A nurse-led minor illness and injury home-visiting service for young children

This article outlines an initiative to support parents at home to reduce unnecessary A&E attendances

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This article outlines an initiative to deliver a nurse-led home-visiting service to support families and develop their knowledge and skills in managing unwell or injured children. The service has reduced unnecessary A&E attendances and has provided extra support for families with children aged 0–5 years in one of the country’s most deprived areas.

INTRODUCTION

We developed a paediatric nurse-led service to improve practice. At the time of developing the service, there were two community children’s nurses working in the area, based with the health-visiting team.

A significant part of our role was to try to reduce A&E attendances. To address this situation, we proposed the development of a home-visiting service for children with acute minor illness and injury. The aim was to offer support and enable parents to manage their children at home and reduce unnecessary A&E attendances.

The Consumer Health Information Centre and Developing Parent Partnerships (2003) found that one in four parents would take their child to A&E to be treated for minor ailments. Another reason for attendance at A&E is minor injuries. The Department of Health (1999) said that ‘accidental injury puts more children in hospital than any other cause’.

BACKGROUND

The area in which the home-visiting service was developed has chronic deprivation issues – it is one of the lowest-income electoral wards in a city which the IMD ranked as the seventh most deprived district in the country [the index of multiple deprivation] (Office for National Statistics, 2004).

There is a correlation between poverty and poor health, and a marked social class gradient for accidental injury, with some injuries being up to six times more common in the poorest areas (Hall and Elliman, 2004).

Parents attend A&E for many minor illnesses that could be managed at home. In 2005, 66% of all children in the local Sure Start area attended A&E, 71% of whom were discharged with no follow-up.

Local data has shown that children are taken to A&E by their parents with minor illness and injuries that could be managed at home with support from community children’s nurses. These illnesses and injuries formed part of the service’s remit.

The National Service Framework for Children, Young People and Maternity Services (standard 6 on illness) said that many parents would need support to deal with the anxiety caused by their child’s illness, to manage the illness effectively and to understand when to seek further professional help (DH, 2004). It added that parents may be disempowered if they are left confused, and will be unlikely to manage further episodes appropriately.

Part of the DH’s (2005) commitment is to improve access to primary care, especially for disadvantaged groups. This should be in the form of ‘responsive, accessible services and advice’.

We decided the current way of working was not reducing A&E attendances in the area and did not offer support for families when it was most needed.

Community children’s nurses are able to offer evidence-based information and advice on managing minor illness as well as providing a safety net for parents so they know when and where to seek further help; prescriptions can be given if needed.

The service aims to deliver health promotion and education to help parents become confident in their children’s care. This process will potentially reduce their future attendances at A&E for minor illness/injury.

THE INITIATIVE

Thorough preparation was an essential part in planning the service.

We recommended the introduction of a home-visiting service for children with minor illnesses and injuries in our area.

A similar service in Derbyshire had been shown to enable parents to become more confident in caring for their unwell children (Moyse, 2006), and provided families with the support they wanted and needed.

Parent consultation and involvement was important throughout the service’s development and implementation. Parents were consulted and kept informed via the children’s centres and discussion during home visits.

IMPLICATIONS FOR PRACTICE

Feedback indicates that there is a need for this type of service in the area; evaluation needs to be ongoing.

Nurses wishing to provide a similar service should consider how it can be tailored to their particular area and how the skills and experience they have can be used and developed further.
Other recommendations included:
- A change in service should be introduced, recognising the factors that are needed to promote a positive impact of that change, supported by discussion and open communication;
- Clinical guidelines should be developed in order to deliver evidence-based care, referring to pyrexia, respiratory and gastroenterological conditions, and limb and head injuries. They should be developed in accordance with evidence-based information;
- Using a framework such as the ‘safety net’ framework should be considered in developing the service (RCN, 2000);
- Risks needed to be identified so that they can be managed;
- To evaluate the impact of the service, questionnaires, patient satisfaction surveys and audit should be used;
- Funding should be secured for equipment;
- An action plan and timescale should be developed for implementing the home-visiting service.

We had discussions with the community children’s nurse (CCN) who implemented this service in Derbyshire, who gave a presentation to local health-visiting teams. The wider team discussed the appropriateness of the service and funding.

Initially there was some resistance, mainly regarding funding and the impact the service may have on staff time.

We consulted with parents, the paediatric lead at the local walk-in centre, the clinical lead and community paediatric consultant, all of whom have been supportive. We then produced an action plan including a timescale for implementation.

We developed algorithms and practice standards, based on the most recent evidence (Fig 1 is an example). A risk assessment was conducted to protect patients and staff who were involved in the proposed service.

We accessed a paediatric-enhanced clinical skills course and also obtained an independent prescribing qualification while developing the service.

We then made presentations to inform the local children’s centres and GP practices of the service and how they might be involved. A leaflet outlining the service was distributed to pharmacies, GP surgeries and children’s centres.

Health visitors give the leaflet out at the birth visit and inform new parents of the service. A landline and a mobile number are available for parents to refer themselves directly to the paediatric nurse.

**COST IMPLICATIONS**

The largest proportion of funding in any change in service development is staffing but, as the staff were already in post and the clinical lead supported the service, this was not an issue.

While there was a need to secure funding for essential equipment such as dressings and diagnostic equipment, the pilot scheme had few cost implications.

At the start of the initiative, time management had to be adapted to allow enough flexibility to respond to calls. This demand on the service has become more manageable with the experience of running the service. The feeling of being on call throughout the working day has also become less stressful.

Our confidence in managing minor illness and prescribing has increased from
attending training and providing the home-visiting service. We have received excellent support from parents, colleagues, the clinical lead and community paediatrician and GPs. Clinical supervision is accessed on a regular basis.

Changes in staffing levels, such as those resulting from taking annual leave, full-day training and sick leave, mean that there are times when the service is unavailable. Therefore, the service has not been actively promoted because of concerns that the potential increase in workload would not be managed.

There have been some developments within the PCT, in that 14 community children’s nurses will come into post after funding was secured from the local operational plan. NHS Nottingham City now has a community children’s nursing service. The nurses will work within health-visiting teams to support the delivery of children’s public health priorities.

It is hoped that, after their induction and training, these 14 community children’s nurses may roll out the minor illness/injury service in their particular areas. Although the service has not yet been bought by commissioners, we hope that the new community children’s nurses will be able to develop their skills to provide a similar service in the future.

EVALUATION

An evaluation of the home-visiting service has just been completed.

Data was collected from referral forms, and a patient satisfaction survey provided qualitative data. The findings are positive and parent feedback shows there is a need for this type of service in the area.

Many parents said they would have attended A&E had the service not been available. The majority of referrals have been appropriate and parents said that they understood the verbal and written information and felt more confident in caring for their children when they had a minor illness/injury (see Figs 2 and 3 for more detail).

CONCLUSION

This nurse-led service has been developed and implemented in an area of high deprivation by nurses who are passionate about providing care nearer to home, providing targeted health promotion and health education.

The process has enabled community paediatric nurses to use and develop their skills in the community. It is part of the overall development of this role and this has led to its expansion across the city. It has also benefited families at the time they needed the support.

FIG. 2. WHY PARENTS CHOOSE TO USE THE SERVICE

FIG. 3. WHAT PARENTS WOULD HAVE ACCESSED IF SERVICE NOT AVAILABLE

REFERENCES


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