Community review of healthcare services

Community Review

- Dwayne Potenteau

The community experience this term has increased my awareness of the social determinants that affect the population of the Comox valley and Campbell River. While patient’s needs in the hospital are addressed and managed, the ongoing care for the client often extends past the hospital borders into the community and home setting. The change in the client’s environment is based on the need to manage costs. The need to be fiscally responsible is of utmost importance if the health care system is to function for the immediate and long term future. One key piece to maintain fiscal responsibility is to move the client from the hospital to their home. The change in environment has exposed gaps in client care with vulnerable populations. Most of the clients facing health challenges suffered from numerous social determinants, but finances that were imposed on their care were a common between the varying community experiences. This is one of the main reasons for discharge from hospital to community. It is not a one sided view, as both the hospital and client do benefit in the discharge, as clients tend to heal or be more relaxed in their own environment.

The aspect of my perception and how I am being perceived in order to develop my ability to communicate with others is absolutely crucial help others in the community. I found in my experiences that obtaining information was not as easy as asking a question. I was always cognizant of how I am being perceived so that I could create trust even at the superficial level. The reason for the huge relational component is that without the gained trust providing the proper avenues for care would be difficult. Many

clients are referred to the community programs and thus without the nurse relating to the client the care may not be received or the client may defer from treatment. In knowing the client, nurses can setup appropriate discharge support that meets the clients' needs.

Another aspect of the discharge is the ability to work with other interdisciplines. The transition from institutional to community care may present more complex patients that in the past, and thus nurses must be able to use other sources of knowledge. This was evident in home care nursing. Many of the resources in Campbell River can be utilized when preparing a client for discharge. Often nurses act as a medium between physicians, physiotherapists, social workers and dieticians while providing care for clients. Working with other disciplines allows nurses to understand potential problems and anticipate challenges prior to discharge.

The ability to anticipate a client's needs is crucial to their care received in community. Without the adequate dialogue many of the services that a client could benefit from would not be available. It is up to nurses to work with the client to understand what is salient in their world, and if possible align services that can assist in caring for the client. In understanding what is important a nurse should discuss some of the following: (this is not an inclusive list but rather just an overview)

1. The actual community: Where is their community located, and what are the physical boundaries (What are the sanitation/water issues?, Is there access to health care services/911? What are the safety hazards?)

2. The Environment: What are the most common or potential illnesses after discharge? Are there concerns regarding client immunization or proper access to nutrition? Is there an available transit system?
3. Social System: Are there resources available for the client to meet social needs?
4. Client: what strengths does the client have? What strengths do I as a nurse discharging the client perceive?

One of the huge benefits most of if not all of the services I visited, would be to visit the client in their home. Most of the clients, outside of home care nursing forced the client to come into the hospital or department. This often posed a problem for clients as they could not make the trip due to the illness, or had no way to make the trip. If some of these services could provide home visits this would reduce the burden to the patients, but may increase costs on an already stressed out system. One element that would benefit is education. The role of preventative health care is in my opinion is key to sustain our health care system. If we could inform to prevent even a single client from developing an illness such as diabetes, that would save the system money. The unfortunate reality is that trying to give qualitative stats where the persons who determine where the funding will go, often want to see empirical quantitative data. Prevention is difficult to show on a graph or pie chart.

In this community experience I have found a few gaps in service even between districts. For example the quality and accuracy in stroke monitoring between Campbell River and Comox valley. Another facet is the hegemony that nurses experience between physicians and specialist. For example the

nurses at the dialysis clinic can call physicians and help make decisions and work with the physician/specialist in Victoria, while the specialists at Nanaimo are not interested in working with the nurses and retain control over the aspects of care resulting in less nurse autonomy. The biggest gap in care comes directly from the health authority. In order to create qualitative data, the health authority had assigned a point system for administering care. One point equates to 15 minutes. The point system is used as a cost measure for staffing. The problem lies in assessing how many points does a client need if they are multi symptomatic. The assessment often takes time and thus puts a great strain on nurses to provide meaningful, salient and proper care while trying to stay within their allotted point system.

To address these issues in Campbell River and Comox, there is discussion on what barriers are impeding Comox Valley from administering additional tests for stroke patients. The barriers could then be addressed and a potential solution discovered. On the issue of varying physician politics, I am not sure how to tackle this issue other than address the concerns to the board of regulations (CRNBC to determine if there is any recourse or perhaps the nurses union for additional guidance or insight). On the topic of managing nursing hours using a point system there needs to be leniency in cases that do not fit the point system. Some patients are complex and thus may need additional time or resources. Neglecting the needs may result in relapse and having the client be reintroduced into the system which ultimately incurs additional costs and is counterproductive. Another point I discovered while at the Comox Valley Nursing Centre, was the gap in communication between clients and the programs and services they were assigned to. Often

marginalized clients (people who were forced to live on the street due to health or other social determinants) were very difficult to contact. These clients missed many appointments, even with specialists for whatever reason, and since they often did not have a phone, and could not be contacted. This left the nurse in a difficult situation of advocating for the client when a specialist wanted to drop the client for not showing up to appointments. To remedy this problem perhaps additional communication and education for the client or use of the phone while at the nursing centre may alleviate the current dilemma. Ultimately one of the most profound learning components was for addiction at the Comox Valley Nursing Center. A nurse had stated this mantra “ Addiction is a way to hide from the real problem, discover and treat the problem, you will treat the addiction”.