

Nurses working as generalists in hard to reach communities

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Hard to Reach Communities?

e.g.

- Rural
- Urban
- Housebound
- Complexity
- Language barrier
- Cultural factors
- Gender

3 examples:-

1. Nurse Practitioner (GP) Trevethin, Pontypool

- Geographically isolated patient populations
- GP services available on more distant premises
- Nurse led primary care supplementary to 4 GP practices
- Access to electronic records (different systems and passwords)
- Assessment, examination and diagnosis skills
- Independent prescriber (4 x different pads etc)

Activity

- Drop-in and booked appointments, acute and chronic conditions, home visits
- No. pts seen Jan – Sep 2009 = 5420 (av. 602/mnth)
- No. of prescriptions given = 830
- Antibiotic, dermatology topical, contraception, weight, dressings, antipyretic, immunology, smoking, other

2. Acute Response Team (ART) Llanelli

- 1 team manager & 1 team leader
- 10 registered nurses – primary and secondary care backgrounds
- 4 HCSWs
- 4 cars – fully equipped with i.v. stands, pumps, defibs., catheters etc.
- (Medicine stock at DGHs)

Aims - avoid hospital admission

- avoid “cycle of dependency”
- early discharge

(pull)

e.g.

- intravenous antibiotics (90% of workload), incl. 40 yr old single mother who could not leave children at home alone – and Polish man who feared hospital admission (HCSW speaks Polish)
- Blood transfusion (5-8 per month)
- Rehydration
- Pleural effusion
- PEG and catheter re-insertion
- Where people want to be treated, i.e. home
- Potential save = £1.2 million

3. Clinical Case Managers, Cardiff

- Variety of primary and secondary care backgrounds/skills across nursing team
- Referrals from GP or secondary care
- Frail, elderly, complexity
- Patient contact variable per dependency level
- Daily, weekly, monthly visits and/or self care management
- Caseload approx. 60 per nurse
- Each nurse based with GP practice, sharing record systems, as per GP team.
- Prescribers using own GP linked pad, system etc

- Hospital pharmacy-reported discharge information
- Alerts nurse to patient discharge
- Clinical portal for in-stay info
- TTH information
- Discharge clinic or home visit to support medication use and continuity of care (sec. care links)
- Links established with Social Services
- Evaluation shows 7% reduction in acute admissions
- Reduction in GP house calls and telephone contact

Generalists?

- If generalist = person who has general knowledge and skill in several areas
- Holistic needs of patient can be met
- Knowing how “it all fits together”; how to harness resources to ensure continuity for patient = expert generalist

