Using referral guidelines to support best care outcomes for patients

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District nurses play a pivotal role in individuals' care pathways by meeting their nursing needs in the community. However, across the UK and within community organizations, there are considerable discrepancies in what individual district nursing teams do, and how they prioritize and respond to different patients' needs (Royal College of Nursing (RCN), 2003; Queen's Nursing Institute (QNI), 2009). These anomalies cause confusion for patients, carers, other care providers and district nurses themselves. This article discusses how a set of district nurse referral guidelines have been devised and implemented in one area, based on what other local health and social services are available and what they currently do. The aim is to help key stakeholders identify what they would like to commission district nurses to do to support individuals in achieving their best care outcomes. Key stakeholders include the emerging GP consortiums, patient representatives and providers of community care. The article then debates the different approaches to managing referrals to district nursing services, and the pressing need to ensure that referrals are effectively managed in practice.

The need for change

Traditionally, district nursing teams have been asked to act as a point of contact for community services, and to take on a wide range of care to support patients to live at home. This includes acting as 'sponges' for issues that other services are reluctant to address, handling health and social care situations, which do not require specialist nursing assessment skills (Drew, 2011). The Audit Commission (1999) noted that unless district nurses clearly identify referral criteria, there will be an unsustainable demand on their limited resources as the population ages. However, district nursing referral criteria still remain poorly defined or inconstant in their application in practice (QNI, 2009).

The transformation of community care is shifting the focus on to health, social and voluntary services working collaboratively to support people in regaining their maximum independence and health after acute and chronic episodes of illness (Department of Health (DH), 2010). Indeed, a recent extensive study by the QNI (2011) found that patients and their families want to be supported by competent, confident and caring practitioners who are able to deliver the best possible care to meet their needs. Unfortunately, because of the conflicting priorities and diverse demands placed upon district nursing services, patients do not always feel they receive good quality care from their nurses.

In recent years, as district nurses tend to respond faster than some other community services, they have been receiving increasing numbers of referrals to see patients who do not need specialist input into their care (Cambridgeshire Community Services NHS Trust (CCS), 2009; QNI, 2009). Conversely, district nurses do not want to see people going in need, and will often go the extra step to provide care which is outside of their field of expertise. However, if the most appropriate practitioner, e.g. a physiotherapist or social worker, is instead involved early on to assess and provide appropriate timely care, the patient will get the best care outcome and experience (DH, 2009a).

There is a great impetus for change now that GP commissioning groups are starting to allocate financial resources to services that provide value for money and can demonstrate the effectiveness of their input in patient care outcomes (DH, 2009a; 2010). This has created an immediate and pressing need for district nurses to identify what clinical care they offer, and to rationalize how they use their limited resources to deliver meaningful quality- and outcome-focused nursing care. As the demand for care in

ABSTRACT

District nurses play a pivotal role in individuals' care pathways by meeting their needs in the community. However, district nurses are frequently referred patients for whom other interprofessional colleagues have more suitable skills to help in achieving their optimum care outcome. Various major reports have identified a clear need to define what district nurses do and how they will respond appropriately to patients' needs. However, there remains only tacit understanding of district nurse referral criteria across the country and within community organizations. This article discusses how a set of facilitative district nurse referral guidelines have been devised to support individuals in achieving their best care outcome. We also debate approaches to managing referrals to district nursing services and the pressing need to ensure these are effectively managed in practice.

KEY WORDS

Community nursing • District nursing • Referral guidelines • Care pathways • Change management • Integrated care

the community increases, organizations providing district nursing services need to demonstrate to commissioners how they use their resources cost-effectively and equitably. District nurse referral guidelines offer a transparent starting point for all stakeholders in the commissioning process to identify what is currently done in practice and how different community resources can best be used in the future.

Identifying district nursing input into care pathways

The example referral guidelines include eligibility and exclusion criteria (*Figure 1*), and have been designed as a starting point to help local stakeholders understand the current role of district nurses in supporting patients' care outcomes and experience. They also encourage district nurses who are triaging referrals to question what other community services are available and best equipped to meet each patient's particular needs depending on where they are in their care pathway (DH, 2010). The triaging guidance also reflects the need to proactively adapt to the changing nursing needs of patients in the community.

Previous attempts by other community trusts and authors to quantify the holistic assessment skills that district nurses practise have often resulted in roles being reduced to a list of nursing tasks (Parkinson, 2006). These have been duly dismissed by key stakeholders, including district nurses, as being unrealistic and impractical. In turn, district nurses have considered prescriptive lists of what interventions they should be undertaking to be too task-orientated and inconsistent with their values of supporting people's holistic needs (Kirpal, 2004). Rather than defining a list of tasks that district nurses will follow in any situation, the referral guidance discussed within this article offers facilitative information to support district nurses' assessment and clinical judgement of each patient's unique situation.

In the geographical area discussed within this article, the referral guidelines are based on the services district nurses have historically been commissioned to provide. District nursing interventions have been commissioned for those aged 18 and over who are housebound with nursing needs. Certain care interventions, such as continence assessments, are always undertaken by district nurses regardless of whether the person is deemed housebound. The clinical need for district nurses' specialist assessment, health promotion and communication skills has been taken into account in deciding if they are the most appropriately skilled community practitioners to support and coordinate an individual's care pathway needs (RCN, 2003; QNI, 2009).

Defining need

Defining someone's need for district nursing input is a notoriously subjective and contentious subject. If we step back and look at what other community specialties (such as therapists or psychiatric teams) do, there is more transparency in the practitioner's role. Conversely, what district nurses will do to support individuals has often been dependant on local historical traditions, as well as the perceptions of, and pressures from, different stakeholders in care. District nurses are often expected to make up the shortfalls in what other services provide (RCN, 2003) and neighbouring district nursing teams can have different interpretations of what qualifies someone to receive their support. This is neither outcome-focused, nor a cost-effective use of resources in the community (DH 2009b; 2009c). Providing inappropriate care can also adversely impact on the district nursing team's capacity to ensure a high-quality experience for people who need nursing support at home (QNI, 2012).

Locally, other care providers have been commissioned to take on activities identified in the exclusion criteria section of the referral guidelines. For example, private care agencies are routinely commissioned to dispense non-specialist oral medication and administer eye drops. These care activities have been identified by commissioners as being, primarily, a social care need. The exclusion criteria have been designed to help the triaging practitioner to question the appropriateness of referrals and signpost people to the right service in the first instance.

It can be difficult to separate different aspects of individuals' complex health and social care needs in practice (DH, 2009a). There are times when an individual requires some health promotion advice alongside a referral to another service to proactively address their ongoing physical support needs (QNI, 2009). However, by identifying the right specialists to lead different aspects of care from the start, district nurses and other practitioners are best placed to work in partnership with individuals to ensure they have a positive experience and the best care outcome.

Rationalizing resources

Making the best use of existing district nursing skills is paramount to ensure that patients receive safe, clinically appropriate and sustainable quality care (QNI, 2011). More complex and varied community nursing interventions, such as the care of chest drains or the administration of chemotherapy, are increasingly needed to support people being cared for at home. The triaging guidance (*Figure 1*) offers cues for district nurses, who receive referrals, to question what steps need to be taken to manage risks and meet patients' more complex nursing needs. For example, district nursing teams may need to access prompt training to enable them to safely support an individual in managing their tracheotomy at home. Equally, practitioners need to look at how staff skills and resources across wider geographical areas can be deployed to support safe, sustainable patient care overnight and during weekends (DH, 2009c). Effective risk management also involves identifying those rare situations where individuals' complex care cannot be safely and appropriately managed in the community at that particular time.

Meeting individuals' care needs also requires care delivery within clinically appropriate response times. Historically, district nurses' response times depended on the availability of resources and local perceptions of what

type of care should be prioritized. For example, someone who has fallen and sustained a skin tear may be seen within a few hours or the next day, depending on which district nursing team covers their surgery. However, rapid assessment and wound care has been shown to aid the healing of skin tears (Battersby, 2009).

The response times guidelines (*Figure 1*) offer practitioners criteria for identifying the priorities of nursing interventions based on the existing pool of agreed knowledge and evidence-based care. This enables practitioners to prioritize new referrals as they come in and call on other colleagues from different geographical areas to help if clinically needed. The guidelines facilitate a consistent approach to referrals, and centralize useful clinical information about suitable response times (Tseng, 2010). This adds consistency to the handling of cases that would otherwise be subjectively prioritized by different practitioners in community care (Harding et al, 2010). This guidance also offers greater transparency to commissioners over how resources are made available across geographical areas to support patients' needs appropriately.

Practical application and feedback

The principles within these guidelines have been effectively used and shaped by the practice of several teams of district nurses. Practitioners have reported that they have been better able to identify their role in meeting patients' needs as part of an integrated community approach. For example, individuals with memory loss issues and the associated anxiety that can come with these problems have historically been referred to district nurses for support. However, through facilitating fast referrals to mental health practitioners, these individuals are now getting the specialist support they need to develop coping strategies and lead more independent lives.

GPs working with a team of district nurses that were openly using these referral guidelines identified that they subsequently valued having faster access to nursing input to prevent people from being unnecessarily admitted to hospital, and that patients were receiving better support in meeting their end-of-life care needs at home. Evidence of end-of-life care outcomes and patient experiences suggests that using this tool has helped the team of district nurses to concentrate their limited resources on providing meaningful, quality care to prevent individuals from being admitted to other settings (Bowers et al, 2010).

Using referral guidelines in practice requires tactful negotiation and judgement skills to ensure the right multidisciplinary practitioners get involved to support individuals in timely ways. District nurses encountered reluctance from some services to get involved as quickly as the patients would like and may need. However, practitioners reported that the guidance has helped them feel more empowered to act as patient advocates by highlighting to other services why there is a clear clinical need for their timely input into people's care. This has taken tactful negotiation skills and interagency partnership working, with district nurses making joint visits with other colleagues on occasions to help individuals identify how they would like their needs met. Rather than using the referral guidelines as a rigid tool, practitioners have valued being able to apply their professional judgement and step in to support individuals based on their unique needs and circumstances (Parkinson, 2006).

Equally, as a result of the team applying these guidelines in practice, patients, their families and other multi-agency colleagues commented that they had a clearer understanding of the district nurses' input into providing suitable care. Patient-reported satisfaction with their experiences of the district nursing team's input remained high; patients felt they had been treated with respect and were given suitable information and care to meet their needs. Satisfaction with other services they were referred to (when they did not also receive district nursing input) is unclear, as this information was not readily accessible or comparable.

Any supporting evidence on whether having discipline-specific referral guidelines improves efficiencies across community services is limited. For example, using more robust district nursing referral criteria undoubtedly puts increased workload demands on social services and mental health services to meet the needs of some patients who have been historically supported by district nursing teams. However, if patient care outcomes and experiences are to be transformed in the community, different services need to identify what they do currently, as well as what they aspire to do. By doing so, different stakeholders are best placed to work in partnership to identify which practitioners are best skilled and equipped to effectively support patients in achieving their best care outcomes.

Involving all stakeholders

Commissioners often have only a vague notion of the scope of care district nurses provide, as the profession has not transparently identified or advertised its role in patient care pathways (QNI, 2009). The referral, triaging and response time guidance discussed in this article is there to help represent what district nurses actually do. Moreover, the guidance is there to be questioned and negotiated as part of developing a responsive integrated model of community care. As commissioners, patient representatives and community services further scrutinize and identify how different care pathways can best be supported, the nature of district nursing input will adapt and change.

The guidance in *Figure 1* is designed to help negotiations with commissioners in deciding how specialist district nurse resources should be used in the future. In order for community resources to be used most effectively, it is important to identify what other services are currently available to provide aspects of care, and which practitioners have the appropriate skills and expertise to provide the best quality outcomes (DH, 2009d; 2010). If there are shortfalls in the capacity of the most appropriate and cost-effective services to support the needs of patients, and other services, such as district nurses, are stepping in to try to cover

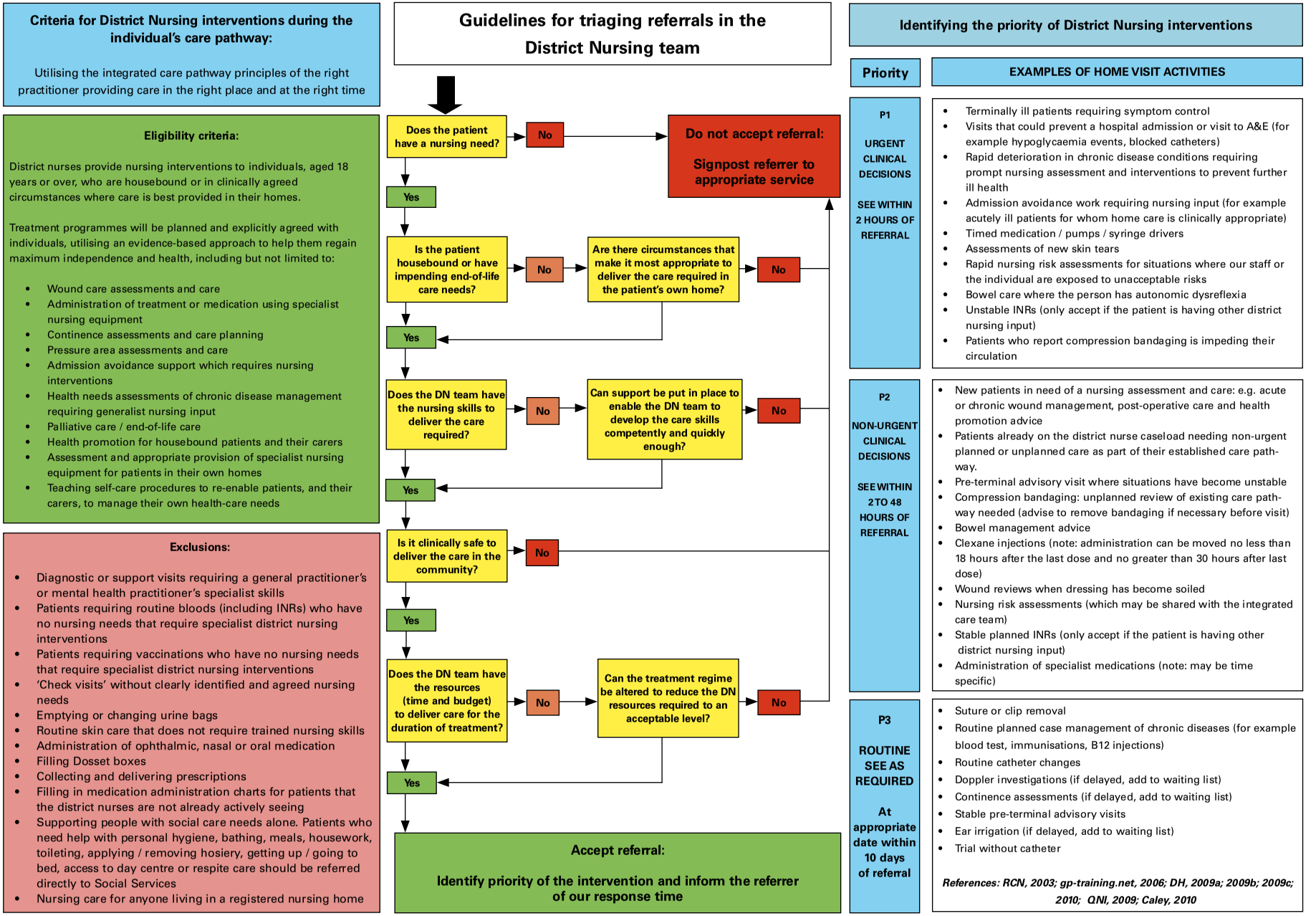

Figure 1. Guidelines for triaging referrals to the district nursing service.

these issues, this needs to be identified as part of the commissioning process.

This example referral guidance is not intended to be a finalized product stating what district nurses should do in the future. It is presented to stimulate wider debate and consensus between key stakeholders involved in the commissioning process, regarding how to use limited district nursing resources effectively to meet patients' needs in the community. The guidance helps identify what district nurses currently do in one area and what core skills they offer. It is a starting point to help commissioners to understand how we can best support patients in the community by using all the available resources. Then we are better placed to transform and integrate services to meet patients' needs, as part of real collaborative inter-agency working.

Commentary from the Queen's Nursing Institute

In discussions with individuals and organizations across the country, it is clear that there are many different approaches to the management of referrals for district nursing services. For example:

- There are teams that use clear criteria, agreed locally, such as those set out in *Figure 1*, to enable district nursing teams to manage their own referrals consistently
- In some places, such as Birmingham, a central 'one-stop shop' for referrals has been set up, using call handlers working with protocols to decide priority and forward referrals to appropriate teams
- Where community services have implemented a remote working system, electronic referrals are assessed at a central point by an experienced nurse and forwarded to the hand-held digital devices of the individual practitioner thought to be the most appropriate responder
- One nursing team, supported by the QNI's Fund for Innovation, has devised its own referral management software, which matches the clinical need with the most appropriate practitioner and the patient's preferred time slot for the visit.

With the continued diversification of providers of community services, now is the right time to initiate this debate about the transparent and effective management of referrals for the crucial services that provide nursing at home. This debate needs to take place both within services, and between service providers and commissioners: and it needs to be led by district nurses themselves. **BJCN**

LEARNING POINTS

- District nurses have invaluable specialist nursing assessment skills for supporting quality care outcomes at home
- As different community services reconfigure themselves, district nurses are receiving ever-increasing numbers of inappropriate referrals for their input into care
- Practitioners need to question and identify how their specialist nursing skills can be best used to support patients' quality care outcomes
- Facilitative referral guidelines, like the one presented in this article, offer a pragmatic starting point in identifying and negotiating with commissioners over how district nursing services can be commissioned to best meet patients' needs

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