Feedback from patient forum group 3/12/18 – community nursing

Current positives

- Example given of the stroke team – coordinated, MDT care delivering intensive post stroke discharge support. Would like to see more services working like this.
- Practice nurses generally seem to make the most out of every contact – e.g. attending for BP and being offered flu jab, doing bloods required, health promotion work. Felt like a full health check.
- Direct access 24 hour number – really good for patients with catheters
- Patients want the staff to feel valued and would be keen for us to put things in place to help with this. For example development opportunities and PDP programmes.

General suggestions for improvement

- Patients want competent staff and continuity of care
- Get rid of tribalism
  - Patients do not want to hear that 'it is not my job'.
  - Allow for crossover between practice and district nurse – DN clinics and PN visits based on skills not job title.
  - Let appropriately skilled community nurses work into nursing homes for dressings etc.
  - Drive to patient focused care as opposed to task focused care
- Coordination of care
  - Named nurse
  - Continuity
  - In reach of community nursing teams to hospitals – pre discharge reviews.
  - Delivery of holistic, patient centred MDT care
  - Focus on early identification of frailty
  - Use of common assessments
  - Telling story once.
- Communication
  - Needs improving across the system.
  - Issues with hospital discharges not being picked up by community nurses.
- One hub where all community services can be accessed
- District nurses better placed in hubs than individual practices
- Single point of access number
  - Often for patients the default is the GP – acknowledge this and build it into the system e.g. select 4 for community nursing and call gets put through.
  - Patients would like to be able just to ask a quick question

Other ideas

- Upskill community teams to screen for mental health conditions
- Think about carers, identify carer stress, improve links with NT carers.
- Increase use of telehealth

- Patient held records – summary health record that can be kept in patient home
- Think about integration with palliative care teams.
- Community pharmacists could link in with day centres/ Age UK/ other groups
    - Medication amnesty where patients bring in the medications they don't use/ don't' know what there for and can ask questions.
- In triage try to get an indication of how urgent the patient thinks their problem is.