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Nursing Associate Case Study Older Adult Community Mental Health Team (CMHT)

Left to right: Heather Reid, Ruth Fortune, Defron Awok, Dr Treloar

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Bromley Older Adult CMHT - Oxleas Foundation Trust London

A community service for adults over the age of 65 with severe and enduring mental health problems and/or a diagnosis of dementia at any age.

Q&A with Ruth Fortune, Nursing Associate (NA)

How long have you worked in the team?

I qualified in April 2019 and did the 2nd year of the NA training within this team. It was a benefit to do the training in the same team I became an NA because I was able to build rapport, the team already knew how I worked and the strengths I brought to the team.

Are you allocated a caseload?

I am not a care co-ordinator, but I do carry my own caseload, which is allocated by a senior member of the team. When I'm allocated a service user (SU) they are care coordinated by someone else if they are on CPA (care programme approach), so for example if Defron (Social Worker) is the care co-ordinator we might alternate visits. If the SU is on Non-CPA they are also allocated to a consultant psychiatrist, who sees them at outpatient appointments. I would meet with them in between these appointments and if I feel that something has changed, I will discuss this with the doctor. This is a collaborative approach between professionals, and is very much a supportive role, working alongside others.

What are your day to day tasks?

No two days are the same, everyday involves home visits and lone working and occasional joint visits with colleagues. Essentially it would be going out to monitor someone's mental state, medication, side effects and physical health. Some of the work would include graded social inclusion but it depends on what that SU's needs are and what the care co-ordinator is requesting support with. I am also able to give depots, most patients that are on a depot have a Nurse as a care co-ordinator, but if there is any reason why the Nurse is unable to give the depot, I will administer this instead so that patients still receive their medication.

The lead OT and I are also setting up a walking group called 'Walking back to Happiness', primarily aimed at people that have a raised BMI related to their lifestyle and the medication they are on. The idea is to help the SU create a healthy habit, which helps to create a healthy lifestyle. Education around lifestyle and eating will also form part of the group's activities. SU's will have a period with the walking group and then be supported to use walking groups in the local community.

Do you feel training course prepared you for the NA role?

Yes Definitely. I've always been very Mental Health orientated and the Physical Health was an incredible learning curve, it was really enjoyable and stimulating. I liked reading and learning those new things.

Have you experienced any difficulties in the role?

I think it will be easier for the next people coming along, colleagues will know what the role is about, there will be less resistance, you know what it's like when anything is new because people don't like change. This is the first year they have done preceptorship for NA's and one of the really good things is that it's been decided that this will be with the newly qualified Nurse's (NQN's), I like that, it's fantastic because you've got NQN's and newly qualified NA's all doing their preceptorship together. This is beneficial because they will understand the role going forward, it's less threatening and we're all just in it together. Some Nurse's felt quite perturbed about the role, but you can see that's getting less as time is going on.'

Bromley CMHT Base

Q&A with Defron Awok, Social Worker

How has the Nursing Associate role supported you in your role?

It is so helpful having Ruth on the team for treatment plans that involve physical health. I've got some complex cases and as a social worker I don't know much about the medical side. For example, Ruth might look at the patient, do their physical health screening and notice signs of dehydration and take immediate action.

Other examples would be that Ruth might inform the GP or the consultant that we are concerned about glucose levels or BP, I don't understand what the readings mean so I would not know when to do this. Sometimes we have patients who would not allow me into their homes as a social worker. They may have a diagnosis of dementia and get worried that I'm coming to take them away from their home. As Ruth is a Nursing associate, they may give her access to support them, that is really helpful.

We may have organised a DST (decision support tool) with the SU, it's from the CCG (Clinical Commissioning Group) continuing healthcare assessment and we fill in the first part to see if it needs a full assessment. Ruth becomes involved with that, she fills in the diagnosis and presentation of the patient while I can be talking to the patient about the social side of things. She also links in with the community pharmacy team.

I'm seeing the difference Ruth has made in the team. We have found it so helpful as care coordinators, she is helping to deliver care in a timely manner.

Q&A with Heather Reid, Locality Manager

How do you allocate NA's caseload?

Factors that are considered when allocating to Ruth are the complexity, the needs of the SU and who the care co-ordinator is. For example, if the care co-ordinator was a Social Worker or Occupational Therapist and their SU needs some Nursing input, that would be an indicator that

they may also be allocated to Ruth. Ruth's caseload size varies and depends on the complexity, it can go up to 15 but currently it's 8.

What are the NA's day to day tasks?

As well as working with her allocated caseload, Ruth does the CQUIN (Commissioning for Quality and Innovation) physical health checks for the whole team caseload. This is a huge piece of work as it means visiting all of the SU's in their own homes. Care co-ordinators refer to Ruth for physical health checks and she implements the Lester Tool and relevant Care plans that are already in place. This is part of the comprehensive care plan for someone that has a diagnosis of Psychosis and includes BMI, smoking status, BP, pulse and cholesterol. If the SU is out of normal parameters Ruth then gives brief advice about healthy lifestyle, signposting to GP if required or requests a medication review by the consultant.

Because it's a new role we are still deciding other tasks. Ruth has just finished a phlebotomy course, so for example, patients that are on Lithium, who need regular blood checks can have them done by Ruth. It may also be the case that some patients can't get to the GP or don't want to engage with the GP. Ruth will visit the patient and do the blood tests and deliver them to the Phlebotomy Dept at the Princess Royal University Hospital. The blood results are incorporated in the cardiometabolic assessment in the Lester Tool. It's a huge role that Ruth is undertaking in the team. She wouldn't have had the opportunity of doing this she hadn't completed the NA training. It's been really helpful with the physical health checks; we weren't always doing them in a timely manner before and now they are all there and up to date. Patients are being reviewed regularly. Ruth is very respected in her role as NA within the team.

What value does the NA role bring to the team?

The phlebotomy has brought real value to the team; we've never had that before. We are considering whether to setup a phlebotomy clinic at this base, so when patients are seen for an outpatient's appointment, they can have a physical health check and their bloods done while they're here. That's a bit further down the line as we are setting up so many other things at the moment, but it's up for consideration. It saves the patient going to the GP, a lot of them won't go and whilst they're here we could make it a one stop shop, it saves time and money further down the line and increases patient care.

Does the role improve patient care? If so, why?

Ruth does seem to build a rapport with the patients very quickly. If there are patients that are difficult to engage, we'll usually ask Ruth to visit and work with them in a person-centred way and that generally works very well. Patients always remember Ruth after her visits. Ruth's notes are very succinct and precise, you would think it was a fully qualified Nurse doing the progress notes and everything that is needed is covered.

Do you think the training course prepared the NA for the role?

When we've talked before, Ruth said that it's helped her think differently, working in a much more holistic way. A lot of the Mental Health workers here concentrate on the mental state, but Ruth looks at the whole picture to see where there's other issues arising and potential for risk. It's all about parity between Mental Health and Physical Health and we are going more that way to treat people holistically.

How does the NA differ from a Support Worker?

Ruth can do Phlebotomy, depots, has more autonomy and less direction is needed from the care co-ordinator. The care co-ordinators have an idea of what they would like Ruth to do when they make a referral, but often Ruth identifies other areas that need work, she will just get on and do that without having to be told. It's so helpful bringing in that experience with physical health. There's also the social side and that links in with housing which Ruth supports with.'

How does the NA differ from a qualified Nurse?

The NA does not create care plans and risk assessments, they can add to ones that have already been written. NA also do not do initial assessments or administer controlled drugs.

Have senior management been supportive with implementing the role? If so, what support did they provide?

Yes, we've had the Lead Nurse and Lead Development Nurse coming to help us and talk to us. In the beginning, we didn't know what we were doing, so we were all fumbling about just trying to get job plans together, whereas now it's a bit more structured and we know what the responsibilities are. Even though there was the senior management support, even they weren't too sure and we're still getting there. I don't think we're totally there yet it's a dynamic role that's evolving to meet the needs of the service, but we seem to know exactly what the NA should be doing now.

How have you decided what the NA's scope of practice is?

I knew right from the start what I wanted the NA role to do in the team, what the team needed, so it was very clear all the way along. It was about meeting the needs of the service.

Has the NA required extra supervision?

Ruth gets monthly supervision like everyone else in the team and then support from the preceptorship mentor. As part of the preceptorship the role of NA in team is being reviewed

What pointers would you give to a team that is considering having an NA for the first time?

Ask the team; what do they want? What do they need? Start from there and shape the NA role to fit that.

Would you recommend the NA role to colleagues? If so, why?

Absolutely, I think in older adults we would benefit from having more than one NA in the team, we certainly have enough need for them. We've just had another support worker from the team go for a TNA position, I absolutely welcome it.

Thank you to Oxleas NHS Foundation Trust and the team at Bromley CMHT for participating in the case study. For more information about the NA role visit https://www.healthcareers.nhs.uk/