The changing face of community and district nursing

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Context

The Royal District Nursing Service (RDNS) of South Australia provides home- and community-based nursing care to people residing in the Adelaide Metropolitan area. The service is funded predominantly by the Home and Community Care Program. It provides community nursing services in the areas of wound management, palliative care, HIV/AIDS care, continence management, disability care, mental health and dementia care, and diabetes management. In 2000-01, the service made 439,700 visits to people's homes or saw them in a nurse-led nursing centre. In addition, the nursing staff had 84,000 contacts other than face to face that were related to client care. These contacts include the co-ordination of care with other service providers for new and existing clients of RDNS.

The story

The Royal District Nursing Service has provided community-based nursing care to the people of Adelaide since 1894. Community-based nurses or district nurses have traditionally provided nursing care such as assisting with activities of daily living, medication management, diabetes care, continence management, wound management, palliative care and dementia management in people's homes.

Anecdotes from the acute sector indicate that some acute-based nursing staff believe community-based nurses see clients who require only simple care. Views have been expressed that community-based or district nurses simply sponge people, have cups of tea with them and drive around in air-conditioned cars.

However, a recent review of the changes in the RDNS client profile and the nursing care required revealed a change to the community-based care provided. The impact of changes in community nursing practice and associated technologies found in the survey of the RDNS expert clinicians (Level 3 nurses) and RDNS Hospital Liaison staff are listed below.

Joint replacement surgery patients are now discharged 3 or 4 days post-operatively. The length of stay used to be 10-14 days only a few years ago. These clients require wound observation, removal of sutures/staples at home, occasional intravenous antibiotics and wound care if dehiscence occurs.

Ambulatory devices have been developed for the administration of analgesia, antibiotics, and chemotherapy via implanted ports, peripherally inserted central catheters (PICC Lines) or subcutaneous means. These also require maintenance of the site.

There is increased incidence of Methicillin Resistant Staphylococcus Auerus and the requirement for long-term antibiotics preferably in the client's home. Some of these clients require 4 visits per day for intravenous antibiotics such as Vancomycin.

The ability of patients to maintain continuous abdomino-peritoneal dialysis (CAPD) at home occasionally requires a Registered Nurse to add antibiotics to the peritoneal bag.

The increased incidence of hospital-acquired infection results in a push to get patients home as soon as possible, and typically 3 to 5 days post-operatively. This results in an increased in acuity for those people who are being cared for in the community.

There have been many changes related to surgical procedures. They include the increasing number of procedures being performed on day surgery lists. Patients require monitoring during their recovery period from general anaesthetic, wound observation and care, management of wound drains, administration of analgesia and anti-emetics.

One example is cataract surgery. A few years ago, patients were admitted to hospital, at times for up to 10 days. Now they have the cataract removed and a lens implanted on a day surgery list with an expectation that community nursing services will visit and administer eye drops four times per day post-operatively as well as perform the necessary eye toilets.

The advances in compression therapy for venous leg ulcer management allow patients to be discharged within days rather than remain in hospital for several weeks.

There have been changing expectations of the general public that terminal care be available at home. This is associated with a common reluctance to return to hospital or hospice as their physical needs escalate.

There have been changes in chemotherapy protocols that require a course of subcutaneous medication to stimulate cell growth (10 days each cycle). There is often a requirement that these people are seen at home due to the risk of acquiring infection in public places while they are neutrapaenic.

The shortage of hospital beds in general often results in elderly people being discharged home (for one more chance) because it is too difficult to keep them in hospital and await placement. These elderly people need medication management (often twice daily), assistance with activities of daily living, and skin integrity checks. These people may also require some additional clinical care such as wound and continence management as well as social supports.

The increasing incidence of pulmonary tuberculosis in the community requires direct supervision of oral medications. Under the World Health Organisation guidelines on directly observed therapy (DOT), these clients have to be observed for periods as long as 3-4 months. These visits are made directly to the clients' homes at times on a daily basis.

The development of advanced wound-healing devices such as the vacuum assisted closure therapy (VAC) enables patients to be home rather than remain in hospital for extended periods while secondary healing occurs. This therapy is particularly successful in the care of large cavity wounds.

There are increasing numbers of mature onset diabetic patients who are commenced on insulin in the community. Only a few years ago, these clients would have been admitted to hospital with a diagnosis of "diabetes for stabilisation."

Clients with more complex wound care being discharged home for care. Examples are skin grafts, cavity dressings, and complicated leg ulcers.

Documentation

There is an increasing requirement by funding bodies for information. Three to five years ago, 15-30% of nursing time was attributable to nursing documentation. This percentage has now been revised to 30-50%. An example of this is the requirement to meet the HACC minimum data set.

Palliative care

The complexity of drugs used in pain control and symptom management has expanded in terms of numbers of drugs now available and used. The increased body of knowledge regarding pain management (and in particular the use of drugs like antidepressants, antiarrhythmic agents, and cardiac antihypertensives) has led to their greater use – not for prescribed reasons, but for the now known effect on pain pathways. One outcome is that

community nursing services, in conjunction with medical practitioners, can and do provide care for people who are much sicker when they get home and for whom we are able to administer much more complicated combinations in terms of drugs and routes. There is also the increased awareness in the community of people's rights. They now expect much more to be available in terms of their right to die at home.

Other changes

An illustration of the changing face of community nursing is a referral received by this organisation a few days ago. The referral was from a clinic that deals predominantly with the homeless population. It concerned a male under the age of 65 years with a diagnosis of Type 2 diabetes, schizophrenia, and history of substance abuse, multiple cerebral emboli, seizures, and previous myocardial infarction and coronary artery disease. The referring agency asked us to administer insulin on a daily basis and to monitor his blood glucose level, as he is incapable of doing these tasks – or even getting sufficiently organised to attend a nursing centre. This care will continue for years if it is managed well and that is certainly the plan. Only a few years ago, he would have been institutionalised.

Conclusion

The changes described in this article are just the beginning of the move to a greater need for and ability to provide complex care in community settings. The balance is changing. In future an increasing number of health care services will be delivered in the community rather than in the acute sector. Community expectations related to what is achievable in terms of home-based care are increasing. At present, these changes are occurring in a rather haphazard manner more with an opportunistic approach than a planned one. The health care industry will need to adopt a planned approach to this change in focus and service delivery for community-based care.