Community Nurse Role within the Integrated Team

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‘An Alternative Place for Palliative Care’

This local initiative in East Ayrshire delivers effective integrated as part of the integrated care fund for East Ayrshire Health and Social Care Partnership (East Ayrshire health and social care partnership, 2018). The initiative facilitates a palliative care bed in a home from home setting for patients and their families to receive high quality palliative care and support

Positive Impact and Meeting Patient Needs

‘An Alternative Place for Palliative Care’ aims to positively impact on meeting patients needs by;

P - protecting patients lives and prioritising patients needs (Scottish Government, 2019)

A - Acting promptly to support patients in their palliative care journey and alleviating symptoms, pain and distress (Sekse, Hunskar and Ellingsen, 2017)

L - listening to patients and their families (Andersson et al, 2018)

L - looking to the future and lessening the pressure on families

I – identifying early those who would benefit from palliative care (Scottish Government, 2015)

A - achieving patient outcomes holistically, Anticipatory Care planning effectively (Smith and Brown, 2017)

T - trying to offer quality palliative care provision in a homely setting (Vandersteen et al, 2017)

I - increasing the knowledge and understanding of palliative care and innovatively challenging difficult topics of care (Horseman, Milton and Finucane, 2019)

V - voicing advice, guidance and treatment

E - enhancing community services, MDT working, care planning and documentation (Scottish Government, 2011)

C - collaborating working with others and championing community services

A - accepting the changing needs of the population and assessing patients using an individualised, person centred approach (Reeves et al, 2018)

R - Responding effectively to the needs go the patient, respecting their wishes and reducing unnecessary hospital admissions (Health improvement Scotland, 2017)

E - educating care home staff (Scottish Government, 2015).

Policy support for “An Alternative Place for Palliative Care”

The national policy ‘Reshaping Care for Older People: A programme for change (Scottish Government, 2011) identifies that people are living longer and consequently the population is becoming frailer. Therefore there is an increasing demand for health and social care services in communities that are unified and able to provide support which promotes optimal quality of life and quality end of life care delivery. A community palliative bed was deemed a priority for community services to empower the rights, wants and wishes of patients (Scottish Government, 2011)

Following this national policy the Ayrshire health and Social Care Partnerships collaboratively developed their own Reshaping Care for Older People – Ten Year Vision for Joint Services (2013) which further explores the aging population and shifting the balance of care form acute to community settings and services with the East Ayrshire Health and Social Care Partnership (EAHSCP) focussing on anticipatory care planning for older people, prevent unnecessary hospital admissions and promote effective multidisciplinary team (MDT) working to support older people within their communities to live and die well

The East Ayrshire Health and Social Care Strategic plan 2018-2020(East Ayrshire Health and Social Care Partnership, 2018) highlights the need for increased community services. It supports new models of care which enables the provision of services for older people that are person centred, preventative to achieve quality care as near to home as possible and reduce unnecessary hospital admissions. The partnership identifies that initiatives such as ‘An Alternative place for Palliative Care’ will endeavour to meet the individual needs of patients in accordance with their wishes and enable care to be delivered in a homely setting

The Palliative and End of Life Strategic Framework for Action (Scottish Government, 2015) recognises that palliative care can be delivered effectively in settings other than a hospital or hospice and that it is the contribution from a variety of health and social care staff and services which enables quality support to be provided to those who are considered a priority. This policy fundamentally supports the improvements and developments of health and social care partnerships to ensure palliative care is provided in a homely setting that is as close to the patients’ home as possible

Community palliative care provisions is reinforced through the Health and Social Care Delivery plan (Scottish Government, 2016) which recognises the changing needs of the population and focuses on anticipatory care planning (ACP) where various MDT members work together to achieve a person centred approach to palliative care in the community

Furthermore the initiative is reinforced through the Health and Social Care: Integrated Workforce Plan for Scotland (Scottish Government, 2019) which also acknowledges the ageing population and the need to develop and expand services that are equipped to support patients effectively. It focuses on early intervention and prevention which the ‘Alternative Place for Palliative Care fulfils through identification of those would benefit from palliative care support. The policy aims to provide increasing support to the independent sector to enable the development of provisions within varying community settings such as care homes.

Role of the nurse and the wider integrated team

- **The role of the nurse and wider integrated team is pivotal in effectively delivering the alternative place for palliative care initiative. In this instance the alternative place is situated within a nursing home which has its own experienced registered nurses. The Palliative care bed is led by the local General Practitioner and the East Ayrshire Social Care Partnership. The G.P with decide when an admission is necessary and although it is primarily their decision, the care home nursing staff, district nursing team, social work and specialist palliative care team work collaboratively to prioritise the needs of each individual patient (Vandersteen et al, 2017)**
- **Communication with the multidisciplinary team is paramount to ensure all levels of staff are involved in the palliative care process and patients’ needs are met holistically (Scottish Government, 2015). Regular meetings involving all members of the multidisciplinary team is essential to ensure priorities are recognised at all levels (Sekse, Hunskar and Ellingsen, 2017). The G.P will have assessed the patients’ prior to admission and will have communicated the outcome of this with the MDT. This allows all members of the multidisciplinary team to discuss a plan of care that will support the patient successfully. Effective communication allows the development of resourceful professional relationships which are aimed at successfully supporting patients’ to achieve the same outcome of high quality palliative care (Scottish Government, 2011).**
- **The district nurses and palliative care specialist nurses may currently be involved in the care needs of the individual however it is the responsibility of the nurses with the allocated nursing home to ensure ongoing assessment, liaison with Multidisciplinary team, symptom management and effective palliative care delivery (Scottish Government, 2015).**
- **The nurses within the care home are required to have increased knowledge and understanding of Palliative care, various long term conditions, symptom management and pain management (Sekse, Hunskar and Ellingsen, 2017) as this will allow appropriate nursing care to be delivered and changes in conditions to be identified at the earliest opportunity (Scottish Government, 2015)**
- **Anticipatory care planning is an integral part of palliative care (Scottish Government,2019). Nurses should be caring, compassionate and empathetic in their approach to supporting patients through their palliative care journey (). This will endeavour to form trusting professional relationships where the patients feel comfortable to express their needs, wants, wishes and be open of any anxieties, pain and other concerns they may have.**
- **Nurses will assess patient using a person centred approach, compile relevant care plans, implement nursing care in accordance with personalised plans and evaluate the effectiveness of care delivery for those receiving palliative care (Scottish Government, 2011). They should fully involve the patients and their families in the process and advocate on behalf of the patient when necessary (Scottish Government, 2016).**
- **The roles within the integrated team will support an effective approach to providing palliative care that focuses primarily on quality of life and quality end of life for everyone who will benefit from this regardless of their diagnosis (Sekse, Hunskar and Ellingsen, 2017)**

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