University of the West of Scotland

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2. This delivery plan sets out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives with supported self-management; is integrated; focuses on prevention, anticipation and supported self-management; will make day-case treatment the norm, where hospital treatment is required; focuses on care being provided to the highest standards of quality and safety; ensures people get back into their home or community environment with the person at the centre of all decisions; and realises these aims, we will continue the patterns of care, demands on the service. 

1. aim is a Scotland with high quality services, that have a focus on intervention and supported self-management. Where people need health and social care, people to be discharged as swiftly as it is safe to do so.
National Health and Wellbeing Outcomes

A framework for improving the planning and delivery of integrated health and social care services

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

National Health and Wellbeing Outcomes: Framework

There are nine national health and wellbeing outcomes which apply to integrated health and social care.

Health Boards, Local Authorities and the new Integration Authorities will work together to ensure that these outcomes are meaningful to people in their area.
practicable, independently ageing in their community.
Frailty
Learning Outcomes

Demonstrate a critical understanding of frailty as a distinctive health state.

Demonstrate a critical understanding of how to recognise frailty.

Discuss effective interventions for supporting frail older people to live well.
The Improvement Hub (ihub) provides support to health and social care organisations to redesign and continuously improve services to ensure they meet the changing needs of people in Scotland.
Paper 3
The district nursing role in integrated community nursing teams
Barbara McFadzean
District Nurse, Queen’s Nurse
Barbara McFadzean
The Queen’s Nurse title was reintroduced in 2017.

The Queen’s Nurse development programme is designed to enable clinical nursing leaders in Scotland’s communities to be the best they can be.

Queen’s Nurses.....Inspire others by making a difference

Queen’s Nurses..... Inspire others with tenacity and resilience

Queen’s Nurses....Inspire others by bringing people together
Frailty

Case study 1.
Jimmy is a 97 year old gentleman, 4 Hospital admissions in the last year.

- Heart Failure (Myocardial Infarction 2016)
- Surgery for Ischiorectal abscess
- Fall - # metacarpal bone right hand
- Delirium - Urinary tract infection requiring IV antibiotics

Last admission required a stay of 3 weeks in Acute care. Jimmy is bedbound and has an Anticipatory care plan in place.
Frailty

Case study 2.
Clara is an 80 year old lady.

❖ Is in the early stages of dementia
❖ Has type 2 diabetes on insulin, twice daily visits by District Nurse
❖ Deteriorating mobility
❖ Increasing lethargy

Divorced son lives with her.
Clara has been in hospital recently for 2 weeks with a chest infection.
Case study 3.
Bob is a 90 year old retired Joiner.

❖ Has COPD
❖ Has macular deterioration
❖ Osteoarthritis

Daughter is his main carer.
Frailty

Case study 4.
Mary is a 91 year old, newly widowed.

- Recently diagnosed atrial fibrillation
- Bilateral leaking legs
- Depressed
- Socially isolated

Only son lives in Australia.