soon. I documented this as a problem in his care plan and gave him the appropriate leaflets about how to avoid pressure damage.

When discussing this with my District Nurse she confirmed to me I had done the right thing and that there was not much more we could have done at this stage. John was deemed to have the capacity

to make decisions and we could only provide him with the correct information to help him make an educated decision.

This experience has highlighted to me that even though all the right care and knowledge was applied the outcome was not how I would have wanted but I needed to acknowledge patient choice. I have learnt about mental capacity and issues related to consent and the role played as the community nurse in these situations. This shows me that nursing can be unpredictable and the patient choice at the end of the day is final, even if I am aware of the identified risks.

In my role I have a better understanding of the outcome of care delivery and the need to document clearly all my findings as an accountable health care professional.

It has also made me consider the importance of building up a relationship with patients in their homes so that they are more accepting of any changes I may try to introduce to improve their health outcomes.

I feel more confident in myself as a result of this experience that I made the right decisions and I am progressing in my decision making skills. I am in no doubt that I will come across this type of situation again as patients in the community are aware of the choices they make. I feel that I will be able to deal with them and assist patients to make decisions based on giving them information to make that choice.'

Quotes

'I had to learn to respect how other people choose to live and not judge them; I am a guest in their home.'

'Trying to find patients and getting familiar with the local geography was challenging… also time keeping and managing my workload…'

'Recognise your own limitations and never be afraid to ask or seek advise if you are unsure.'

'It can be lonely at first but you are not on your own, there is always a senior member of staff to help. This will be an exciting challenge in your professional life.'

Chapter Summary

This Chapter has highlighted some of the differences of working in a hospital setting to the community. It has started to get you to recognise some of the personal challenges and changes of home visiting and how to access support in the community and the importance of working as part of a team.

Finally it has recommended a reflective journal as an aid to learning whist doing this online resource and given you some ideas on how to reflect.

Web Resources

- www.neighbourhood.statistics.gov.uk

- www.census.gov.uk

- www.direct.gov.uk

- www.marmotreview.org

- www.nice.org.uk/guidnace/ng27/resources/transition - From a patients perspective

Transition to District Nursing Service

Contents

Section B - Working in the community nursing setting

Chapter 3 - Working safely

The aim of this Chapter is to:
- Explore some of the legislation that protects nurses working in the home setting

- Discuss 'rights of entry'

- Consider your own personal safety when working in the community

Whilst working in the community there is legislation that exists to support and protect you in this environment and your employers are bound to ensure that measures are in place to prevent or minimise risk.

Some legislation that protects working in the home setting

- Health & Safety at work Act (1974)
- Management of Health & Safety at Work Regulations (1999)
- Manual Handling Operations Regulations (1992) (MHOR) (as amended 2002)
- Control of Substances Hazardous to Health Regulations (2002)
- Personal Protective Equipment at Work Regulations (1992)

Health & Safety at Work Act (1974) – section 7: the two points below particularly relate to community nursing:
1. To take reasonable care of their own health and safety and any other person who may be affected by their act or omissions.
2. To co-operate with their employer so far as necessary to enable that employer to meet their requirements with regards to any statutory provisions.

Guidance on Domiciliary Care Section 51 on the Health and Safety at Work Act (HSWA) (2011)
www.hse.gov.uk/foi/internalops/sims/pub_serv/071105.htm

Other regulators that address working in the home setting for nurses:

The NMC (2015) Code refers to:
'Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.' – Health and Safety Executive
You can find more information at www.hse.gov.uk

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It plays a vital role in ensuring that people have the right to expect safe, effective, compassionate, high quality care.

As a community nurse you may from time to time be involved when the CQC comes to inspect your Trust. You may also be aware of their

'A lone worker is someone who works by themselves without direct or close supervision.'

monitoring role in your day to day practices as Trusts adhere to their recommendations, action points and reporting measures to improve quality care.

To read more about the Care Quality Commission access their strategy document:
CQC Raising Standards – Putting People First – Our Strategy for 2013-2016
www.cqc.org.uk/sites/default/files/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

Lone worker Policy

A lone worker is someone who works by themselves without direct or close supervision. When working as a community nurse you will find yourself in situations of working alone in a patient's house or working at weekends and accessing clinic buildings, etc. It is important that you become familiar with and know how to access your Trust lone worker policy and adhere to it in order to assist with your own personal safety.

As part of your learning for this chapter, it is also recommended that you read your Trust's policy on Lone Working. This is essential, as it will vary from Trust to Trust and also there is a great deal of hearsay around this subject so new employees need to read and refer to it regularly.

NHS lone Worker Framework (2013) Agreement 2013-2017 Service Guidance
www.nhsbsa.nhs.uk/Documents/SecurityManagement/Framework_2013_Service_Guidance.pdf

The NHS Staff Council (2010) Improving safety for lone workers
www.nhsbsa.nhs.uk/Documents/SecurityManagement/Improving_safety_for_lone_workers_-_workers_guide_FINAL.pdf

NHS Security Management Service (2009) - 'Not Alone' A guide for the better protection of lone workers in the NHS
www.nhsbsa.nhs.uk/Documents/Lone_Working_Guidance_final.pdf

Entry Rights for community nurses:
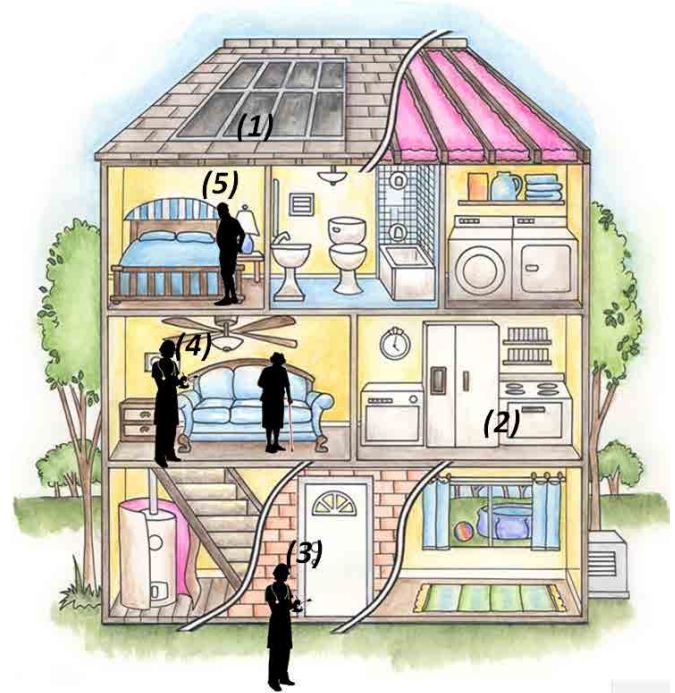
1. **Who is the occupier?** - the occupier is the person who owns the property - so the owner of a private house or landlord of tenant property .

2. **Occupiers' Liability** - There is both statutory duty (this relates to property law that landlords must obey) and common law duty (this relates to law developed through judges and decisions made on similar cases in courts) relating to premises, so that visitors to those premises do not suffer injury. It follows that if a community nurse is injured because of the dangerous conditions of the premises that she is visiting, she may be able to sue the occupier who has a duty under the Occupiers' Liability Act (1957) – as well as the common law to keep the premises safe.

3. **Entering the premises** - asked for permission or implied permission apply here. Normally a community nurse will be a lawful visitor even when visiting a new family uninvited. But that does not mean she has the right of entry to a client's house. A community nurse has the right of entry in an emergency, in order to save life. E.g. if you arrived at a house and could see the patient through the window lying unconscious on the floor. In other situations it would be advisable to call the police who can force entry legally.

Exercise
As part of your learning for this chapter it is recommended that you read your Trust policy on 'Entry'.

4. Trespass - Once a community nurse enters the property of a client, she does so with implied consent of the occupier. If the occupier withdraws consent and asks you to leave, if you do not leave you are trespassing!

5. Vulnerable groups - There are special provisions for mental health and learning disabilities under the Mental Health Act (2007) around access.

6. Other types of private homes - may include caravans, houseboats, and residential care homes.

Looking after yourself:

In order to practice effectively as a nurse, the NMC (2015) Code gives guidance regarding any indemnity arrangement you may require to practice as a nurse or midwife in the UK:

To achieve this, you must:
12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice.
NMC (2015) The Code – page 10
For more information, please visit www.nmc-uk.org/indemnity
It is advised that you are aware of your Trust policy with regard to indemnity and also the terms and conditions of your practice.

Working as a district nurse comes with its own set of risks and here are some statistics related to the physical aspects of the role.

Physical risks
- Musculoskeletal – a quarter of all nurses have at some time taken time off as a result of a back injury
- Stress - work related stress accounts for over a third of all new incidents of ill health
- Slips and trips - two thirds of all major injuries. Slips, trips and falls can have a serious impact on the lives of employees and those being cared for.
Health & Safety Executive (2007)

Preparing to visit

Here are some additional practicalities to think about when preparing to visit a patient in the home. Remember at all times to do as much homework as possible about the patient before visiting, e.g. does the person live alone? Who else lives in the house? Does the person have any history of violence or aggression? If you can, speak with any other health or social care professionals that may be involved in the care of the person.

You could also run through a personal checklist to plan for a few eventualities.

'It may be deemed as NOT policy for you to wear a recognised uniform due to safety reasons.'

Personal checklist:
1. Make sure that you inform others of your whereabouts at all times
2. Ensure that you have a charged mobile phone with you
3. Have a separate work mobile if possible
4. Have your car keys in an accessible place
5. Plan your access and exit route to the property
6. Do not visit known 'risk' people or areas alone
7. Adhere to your Trust policy on Home Visiting
8. Trust your own 'instinctive' feelings if you do not feel safe

Changes to the home environment: A patient's home environment can change between visits and these changes may include:
• Positioning of furniture/ new equipment or furniture
• Inoperable electrical equipment
• People or animals now present
• Altered storage patterns
• Spills or leaks
• Obstructed access

It is advised that upon each visit you undertake a visual scan and risk assessment to ensure the safety of the patient's home as a workplace prior to commencing duties.

What to wear?
In some areas it will be Trust or employer policy to wear a uniform and this is provided. In other areas it may be deemed as NOT policy for you to wear a recognised uniform due to safety reasons. It should be noted that there are advantages and disadvantages of wearing a uniform in the community setting.

If wearing a uniform, you are easily recognisable and some patients relate well to this. It allows you to 'set the scene' early on and boundaries are clearly identified. It also allows patients to understand the different roles according to the colour of the uniform e.g. District Nurse, Health Care Assistant.

Not wearing a uniform can be an advantage in some neighbourhoods where nurses might be targeted as perhaps 'carrying medications' etc. It can be much safer to not be recognised. Some patients prefer for their neighbours to be unaware of who is visiting and again the identity of the nurse is not known. Sometimes a uniform can be viewed by the patient as a 'barrier' and they feel more comfortable with a nurse if they are wearing their own clothes.

Whether wearing a uniform or not you will be acting in the role of a nurse and it will be essential that you remain professional in both your appearance and behaviour regardless of uniform.

Shift Patterns
When joining the district nursing service, you will experience a variety of differences in shift patterns as organisations move towards a twenty-four-hour seamless service. These changes have been proposed in response to demands from GP practices and hospitals to improve handovers between shift patterns and reduce the overtime worked by community nurses.

How will you get around?
Some community nurses work in areas where there are difficulties with parking or no parking. Due to the proximity of the patients e.g. inner city or built up areas it is more appropriate to walk, take public transport or cycle.

Driving your car - when using your own car for work please consider the following:

1. You need a full driving license - obvious - but you must have one!
2. Be aware of the type of vehicle insurance that is required whilst employed. Also your employers' insurance responsibilities.
3. Have an understanding of the procedure if you have a road traffic accident whilst working.
4. Have knowledge of the rules around taking passengers e.g. students, colleagues or patients when driving whilst employed.
5. Be aware of the rules around traffic offences including the accumulation of points - disqualification, speed, alcohol, dangerous driving whilst employed and how to report any incident.
6. What are the rules in your Trust around getting parking tickets whilst on duty?
7. If working in a rural setting, consider the length of some journeys and driver fatigue. Make sure you take regular breaks if feeling tired.

Exercise
As part of your learning for this Chapter it is recommended that you read your Trust policy on Insurances and also policies around Traffic offences. Also your employer's policy on the use of your own car for work purposes - This will be within the Trust policy on Insurances which will vary from Trust to Trust.

District Nursing in the Digital Age

There has never been a more exciting time for District Nurses to engage in the digital world: Oldman (2015). Community nursing services have consistently been characterised by innovation and the current possibilities associated with the increasing use of technologies will present us with some very real tools to support patients and to develop very different responses to their care needs.

As a community nurse there will be an expectation that you will embrace the new technologies available to enhance and improve the care that you deliver.

'….The nurse in me kept saying to myself, 'I'm a nurse not an IT expert' then I realised nursing had become reliant on IT, it was time to embrace it not fear it. Gradually I got used to the new system and even made a few suggestions on how to make it easier to use and prettier to look at.'

Here are a few definitions to terms you may hear:
Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living.

Telemedicine is the practice of medical care using interactive audio visual and data communications. This includes the delivery of medical care, diagnosis, consultation and treatment, as well as health education and the transfer of medical data.'

eHealth is the use of information and communication technologies (ICT) for health to, for example, treat patients, pursue research, educate students, track diseases and monitor public health (World Health Organisation). eHealth is not just about computers. It is about finding, using, recording, managing, and transmitting information to support health care, in particular to make decisions about patient care.

mHealth is the use of mobile telephones for healthcare (2020health). Telephone triage – Telephone Triage is an encounter with a patient/caller in which a specially trained, experienced nurse, utilizing clinical judgment and the nursing process, is guided by medically approved decision support tools (protocols), to determine the urgency of the patient's problem, and to direct the patient to the appropriate level of care.

Mobile Working

There is a move within the NHS to create a paper light service by 2018 in order to save money on resources. Within the district nursing service, the use of hard diaries in some areas still exists and patient allocation tools vary tremendously.

Mobile working refers to a practitioners' ability to access information systems and applications whilst 'on the move' or remotely. This relatively new concept has yielded a number of benefits, including ability to access patient's electronic records in real time and a reduction in travelling time for clinicians, thereby improving efficiency within district nursing practice.

For further information access: QNI (2013) Smart New World : using technology to help patients in the home

'In some situations there may be situations where the patient or relative are unhappy with you or what you represent.'

http://www.qni.org.uk/docs/Smart_New_World_Web_2014.pdf

Violence , Aggression or Harassment

Whilst in most situations patients and their relatives are pleased to have the opportunity to receive care from a community nurse, in some cases there maybe situations where the patient or relative are unhappy with you or what you represent.

Please be mindful of the following:
- The potential for an outburst is a very real one
- Try to avoid vulnerable or volatile situations at all times
- Be aware that pets can be the source of this behaviour also - you can ask for a pet to be kept in another room whilst you are visiting
- This type of behaviour can sometimes necessarily lead to a 'withdrawal' of your service
- Be aware that relatives can be unpredictable at times
- Have a clear understanding of your Trust policy on Violence, Aggression or Harassment
- Employers must take steps to keep staff safe at all times
- DO NOT suffer in silence – communicate and document any fears you may have to your manager immediately. This may ensure the safety of colleagues or the wider healthcare team so timely reporting is invaluable
- Smoking – you can ask the patient to extinguish a cigarette for your health reasons.

In some instances you may find it safer to visit a patient in pairs. The assessment which results in this decision would normally have been performed by the District Nurse and it will be down to team members to adhere to this plan of care. Once a District Nurse has performed a risk assessment on a patient that advises nurses to visit in pairs it will be down to all team members to ensure that this decision is adhered to and that a nurse does not visit alone to save time or because he or she personally does not feel at risk.

Exercise
As part of your learning for this Chapter it is recommended that you read your Trust policy on Violence and Aggression or Harassment.

Medicines Management

The way in which medications are administered and managed is different in the community setting and again it is about you becoming familiar with the differences. The same rules apply in terms of the safe administering and monitoring medicines; however within the community environment more emphasis is placed upon other factors such as risk, storage and disposal of drugs.

Here are some helpful tips:
- Make sure that you have seen a copy of the NMC (2010) Standards for Medicines Management NMC London (Please note these standards are about to be rewritten – so look out for new ones).

- Look at the NMC (2015) The Code – Professional standards of practice and behaviour for nurses and midwives which states: '*Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations*': NMC (2015) page 13.

- Know your Trust Policy on the administration and management of medicines in the community setting

- Some community nurses are qualified to prescribe from the Nursing Formulary

- District nurses can also be independent prescribers and prescribe from the BNF (British National Formulary)

- Others may prescribe working in partnership with GP's under 'Patient Group Directives

- Get to know your local pharmacist who will be invaluable for information and advice

- Ask your mentor if you are unclear!

Exercise
As part of your learning for this Chapter, it is recommended that you read your Trust policy on Medicines Management.

Infection Control

When visiting some homes it will be a challenge to adhere to the same levels of cleanliness as in a hospital environment. It will be down to you to become creative in the way in which you practice. You may be in someone's house without supervision but do not let your standards slip. Hand washing and the use of protective equipment still applies and it will be down to you to minimise the risk of infection and cross infection to all the patients in your care. You

should familiarise yourself with the Trust specific guidance in which you work to ensure the safety of the patients in your care. This includes the safe disposal of sharps and needle stick injury procedure, for example.

Exercise

As part of your learning for this Chapter it is recommended that you read your Trust policy on Infection Control also visit www.hse.gov.uk/biosafety/about.htm to read about infections at work

Scenario

You have visited a patient where the hand washing facilities are below an acceptable standard e.g. the sink and taps are visibly dirty and there isn't a clean towel to dry your hands. The patient does not appear concerned about cleanliness and the whole house is dirty. Possible solution: short term will be to use anti-bacterial hand wash. Longer term maybe to encourage the patient to clean the sink and surrounding area and to ask the patient or carer to provide a clean hand towel and hand pump soap if possible. Community nurses are often supplied with soap and paper hand towels to carry in their nursing bag to solve this problem.

Duty to report incidents

It is your professional duty to act to act without delay if you believe that there is a risk to patient safety or public protection: NMC (2015).

Safe Working Activity

Think about your own day to day practice
- When have you felt at risk?
- Have you ever performed a risk assessment?
- A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm. Workers and others have a right to be protected from harm caused by a failure to take reasonable control measures.
- Whose responsibility is it to risk assess?
- the management of risk is considered one of the fundamental duties of every member of staff and it will be part of your role to familarise yourself with the risk factor .
- Do you have a policy of safe practice eg when finishing at the end of the shift- how do colleagues know you are safe?

Case scenario

Safe working

A community nurse attended an elderly male patient to dress his leg ulcers. The man's wife was in the house, although she was never in the room when the nurse was dressing the wound. The nurse visited twice and on both occasions the man was verbally inappropriate, asking questions about her sex life. There was no reason to believe he was suffering from a mental health issue which could be affecting his behaviour. The first time it happened she tried to avoid the subject but when he increased the intensity on the second visit she brought it to the attention of her team leader.

- What would you do in a situation like this?
- What are your Trust's policies around such incidents?
- What legislation if any could protect you as a worker from this situation?

'It is normal to feel overwhelmed about knocking on a patient's door with no idea what you are about to face.'

Possible action:
- Challenge the man if you felt able and inform him that his behaviour is not appropriate
- Inform the man of the possible implications of his behaviour
- Most definitely inform your mentor and manager and document both incidents
- Ensure that you feel supported before visiting again
- Adhere to your Trust Policy on this type of behaviour

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.

- A diabetic patient who you visit daily to give insulin does not answer the door - what actions would you take?

- A sudden death where resuscitation status is not in place

- There is a confrontation within a patient's home

- A patients home environment does not allow staff to perform the tasks they need to do and it has 'risks' for staff going in - but the patient is not agreeable to change.

Quotes

' …To understand that the risks in a community setting are different and you need to be able to manage those risks differently.'

'always expect the unexpected… .it is normal to feel overwhelmed about knocking on a patient's door with no idea what you are about to face.'

'…knowledge is power - Read up everything from current treatments to weather reports. Have access to all phone numbers you will ever need and create contacts of who does what- learn about finances (it's not all free in the community).'

Chapter Summary

This Chapter has introduced some of the key issues of safe working in the community setting. It has explored the key legislation that protects community nurses and discussed 'rights of entry' when going to people's homes. In particular it has highlighted some of the personal safety issues that need to be taken into consideration when working in the community setting.

Web resources
- www.cqc.org.uk Care Quality Commission
- www.suzylamplugh.org The Suzy Lamplugh Trust
- www.rcn.org.uk RCN
- www.unitetheunion.org Unison & CPHVA/Unite

Legislation Links
- Health & Safety at work Act (1974) www.legislation.gov.uk/ukpga/1974/37
- Management of Health & Safety at Work Regulations.(1999) www.legislation.gov.uk/uksi/1999/3242/contents/made
- Manual handling Operations Regulations (1992) www.legislation.gov.uk/uksi/1992/2793/contents/made
- Control of Substances Hazardous to Health Regulations (2002) www.legislation.gov.uk/uksi/2002/2677/contents/made
- Personal Protective Equipment at Work Regulations (1992) www.legislation.gov.uk/uksi/1992/2966/contents/made
- Occupiers' Liability Act (1957) www.legislation.gov.uk/ukpga/Eliz2/5-6/31/contents
- Health and safety Executive www.hse.gov.uk/
- Nurse prescriber www.nurseprescriber.co.uk

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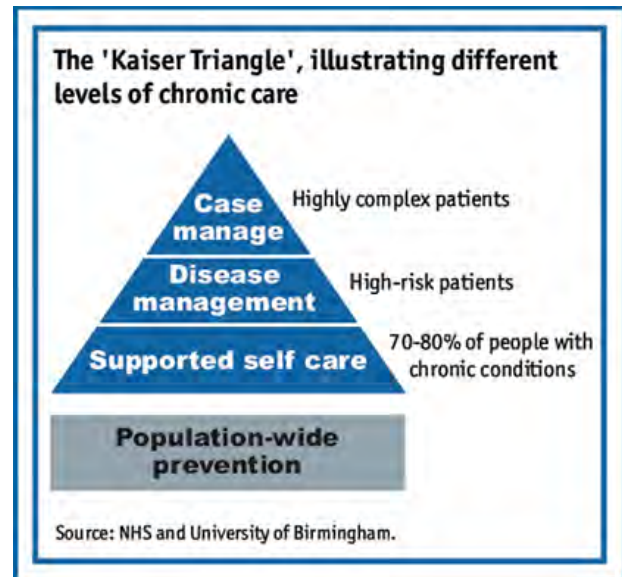
Exercise
As part of you learning for this Chapter find out more about vanguard sites and also whether you are working in one.
www.england.nhs.uk/ourwork/futurenhs/new-care-models

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).

The 'Kaiser Triangle', illustrating different levels of chronic care

Case manage — Highly complex patients
Disease management — High-risk patients
Supported self care — 70-80% of people with chronic conditions
Population-wide prevention

Source: NHS and University of Birmingham.

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

'There are around 750,000 people living with Dementia in the UK.'

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

Transition to District Nursing Service

Contents

Section B - Working in the community nursing setting

Chapter 5 - Mid- point reflection and progress check on identified skills development

The aim of this Chapter is to:
- To reflect upon the experience of the on-line resource so far

- To catch up with reflective diary

- To re-visit additional skills that you may need to achieve in order to work in the community setting

Quality care

Working in the community requires practitioners at all levels to be resourceful, flexible and adaptable to the various situations you may be confronted with. However, whilst adaptability is a key skill, it does not mean cutting back on quality of care. Decisions have to be made around resources and skill sets of individual teams. In many instances there will be limited resources so it is important to have the ability to prioritise care. Community care works best when the individual skills of each practitioner is acknowledged and recognised, regardless of what their grading is. Working in the community can be unpredictable and challenging and skills are required to move from one home where you may be looking after a patient with palliative care needs to another where you may be dealing with a simple wound dressing. The ability to work with the various emotional situations you will encounter is imperative.

Quality care is based on the effective clinical decision making skills of practitioners working in the community. Thompson et al (2013) recognised that the clinical decisions made in the community have very different parameters than those made in a busy ward. Unlike on the wards where there are a number of staff to share decision-making, when you visit a patient in their own home there are often carers and other members of their extended family present, whose needs also may have to be considered when planning care for your patient. Therefore working in the community a practitioner must be prepared for the unexpected at all times, but also be able to look at the needs of the carers/families in the overall planning of care. Decisions may have to be made promptly without discussion with other staff, and on occasions there may be a number of decisions to make in order to give the patient the best quality care. It is the duty of all health professionals to be accountable in demonstrating sound clinical judgement and decision making (Standing, 2010).

'At first I found it daunting to be alone in a patient's house administering medication, as you are solely responsible for doing so.'

When contemplating making a clinical decision Facione (2007:23) suggests the six steps to effective thinking and problem solving:

Ideals	Five Whats and a Why
Identify the problem:	What's the real problem we are facing here?
Define the context:	What are the facts and circumstances that frame this problem?
Enumerate choices:	What are our most plausible three or four options?
Analyse options:	What is our best course of action, all things considered?
List reasons explicitly	Let's be clear: Why are we making this particular choice?
Self correct:	OK, let's look at it again. What did we miss?

Whilst the list below is focussing on clinical skills, it must not be forgotten that the overall success of any nurse/patient relationship is built on communication. Therefore communication channels must be open to generate discussions with your patients so, wherever possible, they are part of the clinical decision-making process in their plan of care. There may be a variation of delivery of care, which is not always a bad thing (Thompson, 2013), but patients need to be aware that every individual health professional they are dealing with will have their own individual approach when making a decision about their care. Nevertheless, if the patient is part of that decision-making and a dialogue has occurred between the health professional and the patient, then the decisions made will be in the patient's best interest.

Skills
- Medicines management in the community setting - e.g. use of controlled drugs
- Intravenous therapy and central vascular access devises – including PICCs
- Nutritional Support – including PEG feeding
- Wound and leg ulcer assessment and management including: use of Doppler, wound products, compression bandaging, Vacuum Assisted Closure (VAC)
- Urinary catheterisation and management e.g. suprapubic, intermittent and male catheterisation
- Bowel management
- Ear irrigation

- Venepuncture
- Palliative Care

Quote from community nurse:

'When I first started to work in the community, I found it daunting to be alone in a patient's house administering medication, as you are solely responsible for doing so. On a ward you always have someone to check doses with you on medicine rounds that are mainly carried out by two nurses.'

Exercise
How would you deal with the two situations below?

1. You are visiting Mrs Knight (75 years) who is a regular patient that you visit three times a week to dress her venous leg ulcer. Mrs Knight lives alone with her cat; she has not been very mobile since she developed her leg ulcer 4 months ago. When you visit Mrs Knight to dress her wound you notice that the leg is very inflamed around the outside of the ulcer. What clinical decisions would you make?

- Would you continue with applying the same dressing to the wound?
- Would you consider applying a new (different) dressing to the wound?
- Would you contact the GP?
- If you are a nurse prescriber would you prescribe for Mrs Knight?

Possible actions:
- You could apply the same dressing to the wound and come back later with a more experienced District Nurse
- You could apply a different dressing to the wound if you are a prescriber and can prescribe from the NPF
- You could contact the GP and ask him to visit to assess the wound. Or you could contact an Independent Nurse Prescriber or Tissue Viability Nurse to assess the wound
- Would any of these actions compromise the care of your patient?

1. You have been working in the community as a District Nurse for more than 10 years and you feel that you have a wide knowledge and skills set. A referral has been made to you asking you to visit a gentleman of 65 years with a catheter in-situ who is having problems passing urine; this is causing him great distress. You have not passed a male catheter for more than two years. It is policy in

your local area for District Nurses to perform male catheterisation. What clinical decision would you make?

- If local policy did not allow District Nurses to perform male catheterisation what action would you take ?
- Would you insert a catheter?
- Would you seek the expertise of a practitioner who is utilising this skill on a regular basis?
- Would you refer the patient to the GP?
- What action would you take in developing and enhancing your skills in male catheterisation?

Possible Actions:
- If you do feel unable to perform a catheterisation you should say so
- You could contact a community staff nurse who is a member of your team – this particular staff nurse prior to joining your team has been working on a male surgical ward and is familiar with catheterising male patients
- If the local policy only permits qualified District Nurses to perform catheterisation what would you do?
- If you felt very unsure about what to do you could contact the GP and ask him to visit and you could be with the patient when the GP visits
- You recognise that you are de-skilled in this area, so you could ask your line manager if you could have training in male catheterisation and then you should ensure that you get the relevant practice. This could be done by arranging to spend time on a male ward where you could gain this experience, or you could let your colleagues know that you need further experience and there may be an opportunity for you to gain this experience by working with other DN teams.
- If policy does not permit District Nurses and their team to insert male catheters, it is still worth while reading up on the anatomy and physiology of the male bladder and urethra so that you gain an understanding of possible complications of a blocked bladder.

Looking at the above suggested actions are there any ethical dilemmas that would need to be considered?
'When I was initially working in the community my concerns about catheterisation was when you face difficulty in removing a catheter particularly supra-pubic and difficulty passing male catheters. On a ward you have the support of your colleagues, but in the community you are alone and cannot always contact your colleagues to help'.

Additional Skills Quotes
Look at the additional quotes below and think of what you would do if you were asked to carry out ear syringing, venepuncture or give an enema. Do you have the right skills to carry out the treatment? If not, what will you do to gain the required skills?

'We are often asked to give enemas by GPs; this goes against first line treatment of constipation and it can be difficult to challenge the GP to try other things first.'
'I feel there is a lack of training in this area - ears are sometimes syringed at patient request, historical expectation before ascertaining actual need for this procedure. There are additional issues of poor ergonomics and Health and Safety in the home setting.'

'You will not have all the skills and you may not have all the answers all of the time.'

'I learnt venepuncture in the hospital, but I believe that it is difficult to learn this skill in the community setting. In the community it's a case of being taught by another member of the team and having a go when you feel confident enough. In the hospital there is a 'training pack' and a certain number of observed sessions before you can do them.'

'I have some concerns that venepuncture is seen as a skill beneath trained nurses because hospitals use phlebotomists. It's not the same in the community as anyone who is housebound and needs a blood test probably needs some form of nursing assessment as well.'

It is important to note that you will not have all the skills and you may not have all of the answers all of the time. In recognising this it is also important to address this and take action where it is needed.

Chapter Summary

The overall aim of this chapter is to revisit the skills that are required to care for patients in their own homes. Whilst it is acknowledged that the skills required to work in the community are multifaceted, it is hoped that this chapter will recognise that not everyone will have all the required skills all of the time. Therefore it is essential that community teams work together to recognise the various kinds of expertise within their teams, and on occasions beyond their teams and to reach out and utilise those people who have the right skills for the task in hand. This supports the QNI's Right Skills, Right Nurse campaign. In highlighting the importance of this you are encouraged to reflect on those people within your team and look at whether the skills each individual has are being used effectively to benefit and enhance patient care.

Further Reading

- Facione, P.A. (2007) Critical Thinking: What it is and why it counts., California Academic Press, California
- O'Brien, L. (2012) District Nursing Manual of Clinical Procedures, Wiley Blackwell West Sussex
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Transition to District Nursing Service

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Section A - Thinking about working in the community

Section B - Working in the community nursing setting

Section C - The future - personal and professional development

Section B - Working in the community nursing setting

Chapter 6 - Team Working and working with other professionals

The aim of this Chapter is to:
- Explore the benefits of working as a team member
- Recognise the importance of working with other professionals in the community
- Understand the importance of various forms of communication in the community setting for effective patient care
- Ensuring we have the right staff, with the right skills in the right place

The QNI has been campaigning for the right balance of skills in community healthcare teams – the Right Nurse, Right Skills Campaign has been running since 2012. If more care is going to be delivered in the community, including in nursing homes, it is vital that there is more investment in well trained staff, including nurses, who have the time and the expertise to give high quality, compassionate and person-centered care to the most vulnerable members of society (QNI 2012). This complexity of district nursing care is highlighted by the work of the QNI (2011) including assessing complex needs, risk assessment, leadership and management, application of specialist knowledge and skills, with the ability to work collaboratively across and within organisations.

Collaborative ways of working

'Collaboration is the act of coming together and working with another, or others, to create something that goes beyond the ability of any one person to produce.' (Teatro, 2009).

Genuine collaborative working is the coming together with a common purpose with clear goals. Multi-disciplinary teams work with the sole purpose of delivering effective care to the patients and clients on their caseload. This is not just a matter of being told to carry out a certain task; it involves discussion and debate about what is best for the patient/client. All members of the team should be involved in the discussion as every team member will have a valuable contribution to make. The philosophy of collaborative working should be to ensure that the patient is at the centre of all discussions and their need should far outweigh those of the professional involved in their care. There should be clear links between public and voluntary services so that a whole systems approach to care is carried out. Access arrangements and clearer discharge planning are essential to a successful whole systems approach to care.

It is well documented that integration of services is needed to provide joined-up care for patients at best value (DH, 2013). The Transforming of Community Services (DH, 2011) focuses on developing and supporting people to design, deliver and lead high quality community services. This cannot be done in isolation, but needs effective team work and a highly skilled workforce to care for the complex needs of many of the patients in the community.

'Currently the District Nursing team and the General Practice Nurse team usually work independently of each other.'

The District Nursing Service Model as mentioned in Care in local communities – A new vision and model for district nursing (DH, 2013) focuses on the following areas:

- Population and Case load management
- Support and care for patients who are unwell, recovering at home and at end of life
- Support and care for independence
- A number of District Nursing teams have a triage system so that the appropriate member of staff can be called upon when a new patient requires a District Nursing team intervention. This also prevents the District Nurses from being interrupted whilst they are on visits.

Find out if your District Nursing team uses a triage system. How does your District Nursing team organise:
- Population and Case load management
- Support and care for patients who are unwell, recovering at home and at end of life
- Support and care for independence

Over recent years new roles have emerged within the community workforce and some of these may now become part of the District Nursing team. The assistant practitioner has long been a member of the District Nursing team, previously known as the health care assistant (HCA). Some areas have Primary Care Navigators who work within the Primary Care setting - they may not be directly part of the District Nurse team, they act mainly as a signposting service for many housebound patients, so it is possible that the District Nursing teams will be in communication with them on occasions. The Physician Associate may also be part of the Primary Care workforce and there may be some blurring of roles between the Physician Associate and the Advanced District Nurse (Level 8 – Career Framework for District Nursing).

What new job roles form part of your District Nursing team or Primary Care team?

Currently the District Nursing team and the General Practice Nurse team usually work independently of each other. Many District Nursing teams are not located within a General Practice and this can make communication between the two services difficult. However the General Practice Nursing in the 21st Century Report (QNI, 2016) commented that the reinstatement of co-location of District Nurses would enable closer team working and would benefit

the patients and carers who are known to both the General Practice and District Nurse teams.

Working in a multi-disciplinary team it is essential that record keeping is kept up to date and that all reporting is followed through. This enables patients' progress to be monitored (continuity of care) and it is also a means of safeguarding patients. It is essential that there is a process for disseminating information between the multi- disciplinary team (Drew, 2011).

- **How is information disseminated within your District Nursing team?**
- **How does it feel to be a member of your team? Do you feel valued?**
- **Apart from your team who else could you potentially collaborate with to benefit the care you give to your patient?**

Exercise:
Can you look at the team that you are working with and identify who you collaborate with on a regular basis?
- What impact does this collaboration have on you as part of the team?
- If you had not collaborated with others would the quality of care have been as good for your patient?
- Spend a few moments to reflect and think of the various ways that you collaborate with others in the workplace: Verbal communication; Telephone Written notes; Emails; Letters

These are just a few methods of collaborating; there are also a number of technical ways of communicating, however this method may not be used so much with your patients.

Can you think of times when you would use media such as Facebook or Twitter with your patients? Would you use this method?

- If you would use this method, what are the benefits?
- If you would not use this method of collaborating – why not?

- You could set up a Facebook page for patients with a similar condition e.g. leg ulcers. This would give patients the opportunity to share stories with other people in a similar position and it may make the patient feel less isolated. If a patient was familiar with Twitter then they could follow someone with a similar condition; they could also

follow NHS Choices on Twitter which would keep them updated.

- Reasons for not using these methods include obvious ones such as your patients not having access to smart phones or computers. Other reasons might be your patient's inability to use technology. Your patient may interpret information incorrectly and therefore cause them more anxiety.

Can you think of more reasons why you would not use social media technology with your patients?

Record Keeping

Record keeping is a way of collaborating with all those involved in the care of your patient. Accurate record keeping and documentation is important in professional practice. Once something is written down, it is a permanent account of what has happened and also what has been said. Remember, if it is not written down there is a sense that somehow 'it didn't happen'. Without a written record of events, there is no evidence to support a decision made or an audit trail from which to follow a sequence of events. It is therefore crucial that accurate and consistent records are kept at all times. Ensure you are familiar with other records that may be kept in the patient's home, e.g. dietitian's notes, social care notes. Also familiarise yourself with record keeping in areas such as residential homes/day units or other areas where you may be visiting patients in the community. The Guidelines for Records and Record Keeping (NMC, 2010), state clearly that:

'The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice.'

The obligation from the above statement is clear that professionally, nurses are accountable for keeping accurate and consistent records. When it comes to making good quality records they should be:

- Clear and accurate.
- Factual, consistent, and relevant.
- Comprehensive and useful.
- Contemporaneous (made at the time).

The other element of accurate record keeping relates closely to investigations and serious untoward incidents (SUI) (DH, 2006b). The principle definition of an SUI is:

'.. something out of the ordinary or unexpected, with the potential to cause serious harm, that is likely to attract public and media interest, that occurs on NHS premises or in the provision of an NHS or a commissioned service. SUIs are not exclusively clinical issues, for example, an electrical failure may have consequences that make it an SUI.' (NHS, 2009).

There is also the issue of 'never events' which are inexcusable actions in a health care setting. There were 312 never events documented between April 2014 – March 2015 www.england.nhs.uk/ourwork/ patientsafety/never-events/. An example of this may be operating on the wrong limb, or administrating an incorrect medication. More information can be found on: www.en.wikipedia.org/wiki/Never_ events. This reinforces the importance of accurate record keeping by all health professionals. Many patients also have patient-held records

and therefore it is essential that this information is kept up to date so that it can be shared with other members of the multi-disciplinary team each time they visit the patient.

The multi- disciplinary may consist of the following professionals:
- District Nurse
- Assistant Practitioner (HCA)
- General Practitioner
- Community Matron
- Physiotherapist
- Speech and Language Therapist
- Occupational Therapist
- Dietitian
- Social Worker
- Learning Disability Nurse
- Community Mental Health Nurse
- Physician Associate
- Primary Care Navigator

(This list is not exhaustive and will vary from team to team)

Can you think of other people involved in the multi-disciplinary team and identify why they are involved?
- Identify a patient on your caseload, or your team leader's case load and carry out this exercise in any way that you are familiar with, e.g. spider plan, post it notes, lists.
- If you are new to working in the community or contemplating working in the community, try to think of who would be the key members of the multi-disciplinary team.

Case scenario

You have been visiting a young woman who has end-stage breast cancer and is experiencing some distressing symptoms. She has expressed a wish to remain at home to die. You have been attending the Gold Standard Framework meetings with your DN and have at times felt that when this patient's case is discussed, there has not been sufficient time to talk through all the issues. You are aware of the important role of the Multi-disciplinary team in ensuring patient choice in all aspects of care.

- What would you envisage your role to be in this situation?
- What areas of care can be provided by other members of the multi-disciplinary team?
- Is there the risk for there to be overlap (duplication) of services?
- What can be done to prevent this happening?

Possible action

- You could call a meeting with the whole multi-disciplinary team, ensuring that you are allocating sufficient time to discuss the patient's situation
- Care could be provided by staff including the GP, DN, Macmillan Nurse, or Breast Cancer Nurse
- There is potential for overlap of services if there is no coordination. Therefore there should be a designated key worker who will oversee the coordination of services.

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.

- What is the role of the community nurse when taking wound swabs? Who is responsible for ensuring that the results are acted upon?

- You are working with another nurse who always seems to be off-loading her patients onto you, saying she has been too busy to complete her list. What would you do?

- You are working with a colleague who seems to arrive early at work and is always the last to leave in the evenings. She seems to get very heavily involved with the patients she cares for and does not appear to appreciate any professional boundaries. What would you do?

- You go to treat a patient that has a leg ulcer dressing. You observe that the dressing currently in situ is not what is recorded within the patient's care plan. What action would you take?

Consider if you are a staff nurse new to working in the community and you visit a patient to remove sutures following hip surgery. You notice that the patient is not mobilising as well as she should be. What action would you take?

- Would you give the patient advice on mobilising?

- Would you inform the physiotherapist?
- Would you take no action because you do not know the patient well enough?

Possible action
- You could advise the patient to gradually increase the amount of walking she does every day, beginning with 5 mins every hour, increasing to half an hour twice a day.
- You could tell the patient that you will contact the physiotherapist to ask them to reassess them and meanwhile advise them not to mobilise more than they have to (e.g. visiting the toilet, walking into the kitchen to prepare food). When the physiotherapist reassesses their mobility, they will be given further advice from the physiotherapist.
- You could tell the patient to rest and to listen to their body and not to mobilise if it is uncomfortable. You will visit them next week to see how they are.
- Think of the impact your decision will have on the patient. Have you collaborated effectively with the correct person in the team? Have you compromised patient care in any of the above scenarios?

Community nurses quotes

"I enjoy working with patients and their families in their homes. Working in a primary health care team and working with other professionals."

"…communicate with the team - no day or patient is the same, open communication helps everyone."

"….teamwork, holistic nursing and multidisciplinary working "

Chapter Summary

This chapter has looked at the importance of team work and collaborative ways of working within a multi-disciplinary team. It stresses that all members of the multi-disciplinary team have a responsibility and all members of the team should be invited to participate in discussions regarding their patients. If a multi-disciplinary team is going to be effective there must be respect across all of the disciplines, which will foster a positive environment. The overall aim of collaboration is to encourage health professionals to work together in the most effective and efficient way to produce the best health outcomes for patients and for providers. This chapter has also highlighted the importance of accurate record keeping, highlighting that no matter how insignificant a task may seem it must be written down or otherwise in a court of law it did not happen!

'No day or patient is the same, open communication helps everyone.'

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Web-links
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- www.gov.uk
- www.comfirst.org.uk
- www.charity-commission.gov.uk
- www.eicp.ca/en
- www.cochrane.org
- www.eoecph.nhs.uk
- www.england.nhs.uk

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Section B - Working in the community nursing setting

Chapter 7 - Working with Vulnerable People

The aim of this Chapter is to:
- Define vulnerability and consider groups at risk

- Identify various forms of abuse

- Raise awareness of systems that protect vulnerable people and how to 'raise concerns'

As a community nurse when visiting patients in their own home you will meet all members of the family, adults and children. There are many similarities in definitions of vulnerability between them; however, there are some very distinct differences between adults and children in terms of how these groups are managed. For this reason, this chapter has two parts, part one will concentrate on adults and part two will concentrate on children.

As practice evolves, so does the need to develop understanding of the terminology around risk and vulnerability. In more recent years the term 'adult at risk' has replaced 'vulnerable adult'; this is because the term 'vulnerable adult' may wrongly imply that some of the fault for the abuse lies with the abused adult (Social Care Institute for Excellence 2011). Under the new Protection of Freedoms Act (HM Government 2012) the definition of vulnerable has been redefined:
'...adults are considered vulnerable because of their age, behaviour, illness and other characteristics. A person will now be considered vulnerable because of the nature of the regulated activity being provided to them, regardless of where or how often that activity takes place.'
(HM Government 2012 P 54)

Protection of Freedoms Act (2012)
http://www.legislation.gov.uk/ukpga/2012/9/contents/enacted

Other Sources of Information:
Department of Health (2013) Statement of Government Policy on Adult Safeguarding www.dh.gov.uk/publications

'Child Protection is the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.'

Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document March 2014
www.rcoa.ac.uk/system/files/PUB-SAFEGUARDING-2014_0.pdf

A further consideration when caring for people at home is the right to dignity and choice and consent to the care being given. Within the primary care setting, community nurses need to be aware that adult patients have the right to refuse treatment even if it may be to their own detriment, as the law recognises that adults have the right to determine what is done to their bodies.

'Community nurses need to be aware that adult patients have the right to refuse treatment even if it may be to their own detriment.'

Here is some UK legislation that is in place to protect vulnerable groups:

- **Human Rights Act (1998)**
The section on 'other rights and proceedings is particularly related to Safeguarding.

- **The Care Standards Act (2000)**
This Act makes provision for the registration and regulation of public and private establishments. Sections 3,7 & 9 particularly relate to community nursing.

- **Race Relations Act (2000)**
This Act relates to discrimination of people on racial grounds

- **Domestic Violence, Crime & Victims Act (2004)**
Part 1 of this Act is particularly relevant to vulnerable adults

- **Domestic Violence, Crime &Victims (amendment) Act 2012**
This amendment to the act has tightened up the law and made protection of victims and prosecution of perpetrators simpler

- **The Disability Discrimination Act (2005)**
This Act makes provision for people with disabilities in areas such as employment, education and access to services

- **DH No Secrets (2000)**
Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse

- **Safeguarding Vulnerable Groups Act (2006)**
This Act makes provision for children and vulnerable adults

- **The Mental Capacity Act (Discrimination) (2013)**
This revised Act makes provision for people that maybe discriminated against on the grounds of mental ill health.

- **The Care Act (2014)**
'putting carers on an equal legal footing to those they care for and putting their needs at the centre of the legislation'.

- **HM Government (2015) Revised Prevent Duty Guidance for England and Wales.**
Guidance for specified authorities in England and Wales on the duty in the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people being drawn into terrorism.

What is Abuse?
It is important to have some understanding of how to recognise forms of abuse:

- **Physical** - hitting, slapping, kicking, pushing and in healthcare this could be forms of restraint or misuse of medication
- **Sexual** - rape, assault or sexual acts that are not consented or pressured into consent
- **Psychological**- emotional abuse, threats of harm, abandonment or withdrawal, deprivation of contact, humiliation, intimidation, blaming, controlling and verbal abuse
- **Financial** – theft, fraud, exploitation, pressure over wills, property or inheritance
- **Neglect or acts of omission** - ignoring medical or social needs, failure to provide access to appropriate health or social care. Withholding medication or nutrition
- **Discriminatory** - racists, sexist abuse and exploitation due to disability.

Adapted from Action on Elder Abuse (2006)

I. Adult Safeguarding
When working with vulnerable groups it is paramount that professionals are aware of both national and local policies for the protection of their patients. Safeguarding is about acting in the best interest of people who are receiving care in health and social care domains. As a community nurse you will be governed also by The Code: Professional standards of practice and behaviour for nurses and midwives NMC (2015), which contains the professional standards that registered nurses and midwives must uphold. The Code contains a series of statements

that taken together signify what good nursing and midwifery practice looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism: NMC (2015).

The section that refers specifically to safeguarding is 'Preserve Safety': You make sure that patient and public safety is protected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that could put patient's public safety at risk. You take necessary action to deal with any concerns where appropriate.

The professional duty of candour is about openness and honesty when things go wrong: *'Every professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.'*
NMC (2015) The Code - Professional standards of practice and behaviour for nurses and midwives. www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

• **To follow up your concerns**
Here are two resources that may assist you:
1. Link to NMC (2010) Raising and escalating concerns – step by step guide
http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Raising-and-escalating-concerns.pdf
2. RCN (2010) Raising concerns document
https://www.rcn.org.uk/support/raising_concerns

Within the UK we have a relatively long history of having a legal framework to protect children from abuse and neglect. However it was not until 2000 that England and Wales developed a framework of policy guidance to protect adults. The approach to adult safeguarding is for one of collaboration and strategic partnership between all concerned. This was highlighted following the serious case review of the death of Steven Hoskins, who was a vulnerable adult.

Social Care TV – link to Steven Hoskins case
http://www.scie.org.uk/socialcaretv/video-player.asp?guid=55E3A233-C880-4CB4-8701-4ACB9D243D39
Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse: (DH London).

The profile of safeguarding adults may have been raised as incidents of abuse in health and social care settings appear in the media all too frequently. More recently in the Francis Report (the review following the Mid-Staffordshire incidents) raised further questions in relation to vulnerability and amongst many recommendations stated that:
'Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights.' The Francis Report (2013) http://www.midstaffspublicinquiry.com/report

'Safeguarding children is everyone's responsibility.'

Groups at Risk

It is generally agreed that globalisation has had both positive and negative effects, it is sometimes less clear exactly how these negative effects impact upon people's lives. The poorest people in almost any community tend to be those who are vulnerable and marginalised and can be targets of long standing discrimination and exclusion WHO (2006). In community nursing as frontline staff you may come across these groups on a daily basis and it will be vital for you to understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it. It is therefore useful if you work in a specified area that you understand how to obtain support for people who may be being exploited. According to the Government Prevent Duty Guidance (2015) all specified authorities subject to the duty will need to provide appropriate training for staff and such training is now widely available.
Her Majesty's Government (2015c) Revised Prevent Duty Guidance for England and Wales. London Stationery Office

The passing of the Immigration Act 2014 has put legal frameworks in place for a new NHS charging regime for migrants in the UK. The new charges will be applied to some primary care services – including GP services beyond initial consultation and also some care given in the community. Aside from the logistical difficulties of implementation, and potentially discriminatory impacts on the regime, there will be real individual and public health consequences. It is advised that you access your local Trust policy and implementation of the Act.

Immigration Act (2014) www.legislation.gov.uk/ukpga/2014/22/contents/enacted
The above section has specifically highlighted two particular marginalised groups in society and it is recognised that within the community setting there are many other groups that might be considered disadvantaged. As a community nurse it will be part of your role to have an understanding of such groups and to work with colleagues to address issues accordingly.

The Homeless Health programme managed by the QNI provides community nurses and health leaders with news, research, workshops and e-learning tools to support:
•   People experiencing homelessness
•   Gypsy and Traveller Communities
•   Vulnerable Migrants
•   Sex Workers

For further information please visit:
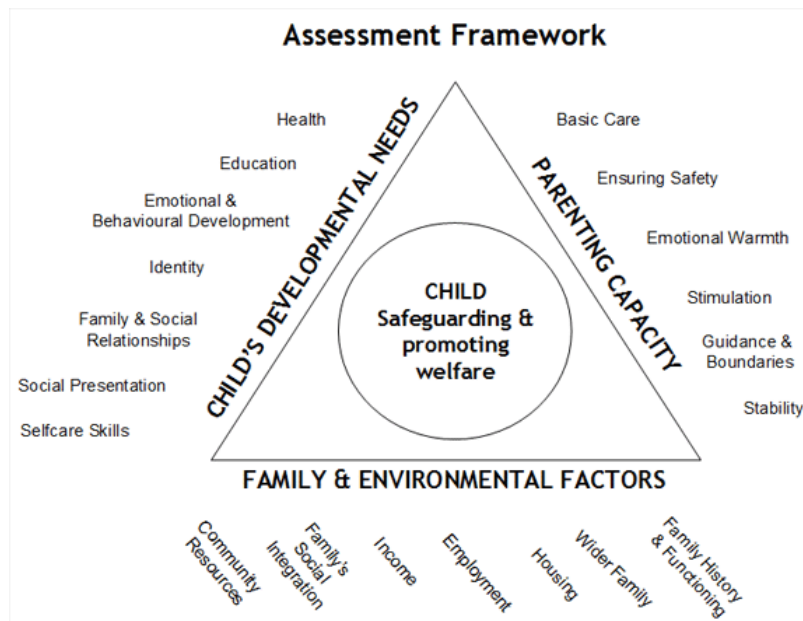http://www.qni.org.uk/for_nurses/homeless_health

II. Child Protection

It is recognised that all staff working in health care settings, even when their client group is mainly adult, should receive appropriate training in matters of child protection (RCN and RCPCH 2012). Safeguarding children is everyone's responsibility and to ensure that services are available to children in need or at risk of harm, every professional and organisation must be mindful of their responsibilities and process of appropriate referral (HM Govt. 2015a). Although community nurses predominantly provide care for adult clients, they are closely involved with families as a whole. Chronic illness, issues of deteriorating mental health and loss and bereavement have a significant impact on family dynamics and the emotional well-being of all the family. It is therefore possible that concerns regarding the welfare of a child may be recognised initially by a practitioner in the home or that the family may disclose their own worries.

Categories of abuse as defined by the National Society for the Prevention of Cruelty to Children (NSPCC) (2010) are listed as:
•   Physical
•   Sexual
•   Emotional
•   Neglect.

It is your duty to be aware of what behaviours happening within a family could be seen to be causing or likely to cause significant harm to any child within that family, or other children who may spend time within the house or be cared for by family members. NICE Guidelines Child Maltreatment - recognition and management (NICE 2014) provide guidance for recognition of both physical and psychological symptoms. It is important to remember that the impact of abusive behaviours and neglect will be dependent on age, resilience and other support networks available. Support from family members may be limited when they are dealing with chronic illness or potential bereavement. The Assessment Triangle (DH 2000) shows clearly the need to consider the impact of family dynamics and pressures on a child's well being.

Assessment Framework

CHILD'S DEVELOPMENTAL NEEDS
- Health
- Education
- Emotional & Behavioural Development
- Identity
- Family & Social Relationships
- Social Presentation
- Selfcare Skills

PARENTING CAPACITY
- Basic Care
- Ensuring Safety
- Emotional Warmth
- Stimulation
- Guidance & Boundaries
- Stability

CHILD
Safeguarding & promoting welfare

FAMILY & ENVIRONMENTAL FACTORS
- Community Resources
- Family's Social Integration
- Income
- Employment
- Housing
- Wider Family
- Family History & Functioning

It has been recognised that early intervention is extremely important to reduce negative long term effects (Munro 2011). This means that prompt referral to appropriate agencies are essential. Nurses are often concerned that by discussing clients they might be breaching confidentiality, but the safety of the child is paramount. Information sharing advice for practitioners providing safeguarding services (HM Govt. 2015b) supports those working in both child and adult services to work effectively to safeguard children. Working closely with GPs, Health Visitors and School Nurses is key to ensuring the best outcomes. The local Safeguarding Nurse for children will also provide guidance and advice in any situation.

The number of young carers is growing, up to 250,000 in England and Wales and they may spend up to 50 hours a week caring for a parent or other family member (ONS 2011). The impact on their social life and educational achievement can be considerable. They will often be reluctant to relinquish their caring role or discuss with their teachers, but they need help to access services and organisations who can provide them with appropriate support and respite.

Over the last years, the level of domestic abuse within families and the need to minimise the long term effects on developing children has been recognised (Peckover et al 2013). Community nurses should be mindful that abusive situations involving adults will be also impacting on any children within the family. There are clear guidelines from NICE (2014) on how practitioners should respond if they are aware of abusive situations within families.

Within the community we are encountering a lot more patients who do not follow the advice or treatment plans provided. This has led DNs to consider the patient's capacity to make a choice and whether they choose to comply or not. Community nurses may find it difficult to accept this and to walk away; this may be due to fear of litigation or ridicule from the patient's family, other professionals or wider community.

Confidence in your decisions/ actions will develop as you work longer in the community setting, together with discussion amongst your team as well as with your mentor.

'Remember it is always challenging when assessing patients' capacity.'

- How difficult is it to assess someone's 'mental capacity'?
- Is there a limit to 'duty of care'?
- Should DNs end up being the 'sponge' when others opt out of care delivery?

Possible answers/discussion points:
- Remember it is always challenging when assessing patients' capacity
- This assessment would usually have a multi-disciplinary approach i.e. GP and social worker could be involved
- The right approach should always be with sensitivity
- As a healthcare professional you will always be divided by your 'duty of care' to protect the patient – this topic is covered in Chapter 8.
- You may have safeguarding leads in your Trust to discuss individual situations or link staff in your team.

Case Scenario
Molly is 68 years old, her husband Frank is 74 and has Parkinson's Disease. He is also becoming increasingly confused and this leads occasionally to aggressive outbursts. You visit Frank weekly to dress his leg ulcer. You are concerned that he may have hit Molly on several occasions but she is very dismissive as she feels she should be able to cope with his behaviour. Molly has had regular care of her grandson Tom since his birth (he is now three and a half years old). She really enjoys caring for him and says it is her greatest pleasure. When you arrive for your visit today Tom is in the road outside the house, crying. He is reluctant to go back in the house with you. Molly is in the kitchen desperately trying to calm Frank down. When you mention your concerns for Tom, Molly also becomes angry and denies that she cannot care for Tom at the same time as looking after Frank.

1. What are your main concerns in this situation?
Molly is at present unable to keep Tom physically safe It is important also to consider the emotional impact on Tom of seeing his grandfather's aggressive outbursts.

2. Who might you want to share this information with?
- In the first instance the parents of Tom
- Other professionals that are involved with Frank's care
- GP, health visitors and social worker.
- You should discuss your concerns with Molly and in the first instance encourage her to inform the parents. You should also share with her that you will be liaising with other professionals.

3. To whom would you go for guidance?
- Health Visitor
- Named Nurse for Child Protection
- Social Services

Case Scenario
You get to a patient who you feel is acutely unwell with 'shortness of breath' and you decide that you need to call an ambulance. The patient says that you 'shouldn't have called the ambulance' and refuses to go to hospital. They ask you to leave the house. How would you deal with this situation?

Possible answer:
- Try to remain calm and supportive – this patient is scared
- Reassure the patient of your good intentions
- Try to explain the reason for and the importance of going into hospital
- You may have to consider leaving the house if the patient insists
- Ensure that you report and record your actions immediately

Reflection trigger point
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.

- A GP asks you to visit a housebound person for a blood test. You are allocated 30 minutes for the visit. When to visit the house is very cold and the patient looks frail and malnourished and unwilling to talk. What would you do?

- You visit a patient in a nursing home and the patient looks underweight and has pressure sores. What would you do?

- You discover during your visit that a patient has been given the wrong medication at the wrong time. What would you do?

- You visit a family and a young child opens the door. There are no adults in the house. What would you do?

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'There has to be a limit to 'duty of care' when we have considered and documented all avenues with the patient.'

Community Nurses Quotes

'…safeguarding in a nursing home can be challenging when dealing with other staff members and professionals.'

'Within the community we are encountering a lot more patients who do not follow advice or treatment plans provided. This has led DNs quite rightly to consider the patients capacity to make a choice not to comply. However the DNs find it difficult to walk away resulting in them continually 'picking up the pieces for fear of litigation or ridicule from the patients, family, other professionals or even the media. DNs remain the sponge when others opt out, there has to be a limit to 'duty of care' when we have considered and documented all avenues with the patient.'

Chapter Summary

This Chapter focused on working with the vulnerable and groups at risk that you will encounter and raised awareness of the legalities of the professional's responsibility when caring for people. It has discussed what may be considered to be harm, abuse or neglect and also ways of detecting signs of abuse. It has also given ideas of how you may report or raise your concerns when protecting the people you encounter in your role.

There is an acknowledgement that this topic is complex and specialist and all professionals need to work collaboratively so that any risk is managed sensitively.

Web Resources
- www.cpa.org.uk Centre for Policy on Ageing
- www.cqc.org.uk Care Quality Commission
- www.jrf.org.uk Joseph Rowntree Foundation
- www.ncb.org National Children's Bureau
- www.scie.org.uk   Social Care Institute for Excellence
- www.saarih.com Safeguarding Adults at Risk Information hub
- www.elderabuse.org.uk Action on Elder Abuse
- www.nursinghomeabuse.net Nursing Home Abuse

Transition to District Nursing Service

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Section B - Working in the community nursing setting

Chapter 8 - Carer Support

The aim of this Chapter is to:
- Consider the role of the carer and the impact that carers have in the community
- Explore nurses reaction to carers and highlight partnership caring
- Look at ways to enhance the carer experience

The role of the carer

When discussing caring for the adult at home it would be impossible to discuss care without recognising the role of informal carers. Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner. Most of us will look after an elderly relative, sick partner or disabled family member at some point in our lives. However, whilst caring is part and parcel of life, without the right support, the personal costs of caring can be high (Carers UK 2012).

The Care Act 2014 sets out carers' legal rights to assessment and support and commenced in April 2015. The Care Act (2014) now gives carer's the right to be assessed by local authorities and this assessment will consider the impact of caring on the carer. Previously the carers did not have a legal right to receive support so the assessment will now consider the carer's needs and identify whether caring is jeopardising their individual needs. Following the assessment a support plan will be developed with the aim of meeting carer's needs. Further details can be accessed at www.careact.org.uk.

Carers act as expert care partners in providing high quality care and make valuable contributions to social services and NHS service providers. There are an estimated 6.5 million carers in the UK today and an expected increase of 40% rise in the number of carers needed by 2037. The financial value of this care is estimated at £87 billion per year (Carers UK 2012). The informal workforce, who provide significant amount of unpaid care, may not be able to meet the demand, leaving a significant 'care gap' (Kings Fund 2012).

It is imperative that important issues such as carer identification, assessment and education and partnership working are acknowledged. Carers have a tendency to ignore their own health needs and are categorised as a high risk group for health problems (Simon 2011). The role of the health and social care professional is to be able to carry out carer assessments, in order to fully understand the carers' experiences and then to implement strategies in order for carers to feel supported in care delivery (Chilton et al 2012).

Overall the carer plays a significant role in keeping the patient at home and preventing hospital admissions. Caring can be a very lonely role and as a member of the District Nursing team should you be in touch with carers and aware of their needs. It is advisable to direct them to a carers forum where they can talk to other people in a similar situation and get support and recognition for what they are doing. There are various support mechanisms in place, such as organised days out and

'Building up a rapport with patients and their relatives is very satisfying.'

workshops for carers and these outings help give carers their life back. For many carers this is a lifeline and gives them the determination to carry on.

For more information on support for carers, contact http://www.carersuk.org/forum

Nurses reactions to carers

'…building up a rapport with patients and getting positive feedback from them and their relatives is very satisfying.'

Nurses recognise that without carers looking after their loved one, it would be impossible to carry out their role as well as they do now, as there would be a much larger drain on the district nurse and community nursing workforce. However, there is the danger that nurses can expect too much of the carer, which in turn can put the health of the carer at risk. Carers save the UK economy an estimated £87bn per year. It is for this reason that the carer and the District Nursing team should develop a partnership to ensure the well-being of the carer as well as the well-being of the patient. The nurse has a duty to inform the carer that they are entitled to an assessment. 'Caring for Carers' (DH, 2006) developed a strategy which values and supports the role of carers and considers the health, education and personal needs of the carer. www.dhsspsni.gov.uk.

As the demography of UK society is changing and there is a large multicultural mix, it is inevitable that there will be an increase in the number of carers from all ethnic groups.

A study carried out in 2007 claimed that 17.5% of carers were of an ethnic minority background. Working with these carers will require sensitivity in planning and sharing the care, as many people from a minority ethnic background see caring as their 'duty' and often will not have requested the services of professional nursing. Diplomacy in working with such groups is essential, as the aim is to work together to give patient and carer the best possible support.

It is estimated that Black and Asian Minority Ethnic (BAME) carers save the state £7.9 billion a year, in contrast to the support that is provided to enable them to care. The research shows that BAME carers provide more care proportionately than White British carers, putting them at greater risk of ill-health, loss of paid employment and social exclusion. There are approximately 503,224 BAME carers in England; 10% of all carers are from a BAME background

and 60,120 BAME carers in England are in 'poor health'(Carers UK. 2001). District Nurses caseloads are demonstrative of this demographic profile, so those working in the District Nursing team must not overlook these statistics. Support should be provided to all carers regardless of their background. The District Nursing team should signpost carers to a carer's website or other resources – www.carersuk.org

As mentioned in Chapter 7, the number of young carers in the UK is growing and young carers may spend up to 50 hours a week caring for a member of their family, who may be a parent or a sibling. This will have a significant impact on their social skills as well as their educational needs. This group of carers will require support that is meaningful to them and this should promote confidence that those being cared for will not be disadvantaged if they take up additional support. Working with this group of carers will require an element of emotional intelligence, which is mentioned in Chapter 10. From April 2015 the law changed for young carers and a social worker from the local authority must now visit to carry out a 'young carer's needs assessment'. This support will assist in recognising what additional support the young carer may require.

Nurses who are working with carers to support a vulnerable person living in their home must also consider how they can work together to keep the patient at home and enable the carer to have some independence, e.g. continue to work or to attend school, as many carers are young carers – in 2001 175,000 carers were under 18yrs. Spending time with the carer is key to the overall successful implementation of planned care. If the carer feels that their needs are being addressed, a more positive caring experience for both carer and patient will result and there will be less chance of resentment on the part of the carer. www.publications.parliament.uk This website will give you links to your local MP and will introduce you to ways of lobbying for a change in policy

Enhancing the carer's experience
It has already been mentioned that the community nurse and the carer should be working in partnership to ensure that patient and carer are supported. The DH (2012a) recognises also that by empowering patients and enhancing the patient experience, this will promote a positive patient and carer experience. What is important to the patient and carer:
•   Adapting to the care setting and respecting patients' home

- Going the extra mile – flexibility and responsiveness
- Making a difference – support and anticipation needs
- Advocacy role and managing risk to keep patients safe
- Family/ home centred
- Hands on and highly skilled
- Core/key worker is centre
- The 'key' to multi-level care
- Harm free care
- Diversity and disability
- Decision making
- Utilising technology
- Being heard

The above list, adapted from the Department of Health (2012a) covers the whole spectrum of care and reflects the 6Cs of Nursing (Compassion, Courage, Communication, Commitment, Care, Competency).

The dialogue between the nurse and the carer must be ongoing, as what could begin as simple caring tasks, such as bathing and feeding, may become more complex if the patient's condition deteriorates. It is important therefore that the carer's needs are reassessed regularly to ensure their experience as a carer is not compromised. The carer should be informed of the importance of taking a break from caring and information about respite care should be given to them so that they can plan a break for themselves. The patient may then either receive care as an inpatient or where possible more services can be put in the home to enable the carer to take a short break. Having a short break is an opportunity for the carer to 'recharge their batteries' and it also recognises how much they are contributing to the overall care of the patient.

Carers have often said that they feel invisible; therefore the amount of time that the carer gives in supporting the patient to stay in their own home must not be underestimated and not taken for granted.

The Carers Trust: www.carers.org There is a wealth of information on the site regarding how carers can apply for respite care, as well as information on education and finance.

www.hscic.gov.uk This site will give you information on topics related to health and social care.

There may be local organisations that you can access. These may be voluntary, private or charitable organisations, - your team can guide you with this.

Care in Local Communities – A new vision and model for District Nursing (2013) publication highlights the importance of working with carers to provide holistic care for vulnerable patients living at home. One of the objectives of the model has been to review professional pathways focussing on supporting carers. It highlights the importance of creating a therapeutic relationship with patients and carers.

- Does good communication between patients, carers and the District Nursing team promote compliance and trust?
- Look for examples within your District Nursing team
- What are the demographics within your District Nursing team

'The partnership between the carer and the community nurse is essential if care is to be ongoing.'

caseload?
- Does it reflect the BAME statistics mentioned above?

Case scenario

Patient and Carer Focus

Margaret has dementia and has been referred by home care with skin tear due to a fall. She is cared for by Henry her 75 year old husband who has diabetes and reduced mobility. While assessing her Henry asks if you will catheterise her as she has started to become incontinent and he is finding it difficult to manage.

- Explore issues such as carers needs – does Henry need an assessment himself?
- What support is in place for carers?
- Are there any ethical implications?
- Risk assessment

Possible actions:

You could make a decision to catheterise Margaret as you can see that Henry is not able to manage her incontinence and often cannot get Margaret to the toilet in time.

Refer to continence service for an opinion as better continence aids could resolve this.

- You could arrange for Henry to have some social support in the form of extra help in the morning and evening which would reduce the amount of times that Henry would have to deal with Margaret's toileting.
- Referral to local memory clinic via GP.
- When considering ethical implications what are you looking at? Are you thinking of what is the best action for Margaret or Henry? Should both needs be considered?

Some areas to be considered when carrying out a risk assessment are as follows:
- Is Margaret able to recognise when she needs to go to the toilet?
- Is Margaret capable of making her own way to the toilet?
- Is the home environment suitable for a commode?
- Where would you place the commode in the home?
- What amount of fluid intake is Margaret having daily?
- What times of the day does she drink?
- Is there a particular time of day when Margaret is incontinent?
- Is Henry able to monitor his own diabetes?

- What is Henry's nutritional status?
- What are the restrictions to Henry's mobility?
- Is Henry's restricted mobility a danger to both Henry and Margaret?

Exercise These are just some of the risk factors to consider. Can you think of more?

The QNI has developed an online resource specifically designed for community nurses to enable their support to carers, look at www.qni.org.uk to find out more.

Chapter Summary

This chapter has looked at the important role that carers play in supporting the community nursing service to look after a large number of vulnerable people being cared for at home. The partnership between the carer and the community nurse is essential if care is to be ongoing. However, it was also recognised that often carers could be taken for granted and therefore there must be acknowledgement of the amount of work that carers do in preventing hospital admissions. The diversity of patient needs due to cultural diversity was also addressed.

Overall this chapter has highlighted that without carers there would be so many more hospital admissions, as there are limited community resources to maintain care in the community without the addition of numerous unsung heroes – carers.

References

Carers UK (2016) Carers Rights Guide 2016 Looking after someone, London

Carers UK (2006) The Voice of Carers- Half a Million Voices: Improving Support for BAME carers

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- www.ageuk.org.uk
- www.youngcarers.net
- www.macmillan.org.uk
- www.carersinthecommunity.org.uk
- www.healthknowledge.org.uk
- www.communitycare.co.uk/ articles/16/08/2011/46026/carers.htm
- www.crossroadscare.co.uk
- www.nhs.uk/CarersDirect
- www.gov.uk/government/organisations/
- www.gov.uk

Transition to District Nursing Service

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Section A - Thinking about working in the community

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Section C - The future - personal and professional development

Chapter 9 - Future- Personal and professional development

The aim of this Chapter is to:
- Raise awareness of the political climate in which the NHS now exists
- Consider the Department of Health (2013) strategy for the future of District Nursing
- Explore some of the impact these changes will have on practice
- How do you keep up to date?

In today's NHS there are so many changes that will impact on the way in which community nursing is delivered and as a nurse you will need a working knowledge of what these changes will mean to you in your role. We will now look in turn at the Department of Health, Queen's Nursing Institute and Royal College of Nursing and their interpretation of some of the changes:

The Department of Health

The NHS faces a period of change both in terms of demographic changes and the shifting burden of disease requiring the reassessment of the hospital based model of care (Commons of Health Select Committee 2012). The Department of Health's Structural Reform Plan recognised the shift of resources and emphasised care out in the community and it also highlighted the need to adjust working practices and roles to promote better healthcare outcomes (DH 2010a). The reconfiguration of the workforce and altering the point of service delivery has become essential.

This redistribution from hospital based provision represents a need to enhance the delivery of care in the community setting. The need to make long-term cost savings whilst attempting to maintain and enhance the quality of services is paramount and the reconfiguration of the workforce by altering the point of service delivery is essential.

This expansion of community services and the emphasis of care closer to home resonate in many recent government and policy reports and the need to engage with the complexities of caring for people at home. The Equity and Excellence white paper outlined significant changes in the way in which services will be delivered in the NHS with a call to remove Primary Care Trusts and strategic health authorities and develop GP consortia and commissioning groups (DH 2010b).

With an ageing population and increased prevalence of disease there will need to be a move away from the current emphasis on acute and episodic care towards prevention, self-care and more consistent standards of primary care to care that is well co-ordinated and integrated (Kings Fund 2011).

Close to Home (DH 2011) was an inquiry into older people and their human rights in home care. It was the first inquiry of its kind and it uncovered some real concern in the treatment of some older people especially when examining how some services were commissioned. Its key findings highlighted neglect around delivery of care packages, financial abuse and a chronic disregard for older people's privacy and

'This redistribution from hospital based provision represents a need to enhance the delivery of care in the community setting.'

dignity. Whilst this report concentrated on older people's experiences of receiving social care in the home setting, its findings were far reaching in terms of the infrastructure and systemic problems related to promoting human rights in the home care setting. The nursing profession has had to evolve in line with changing disease patterns, new treatments and different service delivery. There has been a need to develop new knowledge and skills, accept more responsibility and accountability and create robust education opportunities. However, there has also been a need to return to the fundamentals of nursing, which have been characterised in the '6 C's'. This has been characterised within the DH Strategy for Nursing 6 C's care, compassion, competence, communication, courage and commitment.

There are various ways to get involved in 6C's Live

Twitter
• @6CsLive
• @nhsb
• @JaneMCummings

Follow Hashtag
• #6Cs
• #Caremakers

A new nursing strategy for Nursing and Midwifery was launched in May 2016: Leading Change, Adding Value. This does not replace the 6C's but builds on the work accomplished through this initiative.
https://www.england.nhs.uk/ourwork/leading-change/

Share examples of good practice and success:
www.commissioningboard.nhs.uk/nursingvision

In January 2103 a vision for district nursing was published. This document has been produced by a strategic partnership of The Queen's Nursing Institute (QNI), Department of Health and NHS Commissioning Board, working with professionals from district nursing services, higher education, wider community nursing and social care. This document sets out a vision and model for district nursing to meet future health needs which are based on those enduring values, as documented within 'Compassion in practice:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127500/vision-district-nursing-04012013.pdf.pdf

A number of articles have been written as a result of this.

GP Commissioning and Clinical Commissioning Groups
It is necessary to have some understanding on GP Commissioning and its potential impact on patient care. Watch the short clip below to help you to understand more:
Clare Gerada, former Chair of the Royal College of General Practitioners:
Nuffield Trust – The impact of GP Commissioning on Patient Care
http://www.nuffieldtrust.org.uk/talks/videos/clare-gerada-commissioning-impact-patient-care?gclid=CI2a8dHvg7cCFcXKtAodLG8A1A

You can also read about current issues with The New NHS - Clinical Commissioning groups by visiting the link below:
http://www.kingsfund.org.uk/projects/new-nhs/clinical-commissioning-groups?gclid=CNCZ0eDwg7cCFTMRtAodYzYAsA

As providers, it is evident that district nurse employers will have to sell their services to Clinical Commissioning Groups (CCGs) and promote the care they deliver. They will have to prove and provide evidence that they are able to improve patient outcomes and deliver quality care closer to home and reducing inappropriate hospital admissions. From April 2013 the NHS Outcomes Framework will form part of the way in which the government will hold the new NHS Commissioning Boards to account.

The NHS Outcomes Framework 2013/14:
• explains the purpose of the NHS Outcomes Framework and how it will work in the wider system;
• highlights the main indicator changes across each of the five domains;

Domain 1 - Preventing people from dying prematurely
Domain 2 - Enhancing quality of life for people with long-term conditions;
Domain 3 - Helping people to recover from episodes of ill health or following injury;
Domain 4 - Ensuring that people have a positive experience of care; and
Domain 5 - Treating and caring for people in a safe environment; and protecting them from avoidable harm.

https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

Observing your District Nursing team in action:
• Do you feel that they are working towards the

NHS Outcomes Framework
• What evidence are you able to link to the NHS Outcomes Framework

The Queen's Nursing Institute

The Queen's Nursing Institute (QNI) undertook an extensive survey of patients' and carers' experiences of being cared for in the home in 2011. This resulted in the report: 'Nursing People at Home - the issues, the stories, the actions' (QNI 2011). The findings highlighted three things that patients said they wanted from community nurses: they want them to be competent, confident and caring. These themes fed into the start of the larger DH strategy launched in December 2012 (DH 2012a). The case for integrated care has never been stronger, with the ageing population and increased prevalence of chronic diseases. Care for people with complex health and social care needs must be made a real priority with commissioners and providers (King's Fund 2011). The new model of integrated community care that focuses on prevention of ill health, as opposed to treating people when they become ill must be viewed as forward-thinking. This integrated model will require all key stakeholders to work in partnership in the co-ordination of this care. A network of primary care providers that promote and maintain continuity of care and act as links for the provision of chronic disease management and generalist care is needed (Holland and McIntosh 2012).

Currently, district nurses work in partnership with other health and social care professionals to provide care to people in their own homes. However it has been estimated that 35% of them are eligible to retire within the next 10 years (DH 2009), this has implications for the future district nursing workforce and will impact on the drive for more care closer to home. The QNI (2006) predicts an increase in national demand on the district nursing service in the future. The potential future problem is exacerbated by the projected growth of the UK population to over 70 million in the next 20 years (Office for National Statistics [ONS] 2011).

The QNI released a report in July 2013 – 2020 Vision 5 Years on – Reassessing the future of District Nursing. This report highlights the stresses that District Nurses work under, related to heavy caseloads, poor staffing and the physical location where District Nurses are based. Further information can be found at:
http://www.qni.org.uk/docs/2020_Vision_Five_Years_On_Web1.pdf
The report's final call to action was 'there is no need to 'reinvent' the District Nurse. It is however time to reinstate the District Nurse.'(QNI, 2014). Additional figures supplied by the Health and Social Care Information Centre (HSCIC), show that there were 6,937 full time equivalent district nurses in England in September 2011, 922 fewer than the previous year and down from 10,526 in 2001 (Duffin 2012). This has been recognised as a 'creeping tragedy' for patients and in particular the increasing number of older people living at home with complex long term conditions. We are reaching the point where the district nursing service will not be able to regenerate because the workforce will be 'out of sight' and subject to different educational approaches of a variety of new and inexperienced providers'.

The Queen's Nursing Institute has worked tirelessly over recent years to gain further recognition for District Nurses and the work they do to provide quality care to those vulnerable people who are housebound.

'If the nation fails to invest in community nursing, the long-term costs of health care are likely to increase.'

Visit the Queen's Nursing Institute website regularly to view latest developments regarding the District Nursing workforce.

Royal College of Nursing

The increase on healthcare quality and output strongly relates to staffing and in particular improved outcomes and quality are associated with higher levels of Registered Nurse staffing (Pronovost et al 2002). Newbold (2008) however, suggests that fewer staff could be employed, but there is a need for them to be better qualified. This means training district nurses to a highly specialised level and in particular developing their skills at leadership and management. 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 (RCN 2010).

In the document District nursing – harnessing the potential (RCN 2013) Peter Carter the former General Secretary and Chief Executive for the RCN stated the RCN position on district nursing and highlighted the challenges and the shift of care from the acute to the community setting. He emphasised the need for investment in district nursing with appropriate workforce planning, education and training, as well as clinical and leadership support. District nursing – harnessing the potential will be a useful resource for health care professionals, workforce planners and commissioners in achieving these goals, as we work towards providing community care which meets the demands of a 21st Century NHS.

District Nursing : harnessing the potential The RCN UK position statement on District Nursing : www.rcn.org.uk/__data/assets/pdf_file/0009/511983/004366.pdf

From the three perspectives above it is clear to see that community nursing is evolving rapidly and it is an exciting time to be working in the community. Community nurses will need to be able to rise to the occasion and be involved in decisions about how services will be developed and delivered.

Following the publication of the above documents, the RCN commissioned a survey of district and community nurses in 2013. This survey looked at staffing levels, age of staff and district nursing activities. Recommendations were to improve working conditions for District Nursing and to increase entrants into community nursing, stating that a 7% increase in district nurse training numbers for 2014-2015 is planned .

In 2014 the Guardian published an article stating that District Nurses will disappear by 2025, claiming that the number of District Nurses have almost halved in 11 years to 6,656 District Nurses in England. The article also stated that District Nurses are dissatisfied because they are only spending 37% of their time with patients. Yet whilst this is happening, the demand for the District Nursing service is increasing. This is a dichotomy that those reading this resource need to be aware of. https://www.theguardian.com/society/2014/jun/17/district-nurses-disappear-2025

Government Policies and publications impacting on District Nursing Services:

The Five Year Forward View (NHS, 2014) is a partnership between NHS England, the Care Quality Commission, Health Education England, Monitor, the NHS Trust Development Authority, Public Health England and the National Institute for Health and Care Excellence. The impact on District Nursing and community services would be to bring an integrated out of hospital service together, to provide care for a local population . Some localities applied to become a vanguard site where they would act as a blueprint for the NHS Community services. Thirteen areas have become multispecialty community providers – moving specialist care out of hospitals into the community. The following links will give you more details:

www.coalitionforcollaborativecare.org.uk
www.vanguard.co.uk

Transforming Community Services (DH, 2011). This publication focuses on community indicators and how to select those that measure what is of value to the people who use community services. It will help the District Nursing service to measure and monitor quality improvement, by indicating where change is needed. www.gov.uk

Care in Local Communities - A new vision and model for district nursing (2013)
This supports individual areas in addressing the needs of their local population and developing a District Nursing service model to meet the needs of the population. The overall aim is to increase the healthy years of life and reduce the social isolation that many older people experience and improve the quality of their lives. Community services need to be

responsive to the needs of patients, giving the patient the opportunity to make a choice about their care. The philosophy is to work within the vision for district nursing as documented in 'Compassion in Practice': a vision for nurses, midwives and care staff, the national vision and strategy in England, thus raising the profile of District Nursing. www.gov.uk

Transforming nursing for community and primary care (HEE, 2015) This supports the delivery of new models of care as described in the Five Year Forward View. One of the key concepts of this transformed workforce is having the right number of staff in the right place, with the right skills, behaviours and values.

District Nursing and General Practice Nursing Services Education and Career Framework (Health Education England (2015).This framework sets out the specialist knowledge and skills required to deliver and advance in District Nursing. It contains a framework which outlines the various levels of skills required within a District Nursing team. More discussion can be found in Chapter 10 and further information can be accessed at: www.hee.nhs.uk

Framework for commissioning community nursing – NHS England (2015) This framework supports the commissioning of community nursing – non qualified workforce – community staff nurses, district nurses, community matrons (this list is not exhaustive).
The purpose of the framework is to provide:

- insight into community nursing, the challenges and opportunities to enable effective commissioning of community nursing
- a focus for assurance conversations with providers
- eight components guiding the assessment, planning, commissioning and impact of a community nursing service
- an overview of a range of workforce tools to assist planning in community nursing ' (NHS, 2015)

www.england.nhs.uk

NICE – Guideline scope (for consultation) Safe staffing for nursing in community care settings for over 18s (2015) – This scoping exercise is looking at factors affecting safe staffing for nursing in community care settings and will review outcomes and indicators associated with the delivery of safe care. It will review the organisational factors and the individual skills and activities occurring in the community setting and will review any toolkits that will help assess safe staffing in the community. Visit the NICE website to see when the final guidelines for community care safe staffing will be published.

Exercise: Reflect on your District Nursing team – is safe staffing adhered to within the organisation? How do I keep up to date?

Keeping up to date is a requirement of the NMC registration. You are required to maintain currency in your field of practice to ensure that best, evidence based practice is maintained and therefore, the public protected (NMC, 2015). It is also crucial given the rapidly changing NHS that all nurses monitor changing policy and respond appropriately.

One method of keeping updated is to perform a literature search of a particular topic of interest related to your practice. It is a way of

'Make a habit of reading/listening to one political article/debate/ discussion every week.'

broadening knowledge on a topic and it can increase both general and specialist knowledge. It facilitates a way of honing the skills of searching relevant material and allows for critical appraisal of research, it can also assist with developing confidence and vocabulary of a subject, contributing to the ability to be assertive.

The purpose of a Literature Search
1. It broadens your knowledge on a topic.
2. Increases your general knowledge, specialist knowledge, vocabulary and confidence.
3. Shows your skill in finding relevant information.
4. Allows for critical appraisal of research.

Contributing to consultation documents should also be an important aspect of the community nurse role. This means signing up to relevant professional forums such as the RCN or QNI ensuring that you are on relevant e-mailing lists. Your managers will be on circulation lists from different organisations such as government departments and ask them to forward any relevant information on to you. Anyone can contribute to policy consultation documents either as individuals or groups and this is crucial in raising the profile of community nursing. Even if you do not have a great interest in politics, you cannot fail to take account of government policies that impact on community nursing services, because inevitably the policy will have an impact on you in your role as a District Nurse or as part of the district nursing team.

Activity 1
• What impact do you think GP Commissioning will have on patient care?
• Consider the advantages and disadvantages

Activity 2
• What do you think is the key policy driver for District Nursing?

Activity 3
• Imagine you were elected to sit on a Clinical Commissioning Group – what would be your priority in relation to District Nursing

Activity 4
• Choose a topic that interests you or a topic that you know very little about, either must relate to community nursing
• Search on the DH, HEE, QNI, RCN ,King's Fund or any other related website for information
• Look at any resources you may have in your clinic or local surgeries
• Access all the related websites that are attached to this resource that may assist your search

• Start to compile an information file of your topic

Activity 5
Make a habit of reading/listening to one political article/debate/discussion every week.

Chapter Summary
This Chapter has introduced the importance of understanding the government NHS reforms and other related literature and their impact on community nursing. The emphasis will be on community nurses to sell their service, in order to do this they will need to be up to date and politically aware of how the changes will affect the delivery of the community nursing service.

Web Resources
www.evidence.nhs.uk NHS Evidence database
www.kingsfund.org.uk The King's Fund
www.nice.gov.uk   NICE
www.qni.org.uk The Queen's Nursing Institute
www.hee.nhs.uk Health Education England
www.gov.uk Government Policies

Transition to District Nursing Service

Contents

Section C - The future - personal and professional development

Chapter 10 - Developing your Career in District Nursing

The aim of this Chapter is to:
- Consider your confidence and competence in District nursing

- Start to consider your own personal development plan

- Career planning

As a qualified District Nurse it is imperative that you maintain currency in all aspects of your role. You should be a role model for other members of your team who want to aspire to become a District Nurse. There are numerous opportunities for you to attend study days and refresher courses and it is your responsibility to attend the most relevant and appropriate updates. These will all form part of your continuing professional development and will be necessary for NMC revalidation.

Importance of CPD

What is the purpose of continuing professional development (CPD)? The overall aim of CPD is to give all those working with patients the opportunity to update their knowledge and skills in their area of work. NMC revalidation is the new process that all nurses are required to follow. You must have undertaken 35 hours of Continuing Professional Development (CPD) relevant to your scope of practice as a nurse in the three year period since your registration was last renewed, or when you joined the register (NMC, 2016). For further details of the NMC revalidation process please refer to the NMC website – www.nmc.org.uk/standards/revalidation .

One of the main strengths of the revalidation is that it reinforces the Code (NMC, 2015) by asking nurses and midwives to use it as the reference point for all the requirements, including their written reflective accounts and reflective discussion. All nurses will be required to maintain a record of practice hours, maintain a verifiable record of any CPD activities, show five pieces of practice-related feedback, five reflective accounts and a reflective discussion form. You must also make a declaration of health and character and demonstrate that you have appropriate indemnity insurance in place. Further in depth details can be found on pages 7-9 on the NMC revalidation guidance online.

If you are not sure whether to apply for a District Nurse course, but would like to remain working in the community, attending study days is an opportunity for you to look at various career paths that you might like to follow in the community setting. There may be study days on palliative care, tissue viability, chronic obstructive airways disease, diabetes, tuberculosis, public health – the list is almost endless. However, the obvious career path for a staff nurse working in the community is to apply for the Specialist Practice District Nursing programme. This may not be a chosen career for all community staff nurses, but should you decide to follow the Specialist Practice route an explanation below will highlight where district nursing is today.

The Standards for Specialist Education and Practice (NMC, 2001) remain for now as the sole regulations for district nursing programmes

> '**The overall aim of CPD is to give all those working with patients the opportunity to update their knowledge and skills in their area of work.**'

in England. However, the Queens's Nursing Institute and QNI Scotland have worked with a number of representatives from universities across the UK to develop new voluntary standards for District Nursing, which were published in 2015. These are not regulated by the NMC, but complement the current NMC standards and many universities are now incorporating these standards into their District Nursing programme.

Specialist practice is the exercising of higher levels of judgment, discretion and clinical decision making in clinical care, to enable the monitoring and improvement of standards of care through supervision of practice, clinical audit, the development of practice through research and teaching, the support of professional colleagues and the provision of skilled professional leadership (Boran 2009).

These views are now supported by Health Education England and are articulated within the District Nursing Career Framework (HEE: 2015). In 2004 the NMC (NMC: 2004) created a third part of the professional nurse register for all Specialist Community Public Health Nurses that included school nurses, health visitors and occupational health nurses. This did not include District Nurses who remained on the first part of the register with a recordable rather than registered qualification (Dickson et al (2011)). This division in community nursing has generated much debate around the education of District Nurses. There have been calls for the standards to be revised to meet the needs of contemporary community nursing from organisations such as the Association of District Nurse Educators (ADNE) (Cook et al. 2011), who are committed to raising the profile of District Nursing.

The band 5 and 6 practitioners who may not wish to follow a District Nursing pathway, preferring to practice in more generalist roles in primary care, are being encouraged to follow new educational programmes, aimed at enhancing clinical skills, knowledge and competencies of the support staff workforce (Boran (2009)). For example, since 2011 Buckinghamshire New University has offered a module in 'Transition to Community Nursing' for community staff nurses. The module acknowledges that practitioners are often working alone in homes that are not set up as health care environments and stresses the need to be able to transfer skills and manage collaborative relationships with clients and families, but also with health, social and voluntary agencies. Nurses working in primary care settings also need to be able to make more autonomous decisions than their hospital based colleagues

(Drennan and Davis 2008).

Service and resource pressures are building while the number of people who wish to be cared for in their own homes is multiplying daily. Therefore District Nurses and their teams will need to be resourceful and innovative in the way they approach each new day. The Five Year Forward View (NHS 2014) states that the NHS has dramatically improved over the past fifteen years, but demand has also increased over the same period. The District Nurse is therefore pivotal in providing a quality service to their population.

There are a variety of opportunities for District Nurses to enhance their role. For example the following areas could be explored further and District Nurses could expand their knowledge or take on an active role in these areas:

• Education
• Management
• Leadership
• Research
• New Technology
• Clinical Commissioning Groups

What is your view of NHS careers for District Nursing and working as a member of a District Nursing team?

The NHS careers website will highlight the various nursing opportunities that are available, whether it be working as a member of a primary care team, working as part of a social enterprise or working with a specialist team of health workers. You will know what your specific interests are, so spend time working through this site: www.nhscareers.uk

A number of health care assistants also work as part of a primary care team and they also should be involved in continuing professional development. Whilst they are not accountable to a professional body, they still have their own individual integrity and individual responsibility to ensure that they are working as a safe practitioner.

Unconscious Competence

Conscious Competence

Conscious Incompetence

Unconscious Incompetence

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Exercise

It is imperative to know what your level of knowledge is if you are to work within your competence. Look at the diagram above, where would you place yourself on the ladder of competence?

Level1 – Unconscious Incompetence – You don't know that you don't know
Level 2 – Conscious Incompetence – You know that you don't know
Level 3 – Conscious Competence – You know that you know
Level 4 – Unconscious Competence – You don't know that you know – it just seems easy!

Using this ladder as a tool will assist you in identifying where more learning needs to take place, but it also give reassurance when you are competent.

The following website, www.mind.tools.com/pages/article/newISS-96htm, introduces you to a number of leadership and management strategies which you might find useful when you identify which level on the above ladder you sit. Please remember that leadership and management not only happens in senior management positions, but every member of a team will have some leadership role to play.

Exercise

• Having identified where you are on the ladder what action are you going to take to change your position on the ladder?
• Also acknowledge that you may be at different levels of competence depending on what skill or subject matter is being addressed.
• You may find the exercise uncomfortable because it displays areas where you possibly thought you were more competent than you actually are. This is not a problem as long as you are aware of this and demonstrate an emotional intelligence that is resilient and will assist you to develop/strengthen in these areas

This website www.emotionaliq.org/EI.htm will introduce you to emotional intelligence and the different models used. Emotional intelligence is the ability to perceive emotions, in yourself and in others. Having recognised this it then enables you to identify strategies that will help you to reflectively regulate emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997).

'Emotional intelligence is the ability to perceive emotions, in yourself and in others.'

Case Scenario

You are visiting a patient who is terminally ill and she has a syringe driver in situ. Whilst visiting the patient she appears to be in distress and very uncomfortable. On careful examination of the patient you see that the syringe driver is not working as it should.

You have previously worked in a hospice and regularly worked with syringe drivers. Since joining the community you have been on further training and you have been signed as competent what action will you take to make the patient feel more comfortable?

Reflection trigger point

- Were you competent to deal with the syringe driver?
- If you did not feel competent to deal with the syringe driver – what action would you take?
- Did you compromise the care for this patient in taking this action?

Possible actions taken:

- You may have felt very competent and able to deal with the syringe driver so you insert a new syringe driver with the relevant medication according to the drug chart.

- As you did not feel competent you inform the patient that you are going to contact the District Nurse/Macmillan Nurse to come and attend to this situation. In the meantime the patient continues to have a lot of pain

- Did you consider that there may have been other means of pain relief that the patient could have been given until such time that the DN or Macmillan Nurse arrived to deal with the syringe driver?

- Whichever action has been taken above, have you considered what your Trust/employer's policy is on administering medication on your own?

- If you had worked outside of the trust policy where would you stand regarding the NMC and also your own professional accountability?

- Were there other actions that could have been carried out?

- If so, what were they?

Personal Development Plan

What is required of a personal development plan? A development plan is designed to help you to reflect on your career to date and for you to put together a SMART action plan to assist you to reach your next goal.

There are several key stages in working on a personal development plan:

1. Identify what is required of your current role?
2. Carry out a SWOT analysis – look at the strengths, weaknesses, opportunities and threats that have assisted/prevented you working effectively in your current role and also when considering future roles
3. Develop a SMART (Specific, Measurable, Achievable, Realistic, Timely) action plan to assist you to move forward in the direction of your chosen career
4. Have you considered any other community career paths you may want to follow – e.g. Specialist Nurse, Community Matron
5. What steps/actions do you need to take to follow your chosen career pathway

Having devised this personal development plan it will pave the path for you when you attend interviews and will also assist you when writing your CV as it will have outlined clear objectives in the form of your SMART action plan. www.worldwork.biz/legacy/www/downloads/Personal_Development_Plan.pdf

Applying for jobs

Firstly, find out background information about the company whether it is a NHS Trust or a Social Enterprise, Charity or Private company. Information can be found on the website. Find out what their vision and strategy for the future is. What skill set are they looking for – do you have the skills they are looking for? It is essential that the job description is scrutinised and that you look at the essential skills and desirable skills that are required of the position that you are applying for. When you compile your CV ensure that the CV meets the criteria in the job description. Be as succinct as possible when you answer questions on the application form and do not add unnecessary information that has no bearing on the job application. Refer to the HEE Careers Framework to identify where you are on the District nurse Career Framework (HEE, 2015). Are you applying for a Level 6 District Nurse/Team Leader role/ Level 7 Senior District Nurse/Team Leader role or a Level 8 Advanced Community Nurse Practitioner?
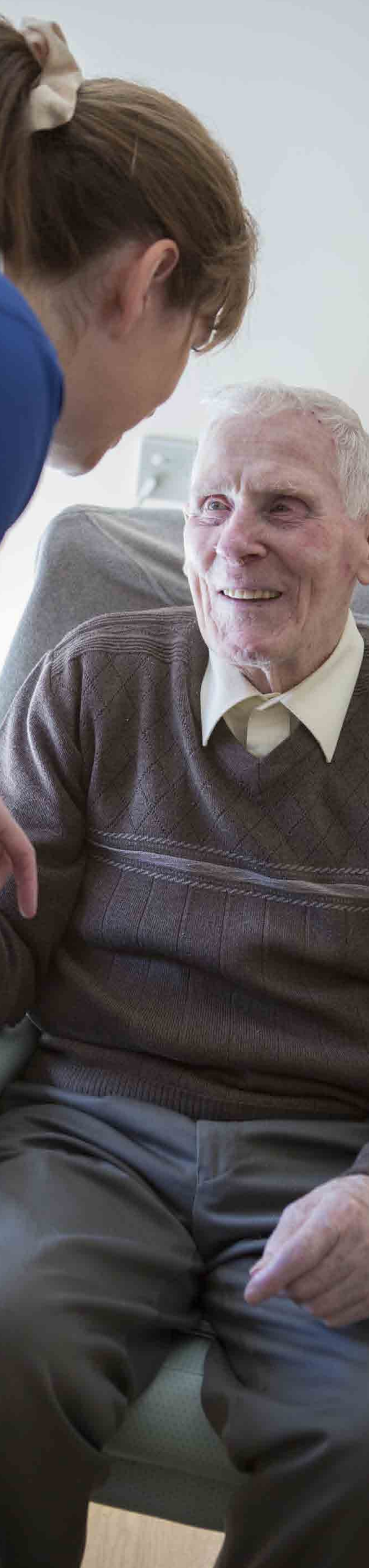
Key responsibilities of a Level 6 District Nurse/Team Leader:

- Enhanced critical thinking and ability to critically analyse a broad range of policies, literature and evidence to support clinical practice
- Ability to analyse service provision both in relation to quality assurance and quality monitoring and to focus on patient outcomes wherever possible
- Strong clinical leadership of the team, including robust preceptorship of new staff, and clarity of expectation of team members with respect to quality of care delivery and values inherent in nursing practice, demonstrating emotional intelligence to recognise pressures on staff and the development of mechanisms to support and develop staff to recognise the impact of caring for people alone in complex situations
- Enhanced knowledge of the local community, needs and resources available and the ability to profile key aspects of the community and the district nursing caseload
- Ability to work collaboratively with others to meet local public health needs for individuals, groups and the wider community
- Ability to build strong relationships with the secondary care teams, particularly for patients receiving shared care to ensure an effective flow of patient information to ensure high-quality care
- Ability to reflect in action and be actively engaged with the NMC revalidation process both for themselves and for others

Key responsibilities of a Level 7 Senior District Nurse/Team Leader:

- A Level 7 Senior District Nurse /Team Leader must have all the essential skills outlined for a Level 6 District Nurse as well as being able to use new knowledge in innovative ways to take responsibility for developing and changing practice in complex and sometimes unpredictable environments.
- They must be able to work in multi-agency environments and interdependent decision-making systems within these teams. They must be able to support staff to feel confident and competent in moving across agency and professional boundaries
- At Level 7 the clinician will be highly experienced in their field and either continues to develop this expertise to be used in a consultancy capacity for advising others on evidence-informed complex community nursing issues or to have management responsibilities for a defined team/section department. They will have responsibility for a caseload, the size depending on their responsibilities, and be expected to provide training, support and supervision to staff.

Key responsibilities of a Level 8 Advanced Community Nursing Practitioner:

- In additional to level 7, this level 8 role will have achieved and consolidated Advanced Nurse Practitioner (ANP) status, demonstrating highly specialised knowledge in community nursing. (HEE, 2015; p 35-38)

If you are invited for an interview it is a good idea to have a practice interview with someone who has an understanding of the role you are applying for. If you have recently completed your SPQ in District Nursing you should be well versed with the government policies and workforce developments within Primary and Community care. Ensure

'Should you be unsuccessful at interview it is always a good idea to ask for feedback from the panel.'

you know about the workforce developments taking place in your area so that you will be able to demonstrate what key skills you as a District Nurse can bring to the organisation. Make sure you are up to date with government and Department of Health policies that potentially will impact on your practice. Be enthusiastic and remember to let the interview panel know what specific skills you will be bringing to the role. If you are asked to present at interview it is likely that you will have ten minutes to present. Prepare your power point slides. Keep these to a minimum (not more than 10 slides) and only write headers or bullet points so that you can talk around the slides and remember to speak slowly and articulate your words. It is also a good idea to bring your portfolio of personal development which will demonstrate how you have been updating yourself and what you have learnt from the updates. https://nationalcareersservice.direct.gv.uk/advice/getajob/interviews

Helpful hints for future interviews:
- Make yourself familiar with the workforce planning strategy in your area
- Revisit your skill set – can you add to this?
- Think broadly and beyond what a job specification requires
- What innovative practice can you draw on and bring to your next interview? This does not have to be your idea, but something you have seen elsewhere and would like to replicate.
- Remember applying for a District Nurse position will require vision and a philosophy – what is yours?

Should you be unsuccessful at interview it is always a good idea to ask for feedback from the panel – this will help you when you apply for further jobs.

Exercise
- Now that you have completed this on line resource what do you plan to do? Has working through the various chapters assisted you in challenging your practice?
- Do you feel more confident now?
- Are you going to pursue your studies further?
- Do you have a clear direction where you want to be in 12 months/ 3 years/ 5 years? This will help you to set personal goals and targets

The website below will give you a lot of valuable information regarding the format of CV writing and the way of using specific words that will enhance your CV: www.monster.co.uk

Chapter Summary
This chapter has looked at the importance of recognising your individual competence in the role you are currently working in. It has given some recognition to how you can recognise your level of competence. This can really only occur if the individual concerned has a self- awareness that will enable them to act on their incompetence and put a strategy in place to deal with this.

The career pathway for working in the community was looked at, recognising that not all staff nurses will want to study for the Specialist Practice District Nurse programme.

The importance of having a personal development plan was discussed and also it was stressed that preparation in the form of CV writing, interview skills and application processes were important when applying for any new role in the community setting.

Further Web Resources
- www.adne.co.uk
- www.nhscareers.uk
- www.jobs.nhs.uk
- www.changemodel.nhs.uk
- www.kingsfund.org.uk
- www.cno.dh.gov.uk
- www.nmc.uk.org
- www.rcn.org.uk
- www.careers.guardian.co.uk
- www.businessballs.com
- www.hee.nhs.org.uk
- www.leadershipacademy.nhs.uk