Community Nursing placement

Allied Health building of AWH – Wodonga Campus.

We are really excited you are coming for a placement with us in the Community Rehabilitation Building. Your “home base” will be in the Hospital Admission Risk Program (HARP) team (see website link or information below for more information on HARP).


During your Community Nursing placement at Wodonga Campus you will have the opportunity to see and experience a diverse range of nursing work within Allied health building and the community.

This will include work with following programs/staff:
- Hospital Admission Risk Program (HARP)
- Pulmonary Rehabilitation (PRP)
- Continence Nurses
- Cardiac Rehabilitation (CRP)
- Falls and Balance Program
- Diabetes Educators (D.E)
- Transition Care Program (TCP).

Within your placement a timetable has been developed to assist in providing you a valuable learning experience. You will be allocated a student supervisor/clinician for your placement, although throughout your placement you will also be working with both nurses and allied health staff.

HARP staff do mostly home visits and you may have the opportunity to visit homes of clients in the community and rural towns. If this is the case you will need to bring your lunch as you may not be returning to the centre. You will be informed of this by staff. All other programs operate from the Allied Health Building.

During your placement wear your nursing student uniform. The hours are 8.30am to 5pm Monday to Friday.

To aid your learning experience some questions have been developed for you research and revision prior to placement. There are also some websites that may be useful.

Summary

Don’t be overwhelmed with all this pre-reading below.

There may be time to complete some of it when you start but ideally do it before you come to maximise your placement options.

Please ask questions as you go and learn as much as you can!

We hope you enjoy your community rehabilitation placement with us.

Don’t forget to complete Step 3 of the package as outlined at the end of this document.
HARP:

1. What is your understanding of a chronic condition verses an acute episode?
2. What are some of the principles used in chronic disease self-management?
3. Find on the internet the evidence based guidelines for COPD (lung foundation), CCF (Heart Foundation) and diabetes (diabetes Australia).

Diabetes:

[link](http://www.awh.org.au/services/allied-health/201473120094.asp)

1. What is the Diabetic Cycle of Care?
2. What is the difference between Type 1 and Type 2 diabetes?
3. What is gestational diabetes?

Continence:

[link](http://www.awh.org.au/services/allied-health/2014626112794.asp)

1. Research the various causes of urinary and faecal incontinence
2. Review the following websites: [www.continence.org.au](http://www.continence.org.au) and [www.pelvicfloorfirst.org.au](http://www.pelvicfloorfirst.org.au)

Pulmonary Rehabilitation

(Best resource is [www.lungfoundation.com.au](http://www.lungfoundation.com.au))

1. Read the pulmonary rehabilitation brochure [click here]
2. Research COPD as it is the main condition seen in the group
3. Be familiar with a COPD Action plan

Cardiac Rehabilitation

(Best resource is [www.heartfoundation.org.au](http://www.heartfoundation.org.au))

1. Read the cardiac rehabilitation brochure [click here]
2. Research the risk factors for heart disease
3. Research the common conditions we see in cardiac rehab – STEMI, NonSTEMI, stenting, angioplasty, CAGS, valve replacement/repairs
4. What medication would you expect a client to be on following a heart attack?

Falls and Balance


1. Read the Falls and Balance Program brochure [click here]
2. List falls risk factors
3. Consider how these risk factors can be reduced (the booklet “Don’t Fall for it” is a great resource. Click here to read "Don’t Fall for it" Booklet)
4. During falls and balance assessments the nurse uses the following assessment form [FROP com falls assessment tool](http://www.nari.unimelb.edu.au/nari_tools/nari_tools_falls.html)
Hospital Admission Risk Program (HARP)

Care Coordination

Emphasis on health literacy including self management and empowerment to enable the client to improve the management of their chronic health conditions to reduce hospital admissions, improve quality of life and encourage a healthy lifestyle.

A care coordinator is allocated to each client. Following a comprehensive assessment, the care coordinator and client develop a care plan together focusing on the client’s identified needs. The care coordinator supports the client through health coaching, education, encouragement to address the identified issues and by referral to appropriate services.

Criteria

Clients who have had at least one admission to hospital related to COPD, CCF or diabetes, who require a co-ordination of services and who agree to participate in the program aiming at improving their ability to self manage. Clients may also be referred if they are identified at being at risk of hospital admission or are accessing the emergency department frequently.

Length of Involvement

Client involvement with HARP varies according to client need – clients have been on program from 2 months to 18 months. Episode of care depends on the client’s participation and achievement towards their goals.

Context

Care coordinators work with clients who have complex needs requiring care co-ordination. Most have COPD, CCF or diabetes including numerous other chronic health conditions such as depression, anxiety, obesity, hypertension, or arthritis. All live in the community or hostel accommodation in Upper Hume or Albury Region. All clients require care co-ordination and support with improving their self management skills.

Defining elements.

Care coordinator supports:

- Knowledge of condition, monitoring symptoms and knowing what to do if changes occur
- Attendance at medical appointments
- Medication adherence
- Responsibility for health
- Healthy lifestyle - including diet, exercise and smoking cessation
The client’s GP is always notified of the assessment, care plan issues and achieved outcomes. If required the care coordinator may attend GP/specialist appointments with the client, and will arrange and attend case conferences. The care coordinator supports the client to work with their GP in developing an action plan to manage exacerbations of their health condition.

Completing the orientation package

Reading this annexe was Step 2 in a 3 step orientation package

Step 3 - please now return to the generic orientation package in Survey Monkey which you should still have open on your computer.

This is the final step of the orientation package.