S c a ca e e

C ca e e ce f . ad a d c \ d e
(a e a e a \ e ca e e ce . d c a ca e e ce)

O e e f \ e e

P a f . 1 Be a \ acc ab e . fe a c e a ca a d \ d be de . a ed a f \ e e :

Community care services provide care and support to individuals of any age in their own homes. The people who use these services are likely to have health and social care needs that they can't meet themselves. These may include physical disability, mental ill health,

As a learning environment we offer an introduction to compassionate, person-centred care and person-centred approaches to care and support that are holistic and rights-based. Community home care environments allow the student to consider what care and nursing requirements are needed to support individuals to remain within their own home and maintain their independence, and how this can link to being a nurse in a community setting. When working in the acute sector and discharging patients home it gives the student nurse a greater understanding of the requirements needed to safely ensure an effective hospital discharge to reduce re-admissions into hospital. It will encourage the student nurse to develop their critical thinking, problem solving through assessment and evaluation, and work with the people they support, helping them identify their outcomes. Nursing students will also achieve a greater understanding of how the domiciliary/community care services work with and alongside other professional teams such as GPs, district nursing services, occupational health, physiotherapy, pharmacists, and various specialist nursing teams.

Working with the people we support, their family members, adult social care providers, and community nurses we work as full partners in the care of the people we support through personalised care and support planning, to help them recover from or manage ill health, stay well, or support and maintain their independence.

As a community care provider, we work closely with the hospital discharge teams, continuing health teams, and adult care teams. It's vital that we have open and effective communication and information on discharge as this will assist in the seamless transition of the people we support from hospital back to their own home environment and avoid unnecessary re-admission.

We assist and care for people with complex needs such as multiple sclerosis, motor neurone disease, chronic obstructive pulmonary disease and various other respiratory issues, brain injury, stroke, cancer, dementia, cardiovascular disease, elderly needs, and frailty. We also support people with mental health needs, including people with depression and people who self-harm.

As a community care provider, we support individuals at home who are terminally ill and require end of life care and support. We provide sensitive care for people who are in the final weeks or months of life. Their wishes at this stage of their care are incredibly personal and we ensure those needs are respected and provided with dignity enabling their end of life decisions to be upheld during this difficult time. We work closely with the district nursing teams and palliative care services to ensure effective pain management throughout all stages of end of life care.

We support the family members in their understanding of these changes which may cause some distress and provide them with any supportive information they may require.

All staff are trained and have experience in catheter care and gastrostomy tube feeding, and care and assist people using continuous positive airway pressure.

Staff are trained to relay all clinical information of any changes in the people they support to the relevant people, for example, urinary infections, changes in skin integrity, raised blood glucose, increased falls, or reduced appetites.

We work closely with specialist nurses, speech and language therapy teams, physiotherapists, and occupational therapists, and have extended training to safely ensure the people we support receive the appropriate care and know when to seek further assistance and advice.

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Changes to medication or monitoring of their clinical needs can also be addressed.

Risk assessments and care plans will require updating as well as ensuring the correct equipment and aids are in situ if required.

Staff wear appropriate personal protective equipment and have rigorous infection control training.

Pe e e be . d . a . a \ f

- care co-ordinators
- team leaders
- community support staff
- registered manager.

Many will be professionals who are not part of the regulated workforce.

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S ec a e

Specialist nurses support people with complex needs such as gastrostomy tube care, epilepsy management, diabetes management, stoma care, respiratory care and palliative care. Training is provided by specialist nurses for staff.

P a ac

Pharmacists liaise with home care services regarding medication issues and issuing various medication aids.

C c a c e

Community psychiatric nurses work with the people we support who have mental health issues to effectively manage these patients in the community. Also, links with crisis teams.

W, a ca be ac, e ed , e e?

This setting can offer the opportunity to experience activity that links to the following NMC proficiencies, click on the proficiency to be taken