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Royal College of Nursing Wales

PRIMARY CARE AND COMMUNITY NURSING FOR A HEALTHIER WALES

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Primary Care and Community Nursing

For the purposes of this report, Primary Care Nursing refers to nurses and health care assistants employed to work in a general practice nursing (GPN) team, usually to assist in meeting the contractual requirements for GPs within NHS Wales. The focus of GPN work is on providing nursing support for people of all ages, though usually adults. Community Nursing refers to nurses employed to work within a team of community nurses, collectively known as a district nursing team. A district nurse (DN) is a registered nurse who has undertaken specific, community-focused post-registration education and leads a district nursing team. The main context of district nursing care provision is usually for adults who are unable to leave their own homes for nursing support. Community children's nurses provide support for children in community settings, preventing unnecessary hospital admissions and facilitating early discharge.

About the Royal College of Nursing (RCN)

The RCN is the world's largest professional organisation and trade union of nurses, representing over 435,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 25,000 members in Wales. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care and public policy as it affects health and nursing. The RCN works locally, nationally and internationally to promote excellence in nursing practice and the interests of patients, nurses and nursing as a profession. RCN members work in all settings, including primary care, community, care homes, schools prisons and hospitals, in both the independent sector and the NHS. Around two-thirds of our members are based in the community.

Please contact the Royal College of Nursing Wales for more information about any points raised in this report.

PRIMARY CARE AND COMMUNITY NURSING FOR A HEALTHIER WALES

Contents

Contributors 2

Executive Summary 4

Introduction 6

Background 7

The primary care and community nursing workforce in Wales 9

The primary care and community nursing commitments 10

Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support *10*

Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care *11*

Consider the whole person and their biological, psychological, social, cultural or spiritual needs *13*

Promote health, healing, growth and development, and prevent disease, illness, injury, and disability *14*

Empower people to achieve, maintain or recover independence. Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences *18*

When death is inevitable, help to maintain the best possible quality of life until its end *20*

Challenges for the development of primary care and community nursing in Wales 22

Requirements for sustainability and growth of primary care and community nursing in Wales. 23

The connection between A Healthier Wales, the primary care and community nursing commitment and the supportive requirements to achieve the commitment 24

Summary of the primary care and community nursing commitment 26

Appendices 27

References 31

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

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Executive Summary

PRIMARY CARE AND COMMUNITY NURSES COMMIT TO ...	SUPPORTIVE REQUIREMENTS TO ACHIEVE THE COMMITMENTS INCLUDE ...
Understand the health and care needs of local populations and individuals, based on available information, data and evidence.	Recognition of the need for time and resources (including connected IT systems) to undertake meaningful, focused health and care needs assessments.
Undertake individualised, holistic assessment of biological, psychological, sociological, cultural and spiritual needs, starting with the question 'what matters to you?'	Recognition of the need for time and resources to undertake meaningful, individualised holistic assessments that result in collaborative care plans.
Understand the elements of quality and safety outcomes and what matters for patients and their care, through the generation, retrieval and use of research and an evidence base.	Focused support and resources for primary care and community nurses to generate empirical research, relating to quality and safety outcomes and what matters to patients.
Take time to work with individuals and families to understand a person's wishes and capacity for independence.	Recognition of the need for time and resources to undertake meaningful, assessments of a person's wishes and capacity for independence.
Take time to agree a plan of care that fosters independence, whilst supporting expressed needs.	Recognition of the need for time to agree and support a plan of care that fosters independence.
Review the effect of nursing care on the person's activity and independence.	Focused support and resources for primary care and community nurses to generate empirical research, relating to the effects of nursing care on a person's activity and independence.
Use knowledge and skills to maximise opportunities for illness prevention interventions with individual or groups of people.	Recognition of the need for time to maximise opportunities for illness prevention interventions with individuals.
Use recognised frameworks, such as Making Every Contact Count (MECC), Motivational Interviewing (MI) or other contemporary aids, to support people with change in a relevant and effective way.	Support and resources for all primary care and community nurses to learn about and be able to use recognised frameworks that help people to make health-related lifestyle or other changes.
Ensure that local, community-based resources and assets are used to their best, for the benefit of every citizen's holistic needs.	Focused resources to enable primary care and community nurses to access directories of information, such as DEWIS, as routine part of their clinical activities.
Work collaboratively alongside and/or co-ordinate a broad range of health and care professionals, to improve people's access to individualised support.	Facilitate environments that are conducive to collaborative team working, including shared IT systems, co-located working premises or other means of instant communication.

PRIMARY CARE AND COMMUNITY NURSES COMMIT TO ...	SUPPORTIVE REQUIREMENTS TO ACHIEVE THE COMMITMENTS INCLUDE ...
Ensure that people do not experience avoidable physical, psychological or other harm or distress, by seeking to understand their perceptions and perspectives of their health-related circumstances.	Education in clinical triage and care navigation, to ensure safe and effective signposting at first point of contact to the most appropriate health and care support.
Ensure development of well-balanced primary care and community nursing teams, so that people can receive safe and competent care from staff at all clinical skill levels, from 3 to 8. Contribute expertise to and support the development of career pathways for primary care and community nursing teams, to enable equal health outcomes for people receiving care from a consistently well-educated skill mix, with standardised job descriptions.	Focused, specific education and career framework for primary care nursing teams, as committed by the Cabinet Secretary for Health and Social Services in Wales.
Ensure at least one nurse independent prescriber within each primary care and community nursing team within Wales	Focused planning, funding and educational support for developing a minimum of one nurse independent prescriber within all primary care and community nursing teams across Wales.
Provide sensitive, individualised, nursing care for people, assisting their wishes for a preferred place of death.	• Co-ordinated education in psychological approaches to supporting health, well-being and decision making. • Co-ordinated education for end of life care and verification of death.
Lead, contribute to and support the development of 'gold standard' best practice for all areas of primary care and community nursing.	Health and care systems continuity to ensure consistent, joined-up approaches.
Use the experiences and learning from pilots and new initiatives in primary care and community nursing, to shape teams that help people receive safe and relevant community-based care, where hospital would otherwise be the only available option.	Focused support and resources for primary care and community nurses to generate evaluations of the impact of nursing practice; including the use of frameworks such as Time Spent at Home, Economic Analysis, Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs).
Continue to shape, lead and provide individualised and population-based, evidence-led, evaluated, efficient and sensitive nursing care to meet the contemporary needs of patients and the community-focused NHS in Wales	• A Welsh Clinical Leadership Training Fellowship scheme, to develop high quality clinical leaders in primary care and community nursing. • Focused development of primary care clinical leadership roles, to ensure increased numbers of nurses with the knowledge, skills and experience for Primary Care Cluster Lead roles. • Recruitment of one Nurse Consultant in Primary and Community Care within each Primary Care Cluster in Wales.

Introduction

This report sets out the RCN's and expert clinicians' views on Primary Care and Community Nursing in Wales.

The report highlights the Primary Care and Community Nursing response to A Healthier Wales (2018) and the Strategic Programme for Primary Care and Community (2018). It defines the Primary Care and Community Nursing contribution needed to meet the transformational aims of Care Closer to Home in Wales. The report is the result of wide consultation with primary care and community nurses and managers across Wales; with the aim to guide and assist stakeholders concerned with the provision and support of health and care within Wales.

Realising the ambitions set out in this report requires strategic partnership working, to support the pledges made by primary care and community nurses in Wales. We look forward to working on and delivering these commitments with people receiving support from primary care and community nurses, Welsh Government, NHS Wales Health Boards, Health Education and Improvement Wales, Education providers and all stakeholders.

In meeting health and well-being needs with and for the people of Wales, Primary Care and Community Nurses commit to:

1. **Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.**
2. **Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care**
3. **Consider the whole person and their biological, psychological, social, cultural or spiritual needs.**
4. **Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.**
5. **Empower people to achieve, maintain or recover independence.**
6. **Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences**
7. **When death is inevitable, help to maintain the best possible quality of life until its end.**

The commitments to deliver safe, effective primary care and community nursing support are underpinned by six, defining principles of nursing, as outlined by RCN (2014):

1. **The purpose of primary care and community nursing** is to promote health, healing, growth and development, and prevent disease, illness, injury, and disability. When people become ill or disabled, the purpose of primary care and community nursing is to minimise distress and suffering, to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of primary care and community nursing is to maintain the best possible quality of life until its end.
2. **Primary care and community nursing interventions** are concerned with empowering people and helping them to achieve, maintain or recover independence. Nursing includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support. In addition to direct patient care, primary care and community nursing practice includes management, teaching, quality improvement and research.
3. **The specific domain of primary care and community nursing** is people's unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves. People's responses may be biological, psychological, social, cultural or spiritual and are often a

combination of all of these. The term people includes individuals of all ages, families and communities, throughout the entire life span.

4. **The focus of primary care and community nursing** is the whole person and the human response, rather than a particular aspect of the person or a particular pathological condition.
5. **Primary care and community nursing is based on ethical values** which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions. These values are expressed in written codes of ethics, and supported by a system of professional regulation.
6. **Primary care and community nurses work in partnership** with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they lead a team, prescribing, delegating and supervising the work of others; at other times they will participate under the leadership of others. At all times, however, they remain personally and professionally accountable for their own decisions and actions.

(Adapted from Defining Nursing; RCN, 2014)

Background

Primary health care provides the first point of contact and main point of continuing care for patients within the health and care system. Primary health care practitioners coordinate specialist care for patients who have multiple biological, psychological and social concerns. Patients commonly receive primary care from professionals like family doctors, practice nurses or district and community nurses. In NHS Wales the main source of primary health care is through general practice (SB 25/2016. Stats Wales, 2016).

The Welsh Government's Vision for "A Healthier Wales"has brought primary care and community health and care services closer into focus, whilst the Strategic Programme for Primary Care and Community details the ways in which the aspirations of A Healthier Wales and Care Closer to Home will be achieved.

A Healthier Wales (2018) notes the following aspirations:

- **Everyone in Wales should have longer healthier and happier lives, able to remain active and independent, in their own homes, for as long as possible.**
- **There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives.**
- **There will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.**
- **This whole system approach will be equitable. Services and support will deliver the same high quality of care, and achieve more equal health outcomes, for everyone in Wales.**
- **It will improve the physical and mental well-being of all, throughout their lives, from birth to a dignified end.**
- **When people need support, care or treatment, they will be able to access a range of services which are made seamless, and delivered as close to home as possible.**
- **Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.**
- **People will only go to a general hospital when that is essential.**
- **The shift in resources to the community will mean that when hospital-based care is needed, it can be accessed more quickly**

The Wellbeing of Future Generations (Wales) Act 2015 outlines the five ways of working including Long term, Prevention, Integration, Collaboration, and Involvement; demonstrating close alignment to the aspirations of A Healthier Wales.

The Strategic Programme for Primary Care in Wales places the actions and activities for health services in Wales within a structured framework. Six Key Work Streams include:

1. Prevention and wellbeing
2. The 24/7 Model
3. Data & Digital Technology
4. Workforce & Organisational Development
5. Communication, Engagement
6. Transformation Programme and the Vision for Clusters

Prudent Healthcare (2016) principles guide the development of health and care services in Wales, by aiming to:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
- Care for those with the greatest health need first, making the most effective use of all skills and resources
- Do only what is needed, no more, no less and do no harm
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

There is clear alignment of nursing skills, expertise and contribution to the overarching policy context within Wales.

Primary care and community nurses welcome the continued move towards integrated, collaborative working with colleagues from multiple agencies and professional groups, in order to support health and well-being for people of Wales. They recognise the crucial roles played by primary care and community nurses in improving outcomes for the people of Wales, whilst achieving the contemporary aims for health and care in Wales, on a 24 hour basis, both 'in' and 'out of hours'.

Nursing is defined as *"the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death"* (RCN, 2014). Nowhere is this definition more comprehensively relevant than in primary care and community settings.

The primary care and community nursing workforce in Wales

RCN Wales has previously recorded its concerns about the lack of accurate and robust data on the primary care and community nursing workforce (RCN Wales, 2018), which Welsh Government has made efforts to address. However, there are still difficulties in accessing reliable information about this workforce.

The Welsh Government's Statistical First Release (SFR 21/2019) identifies that 42% of all directly employed Wales NHS staff are nurses, health visitors or midwives, illustrating the necessity of addressing the nursing contribution to A Healthier Wales.

The SFR 21/2019 does not include practice nurses who are employed by the 462 independent contractor GP surgeries in Wales (Statistical Bulletin: SB 25/2016). Nursing roles are increasing within general practice, due to difficulties recruiting and retaining GPs; therefore it is sensible to assume there to be at least one nurse in post per practice, but usually a team comprising health care assistants (HCAs), general practice nurses (GPNs) and advanced nurse practitioners (ANPs).

The SFR 21/2019 identifies 581 District Nurses within Wales. However, the CNO for Wales' Interim District Nursing Principles (2017) outlines the requirement that each district nursing team should have a staffing complement of no greater than 15 staff/12 WTE. This team will usually comprise two District Nurses with an NMC recordable qualification (SPQ) plus a team of approximately 10 Community Nurses.

The RCN recommends that for an average-sized district with a child population of 50,000, a minimum of 20 whole-time equivalent community children's nurses are required to provide a holistic community children's nursing service, in addition to any individual child requiring specific continuing care investment. In the average CCN team the minimum ratio of registered nurse to unregistered staff should not fall below 70:30 percent, with a minimum of 25 per cent of the registered nurse component being CCNs who have completed a recognisable community education and development programme (RCN, 2013). A review undertaken in 2017 suggests that in Wales we have approximately half of the recommended numbers, which includes supporting children with continuing care needs.

Methods

RCN Wales presents this report, which outlines many conversations between expert practitioners and organisations concerned with providing primary care and community nursing support to the people of Wales. The all-Wales District Nursing Forum and all-Wales Primary Care Nurses Forum have addressed the contribution of primary care, district and community nurses to A Healthier Wales and The Strategic Programme for Primary Care in Wales. Their collective views are represented here.

An RCN Wales' Primary Care and Community Nursing Summit was held in June 2019, the aims of which were to:

1. Facilitate professional discussion about the current and future contribution of primary care and community nurses to meeting the agenda for A Healthier Wales and The Strategic Programme for Primary Care in Wales.
2. Provide support and assistance for Welsh Government, Health Education and Improvement Wales (HEIW) and other stakeholders in developing the programme to meet the Strategic Programme for Primary Care in Wales.

The Primary Care and Community Nursing commitments

Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.

Community and district nurses strongly identify themselves as "specialist generalists". This has been a common theme in discussions during the process of formulating this report. This theme is supported by Barrett, Latham & Levermore (2007) who proposed that district nurses offer a generalist nursing model of care for patients with multiple health problems and social needs by taking a holistic view of the patient and their personal circumstances.

Generalism is defined by Brindle (2011) as a commitment to continuity of care combined with an ability to manage different forms of care and support. Further, "*the generalist sees health and ill-health in the context of people's wider lives, recognising and accepting wide variation in the way those lives are lived, and in the context of the whole person*" (Brindle, 2011 p.4). The UK Royal College of General Practitioners (RCGP) (2012) offer their definition of generalism as seeing the person as a whole and in the context of his or her family and wider social environment; working with the widest range of patients and conditions; addressing continuity of people's care across many disease episodes and over time and coordinating care across health and social care organisations.

The RCGP and the Health Foundation (2011) draw attention to the importance of defining modern generalism, so that public expectations, professional interfaces and future developments can be clarified and planned for. Reeve (2010b) outlines a suggested model for working with patients, based on an exploratory approach which illuminates the interpretive skills inherent in the generalist role of a general practitioner. Reeve argues that such skills define a unique and intellectual discipline.

Due to district nurses' close working with patients and their families within the home, this means that they are the experts in assessing the breadth of factors that might influence a patient at any given time. The results of conversations reported here demonstrate this to be the case for district nurses in Wales.

In their role as first point of contact for people, practice nurses have said that they are often 'gatekeepers' to accessing health care beyond general practice. This has been a title previously attributed to GPs. However, with expanding role of the GPN and the general practice-based Advanced Nurse Practitioner (GPANP), increasingly they are the first point of contact for the patient. As such, GPNs and GPANPs now undertake onward referrals, including as care co-ordinators and for specialist assessment from other colleagues. This illustrates a new understanding of first point of contact and 'gatekeeping'. With this recognition comes the need for contemporary approaches to education and support, for nurses to undertake roles safely and appropriately.

Nurses working within the Urgent Primary Care OOH service are also generalists and can be described as "gate keepers" to accessing health when GP surgeries are closed. Triaging skills, minor illness skills and the role of the ANP are all incorporated in to the multi-disciplinary approach to patient care.

This report makes the case for recognition of the generalist primary care and community nursing roles and the subsequent need for investment in education and developmental support.

EXAMPLE CASE STUDY

When reviewing a patient's need for the annual influenza vaccine, the GPN will discuss whether other family members will need to offered the influenza vaccination. For example, where a patient is immunosuppressed through medical intervention, other family members will need to ensure they do not contract influenza that may put the individual at risk of infection.

Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care

One of the recurring themes has been of care co-ordination by all primary care and community nurses; either following referral to District Nursing teams or directly to General Practice Nursing teams.

A care co-ordinator is defined by Hickam et al (2013 p.3) as "*an agent of the patient, taking a "whole person" rather than a solely clinical or disease focused approach to care, and serving as a bridge between the patient, the practice team, the health system, and community resources*".

Summit participants identified the co-ordinating role of primary care and community nurses from the point of request for support. There was recognition of the skills attributed to primary care and community nurses, resulting in a broad range of referrals, including patient discharge from hospital. The concept of a "ward without walls" has been previously documented (QNI, 2006; Haycock-Stuart et al, 2008). However, this reflects the reality of primary care and community nurses' expertise as co-ordinators of care on behalf of patients who they meet and support. Care co-ordination includes managing the complex needs of a patient, by working with all personnel relating to health, social care, carers and voluntary agencies.

In identifying and addressing personal care needs, district nurses work closely with colleagues from partner organisations such as local authority, social services and third sector, to collaborate, co-ordinate and signpost to suitable support and resources. This aspect of the district nursing role is a long-valued contribution to ensuring people's health and well-being within the home, especially following an early discharge from hospital.

District nurses describe their continued experiences of receiving requests to undertake home visits for discharged patients who are discovered to be unsafe for an often complex range of bio-psycho-social reasons. Whilst it is understood that decisions are made to discharge such patients to enable hospital flow, it must be understood that district nurses require the recognition, support and resources to co-ordinate services that avert crisis and re-establish safety in home-based health and well-being for individuals.

Primary care and community nursing services are very well suited to 'place-based' care approach, where local services are connected to enable people to receive care close to their home and community. This is the historical way of working. However, investment in further developing these services would result in increased opportunities to improve patient care at home.

District nurses and community children's nurses are a key link between adult and children's health and social services and have an important role to play in co-ordination of services between partner health and care agencies commonly engaged in responding to assessed patient need. Such nurses are the ideal care co-ordinators for individuals' bio-psycho-social needs within the community context of care within Wales.

EXAMPLE CASE STUDY

The community children's nurse supports the outreach oncology service to provide shared care for children with a cancer diagnosis. The CCN will see the child and family weekly to manage the central line and take bloods, linking with the tertiary centre and specialist nurses as required. For children with a diagnosis of accute lymphoblastic leukaemia, this is a long journey over a 3-4 year period and the CCNs build a strong relationship with families.

Practice nurses use prudent healthcare principles in signposting people to the most relevant professional to support their needs. This is frequently to agencies and resources such as X-pert (diabetes), Expert Patient Programme (EPP), podiatry, sexual health, pulmonary rehabilitation, cardiac rehabilitation, community resource teams, frailty services, acute response teams, 'social prescribers', 'community connectors' and many more.

Within the Urgent Primary Care Out of Hours (OOH) arena nurses work within a multi-disciplinary team; triaging patients, providing self-care advice, undertaking a face to face consultation in a primary care centre,

undertaking a home visit, or referring and signposting to the most relevant health care professional to support their needs, including pharmacist, optician or specialist secondary care.

EXAMPLE CASE STUDY

- As part of a Chronic Obstructive Pulmonary Disease (COPD) review, Cardiff and Vale-based GPNs assess a patient's breathlessness score and, based on this, co-ordinate support from the local pulmonary rehabilitation course. This is a 6 week course where the patient is supported by physiotherapists, occupational therapists, smoking cessation counsellors and nutritionists to improve health and wellbeing.
- In recognition that it can be a daunting experience to receive a diagnosis of Type 2 diabetes, practice nurses co-ordinate support from the X-pert programme. This is a 6 week programme, run by community dieticians, designed to give individuals the knowledge and understanding of diabetes and how to manage their own health. In the Cardiff and Vale areas this is now being rolled out to include translators for the hard to reach ethnic communities and also offered as evening meetings to allow easier access for the working population to meet their needs
- Practice nurses within the Cardiff and Vale South East Cluster co-ordinate support for people who are isolated, by introducing them to local 'gardening groups'.

EXAMPLE CASE STUDY

District nurses have been instrumental in developing a community-based virtual ward/MDT weekly meeting within Newport. One example of how the virtual ward has supported the needs of an individual patient: A district nurse was concerned about the person's deteriorating health and well-being and believed the collective resource of the virtual ward would help avert a crisis. In addition to bio-medical difficulties, there appeared to be un-treated psychological challenges, social isolation, poor housing, no food in the fridge, and general vulnerabilities affecting the person's ability to make choices. The virtual ward/MDT discussion focused on the person's reduced participation in self-care and suggested treatments, which was leading to worries about his ability to remain safely at home.

Following a collaborative, complex medical, nursing and social assessment, the primary aim was to improve the individual's medical and psychological health and well-being, alongside improvements in the person's home environment. The MDT worked together to develop ideas and care plan, including self-volunteered, pharmacist-led medication review and support from the Older Person's Pathway personnel.The single virtual ward/MDT discussion resulted in the person's active re-involvement with a jointly agreed care plan to support his medical and psychological health problems, along with actively making use of furniture and equipment to help with mobility difficulties. With improved mood, the individual also felt able to receive neighbour's help and company.

Consider the whole person and their biological, psychological, social, cultural or spiritual needs.

District and community nurses are the health professional group that spends most time with patients and their families, communities and social networks. They are therefore well placed to understand the context of care for each individual, whilst adopting a holistic, bio-psycho-social model of care, not purely a biological/medical model.

District and community nurses emphasised their expertise in holistic assessment of patient. Nurses of all levels asserted their role in meeting a person's complex needs through a holistic approach to that person's life and circumstances. Having a close relationship with patients, their families and carers was valued as integral to supporting the person's ability to remain safely at home. Primary care and community nurses reported their role as negotiator and mediator for patients, families and the dynamics related to family lives, often by using skilled communication to assist important and sensitive conversations about health and care decisions.

Practice nurses focus on family connections during contacts with patients, leading to consideration of holistic needs. For example, considering the impact of family health and well-being on a person's long-term condition, such as asthma or immunosuppression medication.

This fits with the modern vernacular of "what matters" to the person requiring support. It is an excellent illustration of the existing skills and approach being undertaken by primary care and community nurses, whilst at the same time addressing a contemporary way of thinking about health and care support for the people of Wales. Primary care and community nurses already practice with this framework in mind and are well placed to continue to do so. However, it would be erroneous not to give adequate recognition and resources that are required to do this properly, including adequate time and educational support.

Community children's nursing services are the bedrock of the pathways of care for all children requiring out of hospital nursing support, these can be divided into four groups:

- Children with acute and short-term conditions;
- Children with long-term conditions;
- Children with disabilities and complex conditions, including those requiring continuing care and neonates; and
- Children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care.

EXAMPLE CASE STUDY

The community children's nurse has a pivotal role in the discharge management of children with complex medical and nursing needs. For example a term baby who following significant birth trauma is assessed as needing naso-gastric feeding, oxygen and suction. The CCN will attend discharge planning meetings, initiate any continuing care assessments, link with social services and support training needs for the parent. On discharge the CCN will visit as frequently as required to ensure the child's needs are being met and that the parents are supported. This is all against the background of supporting the grieving process for parents who are having to come to terms with the reality of supporting a child with significant needs.

EXAMPLE CASE STUDY

Using the Care Aims (Malcomess, 2005) approach to "reasoning, decision making, risk management and reflective practice", district nurses in Newport have reported improved confidence and effectiveness to work with individual patients towards self-management where possible. Use of the Care Aims framework helps to facilitate conversations about what is important to individual patients and their families/carers, in ways that have not been previously explored.

District nurses report that this helps to identify patients' and families' expectations of, involvement in and satisfaction with care and support, where previous reliance on professional support would have been assumed or accepted. Introduction to this new way of working has been described as "the best thing I ever learnt in all my nursing career", and has helped increase the knowledge and skills to work differently with people in their own homes. This is a working illustration of the contemporary community nursing realisation of Prudent Healthcare in achieving health and wellbeing with the public and patients as equal partners.

Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.

Primary care and community nurses help people manage their acute and long term conditions, including cancer, asthma, diabetes, chronic obstructive pulmonary disease, leg ulcers and mental health problems. Such co-morbidities are known to be associated with poorer health outcomes and greater health care costs as well as more complex management or care (Valderas, 2009). Through these interactions with patients, practice nurses provide large aspects of the GMS contract for general practice.

The range of practice nursing involvement in long term conditions management varies, from condition review, help with device technique, self-management plans, medicines commencement, optimisation and adjustment, education for people's own home medicines management such as 'rescue packs' for COPD.

Children with long term conditions are often supported by a clinical nurse specialist (such as for diabetes, respiratory, epilepsy, endocrine and continence) along with a community children's' nurse in the home or community setting.

EXAMPLE CASE STUDY

- **Specialist diabetes nurses work with practice nurses, to help provide specialist care for people with diabetes who would previously have been required to attend hospital for insulin therapy. This means that people do not need to travel to and wait at a busy hospital out-patients clinic to receive specialist care. It also means that people can benefit from a blend of specialist and generalist approaches to their health and well-being, in the context of their lives, family and community.**
- **Practice nurses liaise with the local wound healing service for specialist assessment and care planning of complex wounds, before the individual returns to general practice-based support and care. This shared learning with TVNs means that practice nurses maintain an individualised complex wound care plan, with increased confidence and competence, whilst ensuring continuity of care across the Multi-Disciplinary Team (MDT).**

Table 2: The role of the general practice nursing (GPN) team in fulfilling the General Medical Services (GMS) elements of the General Practitioner (GP) Contract

Essential services provided by general practice (GMS)	Example of GPN role
Management of patients who are ill or believe themselves to be ill with conditions from which recovery is generally expected	**GPN- led minor illness and minor injury services, especially independent nurse prescriber and ANP**
Management of chronic disease	**GPN led service, especially independent nurse prescriber**
Screening services	**GPN-led service for cervical cytology. GPN-assisted for national screening services of bowel and breast cancer, diabetic retinopathy, aortic aneurysm**
Vaccinations & immunisations	**GPN led services for national immunisation programmes (tier 1 target), including influenza, shingles, pneumococcal, meningitis, pertussis in pregnancy, and the childhood vaccination schedule. Also includes travel immunisation for hepatitis A, DTP and Typhoid**
Child health surveillance	**GPN signposts to PHCT**
Contraceptive services	**GPN assisted and/or led e.g. IUCD fitting, Nexplanon fitting and removal, Depo-Provera, oral contraception, especially independent nurse prescriber**
Minor surgery services	**GPN team assisted**
The domains of QoF/QAIF include:	
Clinical - this domain has indicators across different clinical areas e.g. CHD, heart failure, asthma, COPD and hypertension.	**Usually GPN led**

Table 2 illustrates how achievement of the 2 core areas of the GMS contract (essential services and the Quality and Outcomes Framework (QOF) is dependent on the contribution of nurses working in general practice.

A Cochrane review (Laurant et al, 2018) reported that "for chronic (long term) conditions, trained nurses, such as nurse practitioners, practice nurses, and registered nurses, probably provide equal or possibly even better quality of care compared to primary care doctors, and probably achieve equal or better health outcomes for patients".

This need not be limited to surgery-based contact. For example, increasing numbers of practice nurses are supporting people with long term conditions who are unable to attend the surgery, by visiting them. This ensures equity of service provision to people who are housebound, are not receiving district nursing services, and who would otherwise would fall through a gap in existing service provision.

Children with long term conditions are often managed by a clinical nurse specialist along with the CCN in the community setting.

Children and young people with long term conditions want to live as normal a life as possible; however, they often experience frequent disruption to their everyday lives, especially absence from school for hospital appointments or due to an exacerbation of their condition. Person centred healthcare helps children and young people to meet their wider aims and needs. For example, by having access to a community children's nurse in collaboration with the school nursing team, a child can have an individual health plan. This enables them to learn how to manage their illness and its treatment, to recognise early signs.

EXAMPLE CASE STUDY

GPNs undertake shared-care annual review for people living with Rheumatoid Arthritis. This includes; undertaking Disease Activity Scores and Osteoporosis scoring; reviewing and discussing management of prescribed medication; ensuring DMARD blood levels are monitored at recommended intervals; referring for DEXA scan where appropriate; offering health promotion advice about reducing risk of cardiovascular disorders.

EXAMPLE CASE STUDY

GPNs are the most usual health professionals to perform community-based spirometry as the diagnostic test for COPD. GPNs are usually responsible for interpreting spirometry results and then conveying the results to people about this long term, irreversible condition. From the start of the patient's journey GPNs co-ordinate and facilitate; diagnosis; medicines management; inhaler device selection; referral to secondary care and pulmonary rehabilitation; smoking cessation support; personal and emotional support; recognising deterioration in lung health; arranging third sector services; and having end of life care discussions with people and their families.

This locally accessible service is not delivered as flexibly in secondary care settings and it is essential that these patients are supported in their own community for as long as possible. People with COPD have poorer outcomes following hospital admissions, therefore enabling seamless, local, holistic care in the community helps patients to live healthier lives, at home, for as long as possible.

GPNs provide an extensive range of contraceptive services for women, through general practice.

EXAMPLE CASE STUDY

Population data showed a high incidence of unplanned teenage pregnancies within a GP practice. To broaden the range of choice options for long-term contraception, the GPNs undertook accredited training to be able to offer fitting and removal of IUDs/IUS and Nexplanon devices. GPNs now offer weekly practice-based appointments and have successfully met patients' needs, resulting in reduced demand on midwifery services. More importantly, this practice-based initiative has offered improved choice and easily accessible contraceptive services.

EXAMPLE CASE STUDY

Recognising that 30% of presentations in GP are for mental health concerns, a new service is being introduced into all Cardiff and Vale UHB GP practices, so that patients will have access to mental health nurses for a range of concerns from insomnia to bereavement support. Patients are able to access the mental health nurses as a self-selected first point of contact, rather than seeing a GP first. This is helping to improve options for access to appropriate members of the primary care team.

Nurses are a key resource used within the Urgent Primary Care OOH service. They work as part of a multi-disciplinary team providing care for patients with urgent health care needs that cannot wait until their own GP practice re-opens. Over recent years the Urgent Primacy Care OOH Service has moved from a GP only workforce to a more multi-disciplinary team approach. Recent capacity and demand exercises have shown that a more sustainable 60:40 model (60% MDT, 40% GP's) is what the OOH services need to move towards within their workforce plans.

EXAMPLE CASE STUDY

Out of Hours (OOH) Triage Practitioner:

These nurses or paramedics are trained to a minimum of BSc (degree) level and usually have a background of working in one or more of the following areas of care: general practice, community, Welsh ambulance service or A+E. They undertake telephone triage using decision making templates that aid the safe triage of patients via a telephone consultation. They are able to provide self-care advice, refer to alternative services (including ambulance, A+E, own GP) or direct patients to the primary care centres for a clinical consultation that will be undertaken by a GP, Clinical Practitioner or Minor Illness Practitioner. They can work alone but are supported within the OOH service by the Clinical Practitioners or GP's. All of these practitioners triage patients who are 3 years and over

Out of Hours (OOH) Minor Illness Practitioner:

These nurses or paramedics are trained to a minimum of BSc (degree) level and have completed an additional diploma qualification in Minor Illness. They are able to undertake consultations for patients presenting with minor illness only. They can work alone but are supported within the OOH service by the Clinical Practitioners or GPs. All of these practitioners see patients 5 years and over. Some of the nurses are qualified as Independent Prescribers (IPs), enabling them to generate and sign prescriptions; whilst those who are not IPs utilise PGDs to enable them to dispense from the OOH pharmacy.

Out of Hours (OOH) Clinical Practitioner:

These nurses or paramedics are trained to MSc (Masters) level and are either an Advanced Nurse Practitioner or an Advanced Paramedic Practitioner. They can undertake autonomous consultations and are able to assess, diagnose, treat/prescribe and refer on to other health care professionals as and when needed. They have admission rights, which allows them to refer in to the secondary care system, including medicine, surgery, ENT, children's assessment unit (above 5yrs of age), and A+E. If support is required they may call upon one of their OOH GP colleagues. All of these practitioners see patients 5 years and over. Some of the nurses are qualified as Independent Prescribers enabling them to generate and sign prescriptions while the paramedics are currently utilising PGDs to enable them to dispense from the OOH pharmacy.

Empower people to achieve, maintain or recover independence.

Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences

Using a biopsychosocial understanding of health, **complex conditions** refers to the presence of multiple health disorders or the interaction between two or more health disorders. **Complex need is defined** as relating to patients whose requirements are multi-factorial, overlapping and which vary in their presentation for person to person. Contributory factors are biological, psychological or sociological in nature; including long-term (chronic) conditions, co-morbidities, increasing age, frailty, psychological or mental health related, and social or family circumstances. A person with complex need may require the support of both health and social services.

Along with the primary care shift and demographic changes of age and disease profile, it is stated that patients now need care for complex conditions at home (Queen's Nursing Institute, 2011) or that patients at home have greater need for more complex care (Coleman, 2003; King's Fund, 2012a; Department of Health, 2013). Thus, community-based patients are increasingly likely to have complex needs (Kings Fund, 2012b).

The increasing multiplicity and complexity of community-based patients' needs has been described as a "*care quake*" (Department of Health, 2010) and primary care and community nurses are a central position to meet such needs. In addition, the environment of contemporary health and social care is complex, which requires knowledge, skills and confidence to negotiate for the benefit of patients and families.

Primary care and community nurses report the need to maintain a broad, diverse set of skills to deliver expert clinical care and reduce avoidable hospital admissions. An increasing assortment and sophistication of medical equipment is being used within the home, which district and community nurses need to be familiar with and practised at using. This expertise enables complex patients to stay at home or be discharged from hospital earlier than would have previously been possible..

Recognition of sepsis is made through use of the community-based NEWS assessment, which means that early identification can be made of individuals exhibiting clinical signs of sepsis.

EXAMPLE CASE STUDY

The emergence of general practice ANP or frailty nursing roles enables patients to be supported in their own homes, due to being house-bound but not requiring acute health or social support. This ensures new ways of reaching people who have fallen outside traditional care provision models, such as GP-based or district nursing-provided. GPANPs and frailty nurses are taking the opportunity to review and support the management of long term conditions, through such actions as checking inhaler technique, checking medicines usage and efficacy, discussing lifestyle choices, assessing risk of falling in the home and administering annual flu vaccinations, through use of a generalist bio-psycho-social approach.

EXAMPLE CASE STUDY

The Acute Response Team (ART) is a nurse-led service providing care for the local population. Their aim is to prevent hospital admission and expedite discharge from hospital. Their main specialities are: administration of IV medication in the community hospital or patients' home, if housebound; monitoring of anticoagulation therapy following hospital admission; pre and post-operative bridging; and DOAC counselling/loading of warfarin following diagnosis of a new VTE. Referrals can be made by any hospital or community-based professional, including care homes.

District and community nurses excel at holistic assessment, tackling this through juggling the interlinking elements at play for an individual patient. Reported by the district and community nurses in Wales as being complex, the policy-driven shift of health services away from hospital towards community care settings, changing health needs within the community-based patient population and the Welsh Government's aim to "*enable nurses to assess the severity of patients' conditions, whether they are likely to deteriorate, and what their ongoing needs will be",* a research study within Wales investigated district nursing assessment for community-based patients with complex needs.

EXAMPLE CASE STUDY

An RCBC-funded PhD study aimed to develop and validate an instrument to identify and measure complex need for community-based patients. The investigation addressed district nursing assessment for community-based patients with complex needs and the Welsh Government's aim to "enable nurses to assess the severity of patients' conditions, whether they are likely to deteriorate, and what their ongoing needs will be".

The development of the Patient Complexity Instrument (PCI) involved widespread stakeholder participation and continuous consultation. Through gaining all-Wales agreement from a diverse range of perspectives, the instrument's items targeted the areas that district nursing clinicians, managers and strategic planners regard as crucial components of complexity for community-based patients. The PCI was tested in practice by district nurses, during assessments of community-based patients' needs. Validity and reliability of the instrument was established in its applied context.

The results demonstrate the issues, identified by district nurses, associated with complex care in the community, including: patient engagement, social contact, clinical need, family and care givers, resources and safety, which may predispose an adult patient to increased complexity of need.

It is more important than ever to recognise, acknowledge, understand and support the educational requirements of primary care and community nurses who support people 24 hours a day, 7 days a week, so that prudent healthcare principles can be applied to ensure patients' holistic and complex needs are addressed safely and by the person best placed to support continuity and expertise.

When death is inevitable, help to maintain the best possible quality of life until its end.

With an increasingly ageing population, myriad long-term conditions, better treatments to manage symptoms and prolong life and an increased focus on community-based care for people living with long-term and/or life-limiting conditions, there is a growing need to provide well-planned, un-interrupted community and home-based palliative and end of life care for people, including children.

The Queen's Nursing Institute (QNI) defines palliative care as the *"active holistic care of patients with advanced progressive illness. Symptom management, and the provision of psychological, social and spiritual support is paramount. The key goal of palliative care is the achievement of best quality of life for patients and their families".*

Key issues for primary care and community nursing include; provision of support for patients with life-limiting conditions other than cancer, advanced care planning to determine people's needs and preferences, enhanced carer support and self-care, high quality 24 hour clinical management and service provision, achievement of gold standard expectations and good communication across health, care and third sector boundaries.

Primary care and community nursing teams deliver excellent palliative care for patients at the end of life and enable patients to die well where they choose, when supported by open and easy access to timely specialist support and expertise. District Nursing teams are central to supporting patients', families' and carers' needs for palliative care within the community, where approximately 40% of district nursing time is spent in this way.

In recognition of the importance of the nursing role in supporting people's needs for palliative and end of life care, RCN (2015) recommends that nurses are enabled to:

- treat people compassionately
- listen to people
- communicate clearly and sensitively
- identify and meet the communication needs of each individual
- acknowledge pain and distress and take action
- recognise when someone may be entering the last few days and hours of life
- involve people in decisions about their care and respect their wishes
- keep the person who is reaching the end of their life and those important to them up to date with any changes in condition
- document a summary of conversations and decisions
- seek further advice if needed
- look after themselves and their colleagues and seek support if needed

EXAMPLE CASE STUDY

GPNs are involved in end of care matters on behalf of patients, their families and carers. For example, through their on-going knowledge of patients and their families, simply removing patients from practice-based invitations for appointments has alleviated distress.

EXAMPLE CASE STUDY

Heart Failure specialist nurse are working with GPNs in practice to update GPNs' knowledge of heart failure. This has resulted in GPNs being more confident and competent to support individuals with key aspects of heart failure care, including; medication usage and efficacy, maintaining a healthy blood pressure, lifestyle choices. It is also enabling individuals to discuss aspects of their care planning, including end of life care.

District and community nurses help people to stay at home, to receive care in their preferred place and wherever their home is situated, including in a care home.

EXAMPLE CASE STUDY

To improve the care journey for people living in local care homes, district nurses within Newport have worked with care home colleagues to undertake advanced care planning with residents and their families. This initiative aims to ensure that residents' wishes are met, as a result of facilitated discussions between an individual resident, their families, carers and all staff who come into contact with the resident during their day and nights.

Working in this way has increased the confidence of care home staff to provide the support and care during any period when care needs change, for example when health deteriorates temporarily or longer term. It enables district nurses and care home staff to work as a co-ordinated team to provide the holistic care needed by an individual, as conversations have already been shared and plans made for anticipated eventualities. Such discussion enables planned care within the person's own home, instead of resorting to unplanned admissions if and when deterioration occurs.

To further enhance the care experience, district nurses have also completed training in verification of death, so that continuity of care and support is maintained for residents and families when death occurs.

Community Children's Nurses are actively involved in supporting the palliative care and end of life care needs of children.

EXAMPLE CASE STUDY

A large proportion for the CCN caseload is children and young people with life-shortening conditions and who are classed as requiring palliative care. The CCN is responsible for providing healthcare within a partnership approach, working closely with other health professionals and Children's Disability Services in the Local Authority; acting as the key worker where appropriate. This approach has resulted in a move away from the medical model of care towards person centred approaches with the focus on the child's voice and co-produced plans. The child's journey through levels of care needs is monitored and the CCN has a joint role with the social worker in ensuring that support services are identified and increasing need is identified early with the move into continuing care and/ or end of life care made appropriately. The CCN provides direct end of life care liaising with the paediatric palliative care clinical nurse specialists and the Children's Hospice to support families for the end of life phase.

Challenges for the development of primary care and community nursing in Wales

The workshop identified the challenges of delivering current and anticipated increased levels of care and support without the workforce numbers required. **Recruitment and retention were identified as the biggest challenges** for primary care and community nursing.

Primary care and community nursing colleagues identified variation in service provision across Wales, including in NHS and general practice environments. Whilst this enables individualised support and care for patients and families, there is a risk of not having '**gold standards**' across Wales. For example, in development of new roles such as community nursing health care support workers at band 4 and general practice-based advanced nurse practitioners.

The variation of service provision within general practice nursing is celebrated for its ability to meet the needs of local population, whilst also appreciated as a limiting factor in achieving consistent standards and role development across Wales. For example, an all-Wales policy for **every primary care and community nursing team to include at least one independent nurse prescriber** would singularly improve the ability of primary care and community nurses to provide complete episodes of support for people with long-term conditions. There should be a renewed Welsh Government focus on **rolling out nurse independent prescribing within primary care.**

Primary care nursing leadership is neither formalised nor standardised within Wales, despite the policy direction of travel. An all-Wales policy for **every Cluster to include a Nurse Consultant in Primary and Community Care** would ensure locally-based leadership for clinical development, education, learning and research, based on the needs of local communities (see role descriptors at appendix 1).

Primary care and community nursing colleagues recognise the place of Primary Care Clusters as the vehicles for transformational change. However, it can be **difficult for primary care and community nurses to take part in Cluster activities**, especially where there is a dominant focus on general practice and the business model of independent contractor-based primary care. Primary care and community nurses are key partners in achieving the strategic and policy-led aspirations being developed through Cluster working and call for nursing leadership to maximise the ability to contribute expertise and work in closer partnerships through this model.

Whilst celebrating the unique ways of working that general practice nursing offers in partnership with GP teams, GPNs proposed that **opportunities could be enhanced through direct connectivity to nursing leadership at Health Board level**, including to Directors of Nursing. Some workshop participants argued that Health Board employment would benefit patient care, through the ability to address standards, education, CPD and other professional issues on a broader basis than employment by individual, independent contractor practices currently allows.

It is reported that, as **community children's nursing (CCN) services and teams often sit within secondary care** funding, this impacts on fully maximising the CCN collaboration within primary and community care. This could be considered when seeking ways of improving community-focused, place-based care and support for children and young adults' health and well-being.

Requirements for sustainability and growth of primary care and community nursing in Wales

- Primary care and community nurses are mindful of the need for a **contemporary understanding of the range and scope of their roles**, to enable flexible responses that meet patients' needs.
- There is a need for **continued and appropriate education provision and opportunities** suited to the contemporary context of care.
- There is recognition of the value of a **joint training culture**, to support MDT sharing and learning.
- The need for **technological support** is highlighted as an enduring concern, to enable continuity and safety through access to patient information, information capture and sharing.
- There is a need for **investment in workforce planning structures and processes**, such as **a** career pathway and education framework within general practice nursing. This is an explicit requirement relating to a workforce that falls outside NHS terms and conditions of employment.
- A **career pathway and education framework which is focused specifically on general practice nursing** is identified as central to the achievement of consistent, safe levels of nursing care and support within general practice.
- There is an identified need for investment in **primary care and community nursing leadership** roles, development and succession planning, including at Consultant Nurse and Cluster Lead level.
- There is an identified need to support a **culture of enquiry and learning through a research-based approach within primary care and community nursing clinical practice**, which is not currently addressed through existing structures or processes. The role of **Consultant Nurse within Clusters** would enable a focused, professionally-led emphasis on practice and service development through use of empirical approaches to research and evaluation (see role descriptors at appendix 1).
- There are opportunities for Primary Care and Community Nursing to improve healthcare continuity for the people of Wales. For example, a minimum of **one nurse independent prescriber in every Primary Care and Community Nursing team** would result in the ability to complete episodes of care within the home or surgery setting, without the need to involve a medical health professional. This would also reduce time pressures on GPs, thereby improving access to GP resources.

An illustration of the connection between A Healthier Wales, the primary care and community nursing contribution and commitment, and the supportive requirements to achieve the commitment

A Healthier Wales	Primary care and community nurses ...	Primary care and community nurses commit to ...	To achieve this, primary care and community nursing requires ...
Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.	Consider the whole person and their biological, psychological, social, cultural or spiritual needs.	**Understand the health and care needs of local populations and individuals, based on available information, data and evidence.** **Undertake individualised, holistic assessment of biological, psychological, sociological, cultural and spiritual needs, starting with the question 'what matters to you?'** **Understand the elements of quality and safety outcomes and what matters for patients and their care, through the generation, retrieval and use of research and an evidence base.**	**Recognition of the need for time and resources (including connected IT systems) to undertake meaningful, focused health and care needs assessments.** **Recognition of the need for time and resources to undertake meaningful, individualised holistic assessments that result in collaborative care plans** **Focused support and resources for primary care and community nurses to generate empirical research, relating to quality and safety outcomes and what matters to patients.**
Everyone in Wales should have longer healthier and happier lives, able to remain active and independent, in their own homes, for as long as possible.	Empower people to achieve, maintain or recover independence.	**Take time to work with individuals and families to understand a person's wishes and capacity for independence.** **Take time to agree a plan of care that fosters independence, whilst supporting expressed needs.** **Review the effect of nursing care on the person's activity and independence.**	**Recognition of the need for time and resources to undertake meaningful, assessments of a person's wishes and capacity for independence.** **Recognition of the need for time to agree and support a plan of care that fosters independence.** **Focused support and resources for primary care and community nurses to generate empirical research, relating to the effects of nursing care on a person's activity and independence.**
There will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.	Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.	**Use knowledge and skills to maximise opportunities for illness prevention interventions with individual or groups of people.** **Use recognised frameworks, such as Making Every Contact Count (MECC), Motivational Interviewing (MI) or other contemporary aids, to support people with change in a relevant and effective way.**	**Recognition of the need for time to maximise opportunities for illness prevention interventions with individuals.** **Support and resources for all primary care and community nurses to learn about and be able to use recognised frameworks that help people to make health-related lifestyle or other changes.**
There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives.	Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.	**Ensure that local, community-based resources and assets are used to their best, for the benefit of every citizen's holistic needs.** **Work collaboratively alongside and/or co-ordinate a broad range of health and care professionals, to improve people's access to individualised support.**	**Focused resources to enable primary care and community nurses to access directories of information, such as DEWIS, as routine part of their clinical activities.** **Facilitate environments that are conducive to collaborative team working, including shared IT systems, co-located working premises or other means of instant communication.**

A Healthier Wales	Primary care and community nurses …	Primary care and community nurses commit to …	To achieve this, primary care and community nursing requires …
When people need support, care or treatment, they will be able to access a range of services which are made seamless, and delivered as close to home as possible.	Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences	Ensure that people do not experience avoidable physical, psychological or other harm or distress, by seeking to understand their perceptions and perspectives of their health-related circumstances.	Education in clinical triage and care navigation, to ensure safe and effective signposting at first point of contact to the most appropriate health and care support.
People will only go to a general hospital when that is essential.		Ensure development of well-balanced primary care and community nursing teams, so that people can receive safe and competent care from staff at all clinical skill levels, from 3 to 8. Ensure at least one nurse independent prescriber within each primary care and community nursing team within Wales	Focused planning, funding and educational support for developing independent prescribers within all primary care and community nursing teams across Wales
Improve the physical and mental well-being of all, throughout their lives, from birth to a dignified end.	When death is inevitable, help to maintain the best possible quality of life until its end.	Provide sensitive, individualised, nursing care for people, assisting their wishes for a preferred place of death.	Co-ordinated education in psychological approaches to supporting health, well-being and decision making. Co-ordinated education for end of life care and certification of death.
This whole system approach will be equitable. Services and support will deliver the same high quality of care, and achieve more equal health outcomes, for everyone in Wales.	Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of community-based care	Contribute expertise to and support the development of career pathways for primary care and community nursing teams, to enable equal health outcomes for people receiving care from a consistently well-educated skill mix, with standardised job descriptions. Lead, contribute to and support the development of 'gold standard' best practice for all areas of primary care and community nursing.	Focused education and career framework for primary care nursing teams, as committed by the Cabinet Secretary for Health and Social Services in Wales. Health and care systems continuity to ensure consistent, joined-up approaches.
The shift in resources to the community will mean that when hospital-based care is needed, it can be accessed more quickly		Use the experiences and learning from pilots and new initiatives in primary care and community nursing, to shape teams that help people receive safe and relevant community-based care, where hospital would otherwise be the only available option. Continue to shape, lead and provide individualised and population-based, evidence-led, evaluated, efficient and sensitive nursing care to meet the contemporary needs of patients and the community-focused NHS in Wales	Focused support and resources for primary care and community nurses to generate evaluations of the impact of nursing practice, including the use of frameworks such as Time Spent at Home, Economic Analysis, Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs). A Welsh Clinical Leadership Training Fellowship scheme, to develop high quality clinical leaders in primary care and community nursing. Focused development of primary care clinical leadership roles, to ensure increased numbers of nurses with the knowledge, skills and experience for Primary Care Cluster Lead roles. Recruitment of one Nurse Consultant in Primary and Community Care within each Primary Care Cluster in Wales (see role descriptors at appendix 1).

Summary

In continuing to meet the health and well-being needs with the people of Wales, primary care and community nurses will...

1. Work with individuals, their families and carers to identify nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.
2. Consider the whole person and their biological, psychological, social, cultural or spiritual needs.
3. Promote health, healing, growth and development, and prevent disease, illness, injury, and disability.
4. Empower people to achieve, maintain or recover independence.
5. Minimise distress and suffering, and enable understanding of and coping with conditions, treatments and consequences
6. When death is inevitable, help to maintain the best possible quality of life until its end.
7. Work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team, often as the co-ordinator of care

Appendices

Appendix 1:
A Selection of Primary Care and Community Nursing Role Descriptors (taken from RCN Wales, 2017)

General Practice Nurse (NMC Registered with additional specialist registerable qualification)

- Autonomous practitioner
- Work closely with the general practice team to meet the needs of patients, whilst supporting the delivery of policy and procedures, providing nurse leadership
- Assess, plan, develop, implement and evaluate wellbeing programmes
- Implement and evaluate individual treatment plans for patients with long-term conditions
- Undertake a range of practice nurse duties including management of long term conditions, wound care, cervical cytology, travel vaccinations and childhood immunisations, undertake relevant diagnostic tests
- Prioritise health problems and intervene appropriately to assist the patient in complex, urgent or emergency situations, including initiation of effective emergency care
- Promoting the Public Health including national screening programmes

Advanced Nurse Practitioner (NMC Registered with additional specialist recordable qualification, opportunity to be RCN credentialed)

- Autonomous, advanced practice, with an extended scope of practice delivering care within relevant specialism following referral
- Provide specialist assessment, diagnosis, treatment and evaluation of care
- High level of clinical reasoning /diagnostic skills, offering a wide range of treatment/rehabilitation programmes to patients with highly complex needs
- Provide a first point of contact within the Practice for patients presenting with undifferentiated, undiagnosed problems, making use of skills in history taking, physical examination, problem-solving and clinical decision-making, to establish a diagnosis and management plan
- Initiate, lead and develop regular research, audit, evaluation and implementation of evidence based practice and support others undertaking research projects
- Demonstrate advanced critical thinking and analytical skills acting as a source of clinical expertise and knowledge to other professionals
- Advise on recommended management across the whole patient pathway, which includes prevention, community, long term and end of life care
- Order, interpret and act upon medical investigations and expedite access to appropriate medical staff

Consultant Nurse in Primary and Community Care (NMC Registered with additional specialist registerable / recordable qualification)

- Autonomous practitioner with a minimum of 50% provision of direct care
- Expert advanced practice working with patients, clients and/or communities making critical clinical judgements and decisions where a precedent may not exist
- Responsible for management of a complex caseload providing and managing an expert clinical advisory service
- Ensure there is adherence to the ethical and moral dimensions of practice
- Fulfil a role in clinical governance, providing expert input and working to secure quality improvement across a wide spectrum of care provision
- Contribute to strategic planning and local implementation of national policies
- Evaluate clinical services, leading development of new services and/or redesign
- Take the lead in initiating and developing cross-disciplinary services and interagency working that contribute to multi-professional standards and guidelines
- Make and receiving direct patient/client referrals; undertaking an assessment of individual need and drawing on appropriate interagency and cross-boundary collaboration and expertise to best meet the needs of the patient/client.

- Provide effective leadership and example that inspires and sustains commitment of colleagues and facilitates empowerment of others
- Publish research or have, or be working towards a doctorate
- Contribute to the development, and evaluation of educational programmes
- Lead research and audit and contribute to the wider research agenda, establishing research partnerships with HEIs and other research communities.

General Practice Health Care Support Worker (Non-registered)

- Deliver nursing care as part of a nursing team under direct or indirect supervision within an agreed framework, and report any changes without delay
- Assist in communicating and sign-posting towards self-care and health promotion
- Work within guidelines, undertake delegated activities including stock control, vaccines cold chain, patient chaperone and infection control
- Work within guidelines, provide care such as spirometry, health checks, venepuncture and physiological measurements, reporting results to the registered nurse

District Nursing Team Leader (NMC Registered with additional specialist registerable qualification)

- Autonomous practitioner
- Provide enhanced clinical support and expertise to the patients within the locality attending complex MDT's in the hospital & community settings
- Coordination between caseload holders, community resource services, secondary care wards and specialist nurses to ensure safe effective discharges and proactive preventive interventions to maintain people within their home environment
- Lead on standards and professional practice supporting staff in new ways of working
- Work closely with primary care teams within the networks, ensuring effective communication and safe effective care pathways within the networks including assessment and referral to prevent unnecessary hospital admission
- Improve end of life care planning and implementation
- Operationally line manage and professionally lead, the community nursing team

Community Nurse (NMC Registered)

- Take responsibility for all aspects of ongoing nursing care and provide comprehensive packages of nursing care in people's own home under the indirect supervision of the Caseload Holder
- Ensure close collaboration with the multi-disciplinary team participating in MDT discussions in relation to risk assessments to ensure safety of the individual, fellow patients and staff
- Conduct interim first visit/patient contact, which will be re-assessed by the Caseload holder within 24 hours. Signpost individuals to appropriate community services to meet their ongoing needs
- Report any risks or hazards and assist in developing and establishing methods and procedure to prevent/minimise the risk
- Ensure the health, safety and welfare of self, colleagues, patients/clients, carers and all other persons involved in their field of practice
- Make changes to care plans following review, reporting these to the Senior Nurse

Occupational Health Nurse (NMC Registered with additional specialist registerable qualification)

- Autonomous practitioner
- Work with individuals and teams in the prevention of health issues, promotion of healthy living and working conditions with specific knowledge and skills in the understanding of the effects of work on health and health at work.
- Undertake health screening, including workforce and workplace monitoring and health need assessment and health promotion; education and training and where appropriate counselling and support and risk assessment and risk management.
- Manage a multidisciplinary team of health professionals

Children's Community Nurse (NMC Registered with additional specialist recordable qualification)

- Support the child, family and carers, in response to maximise the child or young person's independence and quality of life
- Provide nursing care to children and young people with complex care needs, including complex medical support as part of everyday or end-of-life care
- Support children and young people receiving Continuing Care packages and end of life care across 24/7 including weekends and bank holidays
- Provide clinical assessment and support for children in community settings who have a health care need as part of working with primary care services preventing unnecessary hospital admissions and facilitate early discharge
- Carry out specific health care assessments or interventions in community settings
- Plan care for children with acute health needs for review with the senior staff as appropriate, report changes in the child's condition or outcomes of interventions
- Participate in the administration of medicines, including intravenous therapy and be aware of current drugs/therapies in the treatment of pain and other symptoms.

Community Clinical Nurse Specialist (NMC Registered with additional specialist recordable qualification)

- Work autonomously and plays a pivotal role in leading clinical practice and improving standards of care, promote a seamless service through clinical practice, management, education, research, audit and professional activities
- Work as part of a team, developing nurse led services and provide specialist nursing input at all stages of the patient's episode of care
- Lead clinical care by managing a defined patient caseload, providing an expert assessment, plan and evaluation, facilitate education for patients and their families
- Provide Rapid Access Clinics that do not require Consultant supervision
- Ordering, analysis and interpretation of pathology, radiology and microbiology investigations
- Act as a point of referral for patients in the community experiencing problems arising from their condition and /or its treatment by providing a telephone help line service

Appendix 2:
Programme, RCN Wales Primary Care and Community Nursing Summit: June 12th 2019

TIME	RCN Wales Primary Care and Community Nursing Summit: 'Meeting the Agenda for A Healthier Wales' June 12th 2019 PROGRAMME
12.00 – 13:00	**Registration & Lunch**
13:00 – 13:10	**Welcome** Nicola Davis-Job, Interim Associate Director (Professional Practice) RCN Wales
13:10 – 13:15	**Chair's Introduction to the Summit** Dr Sue Thomas, Primary Care, Community and Independent Sector Adviser, RCN Wales
13:15 – 13:35	**The Strategic Programme for Primary Care in Wales** Sue Morgan, National Director & Strategic Programme Lead for Primary Care
	Questions
13.40 – 14.05	**The Contemporary Picture for Primary Care and Community Nursing** Dr Crystal Oldman, Director, Queen's Nursing Institute, UK
	Questions
14.10 – 14.30	**The Role of Health Education and Improvement Wales (HEIW) and Primary Care and Community Nursing** Stephen Griffiths, Director of Nursing, Health Education and Improvement Wales
	Questions
14:40 – 15:00	**Tea and Coffee**
15:00 – 16:30	**Workshops** Delegates will be invited to work with colleagues to address key questionsFacilitators: Sue Thomas, Diane Powles, Lisa Turnbull
16:30 – 16:50	**Feedback, Early Conclusions, Recommendations and The Way Forward**
16:50 – 17:00	**Summary and Closing Remarks** Stephen Griffiths, Director of Nursing, Health Education and Improvement Wales
17:00	**Close**

References

Barrett A, Latham D & Levermore J (2007) Defining the unique role of the specialist district nurse practitioner. Part one. *British Journal of Community Nursing*. Vol. 12(10), 442-8

Brindle D (2011) *Guiding Patients through Complexity: Modern Medical Generalism*. Report of an Independent Commission for the RCGP and the Health Foundation. The Health Foundation, London

Coleman E (2003) Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society*. Vol. 51(4), 549–555

Department of Health (2010) *Front Line Care: the future of nursing and midwifery in England.* Department of Health, Public Health Nursing, Leeds

Department of Health (2013) *Care in local communities: A new vision and model for district nursing.* Department of Health, Public Health Nursing, Leeds

Future Generations Commissioner for Wales (2015) The Wellbeing of Future Generations (Wales) Act https://futuregenerations.wales/about-us/future-generations-act/ Office of the Future Generations Commissioner for Wales, Cardiff

Hickam D, Weiss J, Guise J, Buckley D, Motu'apuaka M, Graham E, Wasson N & Saha S (2013) *Outpatient Case Management for Adults With Medical Illness and Complex Care Needs. Comparative Effectiveness Review No. 99*. Oregon Evidence based Practice Center.

King's Fund (2012a) *Transforming the Delivery of Health and Social Care: The case for fundamental change.* King's Fund, London

King's Fund (2012b) *The care of frail older people with complex needs: time for a revolution.* The Sir Roger Bannister Health Summit, Leeds Castle. Kings Fund, London

Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E & van Vught A (2018) *Nurses as substitutes for doctors in primary care*. Cochrane Database of Systematic Reviews

Malcomess K (2005) *The Care Aims Model*. In Anderson C & van der Gaag (2005) Speech and Language Therapy: Issues in Professional Practice. Whurr Publishers, London

NHS Wales (2018) *Strategic Programme for Primary Care in Wales.* Available at http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Strategic%20Programme%20for%20Primary%20Care.pdf (accessed on 30 July 2019)

Prudent Healthcare Wales (2016) Prudent Healthcare: Securing Health and Well-being for Future Generations. Available at http://www.prudenthealthcare.org.uk/wp-content/uploads/2016/02/Securing-Health-and-Wellbeing-for-Future-Generations1.pdf (accessed on 30 July 2019)

Queen's Nursing Institute (2011) *Nursing People at Home: The issues, the stories, the actions.* Queen's Nursing Institute, London

RCN (2013) *Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers.* RCN, London

RCN (2014) *Defining Nursing.* RCN, London

RCN (2015) *Getting it Right Every Time: fundamentals of nursing care at the end of life.* Available at http://rcnendoflife.org.uk/my-role/ (accessed on 30 July 2019)

RCN Wales (2017) *Role Descriptors: The unique contribution of primary and community nursing throughout the life course*. RCN Wales, Cardiff

RCN Wales (2018) *Nursing Numbers in Wales*. RCN Wales, Cardiff

Reeve J (2010a) Protecting generalism: moving on from evidence-based medicine? *British Journal of General Practice*. Vol. 60(576), 521–523

Reeve J (2010b) I*nterpretive Medicine: Supporting generalism in a changing primary care world. Occasional Paper 88*, i-viii, 1-20. Royal College of General Practitioners, London

Royal College of General Practitioners (2012) *Medical generalism: Why expertise in whole person medicine matters*. Royal College of General Practitioners, London

Royal College of General Practitioners and the Health Foundation (2011) *Guiding patients through complexity: Modern medical generalism. Report of an independent commission for the RCGP and the Health Foundation*. Health Foundation, London

Unsworth J, Tuffnell C & Platt A (2011) Safer care at home: use of simulation training to improve standards. *British Journal of Community Nursing*. Vol. 16(7), 334-9

Valderas J, Starfield B, Sibbald B, Salisbury C & Roland M (2009) Defining comorbidity: implications for understanding health and health services. *Annals of Family Medicine*. Vol. 7(4), 357-363

Welsh Government (2017) *Interim District Nurse Guiding Staffing Principles.* Available at https://gweddill.gov.wales/docs/phhs/publications/171004letteren.pdf (accessed on 30 July 2019)

Welsh Government (2018) *A Healthier Wales: our Plan for Health and Social Care.* Welsh Government, Cardiff

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Nyrsio Gofal Sylfaenol a Chymunedol

gofal iechyd a gyflogir i weithio mewn tîm nyrsio ymarfer cyffredinol, fel arfer i gynorthwyo â bodloni gofynion cytundebol meddygon teulu yn y GIG yng Nghymru. Mae gwaith y tîm nyrsio ymarfer cyffredinol yn canolbwyntio ar ddarparu cymorth nyrsio i bobl o bob oedran, ond i oedolion yn bennaf. Mae Nyrsio Cymunedol yn cyfeirio at nyrsys a gyflogir i weithio mewn tîm o nyrsys cymunedol a elwir ar y cyd yn dîm nyrsio ardal. Mae nyrs ardal yn nyrs gofrestredig sydd wedi cael addysg benodol â phwyslais ar y gymuned ar ôl cofrestru ac sy'n arwain tîm nyrsio ardal. Gan amlaf, mae prif gyd-destun y ddarpariaeth gofal nyrsio ardal ar gyfer oedolion nad ydynt yn gallu gadael eu cartrefi i gael cymorth nyrsio. Mae nyrsys cymunedol plant yn darparu cymorth i blant mewn lleoliadau cymunedol, gan atal derbyniadau diangen i'r ysbyty a hwyluso rhyddhad cynnar.

Ynglŷn â'r Coleg Nyrsio Brenhinol (RCN)

Y Coleg Nyrsio Brenhinol yw'r sefydliad proffesiynol a'r undeb llafur mwyaf yn y byd ar gyfer nyrsys, ac mae'n cynrychioli dros 435,000 o nyrsys, bydwragedd, ymwelwyr iechyd, gweithwyr cymorth gofal iechyd a myfyrwyr nyrsio, gan gynnwys dros 25,000 o aelodau yng Nghymru. Mae'r RCN yn sefydliad sy'n gwasanaethu'r DU gyfan ac mae ganddo ei Fyrddau Cenedlaethol ei hun yng Nghymru, Yr Alban a Gogledd Iwerddon. Mae'r RCN yn cyfrannu'n fawr at arfer nyrsio, safonau gofal a pholisi cyhoeddus sy'n effeithio ar iechyd a nyrsio. Mae'r RCN yn gweithio ar lefel leol, genedlaethol a rhyngwladol i hyrwyddo rhagoriaeth mewn arfer nyrsio a buddiannau cleifion, nyrsys a'r proffesiwn nyrsio. Mae aelodau'r RCN yn gweithio ym mhob lleoliad, gan gynnwys gofal sylfaenol, cymunedol, cartrefi gofal, ysgolion, carchardai ac ysbytai, a hynny yn y sector annibynnol a'r GIG. Mae tua dwy ran o dair o'n haelodau wedi'u lleoli yn y gymuned.

Cysylltwch â Choleg Nyrsio Brenhinol Cymru i gael rhagor o wybodaeth am unrhyw bwyntiau a godwyd yn yr adroddiad hwn.

NYRSIO GOFAL SYLFAENOL A CHYMUNEDOL AR GYFER CYMRU IACHACH

Cynnwys

Cyfranogwyr 2

Crynodeb Gweithredol 4

Cyflwyniad 6

Cefndir 7

Y gweithlu nyrsio gofal sylfaenol a chymunedol yng Nghymru 9

Ymrwymiadau nyrsio gofal sylfaenol a chymunedol 10

Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsys; ymyriadau therapiwtig a gofal personol; gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol *10*

Gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, ac mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth, yn aml fel cydgysylltydd gofal *11*

Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol *13*

Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anafiadau ac anabledd *14*

Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth
Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr, triniaeth a chanlyniadau *18*

Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl hyd y diwedd *20*

Heriau ar gyfer datblygu nyrsio gofal sylfaenol a chymunedol yng Nghymru 22

Gofynion ar gyfer cynaliadwyedd a thwf nyrsio gofal sylfaenol a chymunedol yng Nghymru 23

Y cysylltiad rhwng Cymru Iachach, yr ymrwymiad nyrsio gofal sylfaenol a chymunedol a'r gofynion ategol i gyflawni'r ymrwymiad 24

Crynodeb o'r ymrwymiad nyrsio gofal sylfaenol a chymunedol 26

Atodiadau 27

Cyfeiriadau 31

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Jo Webber
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Shirley Willis
Darlithydd: Nyrsio Gofal Sylfaenol ac Iechyd Cyhoeddus
Prifysgol Caerdydd

Fiona Wood
Uwch-nyrs, Tîm Adnoddau Cymunedol
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Crynodeb Gweithredol

MAE NYRSYS GOFAL SYLFAENOL A NYRSYS CYMUNEDOL YN YMRWYMO I...	MAE'R GOFYNION ATEGOL I GYFLAWNI'R YMRWYMIADAU YN CYNNWYS...
Deall anghenion iechyd a gofal poblogaethau lleol ac unigolion ar sail yr wybodaeth, data a thystiolaeth sydd ar gael.	Adnabod yr angen am amser ac adnoddau (gan gynnwys systemau TG cysylltiedig) i gynnal asesiadau iechyd a gofal ystyrlon a phenodol.
Cynnal asesiad unigol a chyfannol o anghenion biolegol, seicolegol, cymdeithasegol, diwylliannol ac ysbrydol, gan ddechrau gyda'r cwestiwn o 'beth sy'n bwysig i chi?'	Adnabod yr angen am amser ac adnoddau i gynnal asesiadau cyfannol unigol ac ystyrlon sy'n arwain at gynlluniau gofal cydweithredol.
Deall elfennau canlyniadau ansawdd a diogelwch a'r hyn sy'n bwysig i'r cleifion a'u gofal trwy greu, casglu a defnyddio ymchwil a thystiolaeth.	Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud â chanlyniadau ansawdd a diogelwch a'r hyn sy'n bwysig i gleifion.
Neilltuo amser i weithio gydag unigolion a theuluoedd i ddeall dymuniadau a gallu unigolyn i fod yn annibynnol.	Adnabod yr angen am amser ac adnoddau i gynnal asesiadau ystyrlon o ddymuniadau a gallu unigolyn i fod yn annibynnol.
Neilltuo amser i gytuno ar gynllun gofal sy'n meithrin annibyniaeth ac yn cefnogi'r anghenion a fynegwyd.	Adnabod yr angen am amser i gytuno ar gynllun gofal sy'n meithrin annibyniaeth a chefnogi'r cynllun hwnnw.
Adolygu effaith gofal nyrsio ar weithgarwch ac annibyniaeth yr unigolyn.	Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud ag effaith gofal nyrsio ar weithgarwch ac annibyniaeth unigolyn.
Defnyddio gwybodaeth a sgiliau i greu'r cyfleoedd gorau posibl ar gyfer ymyriadau atal salwch gydag unigolyn neu grwpiau o bobl.	Adnabod yr angen am amser i greu'r cyfleoedd gorau posibl ar gyfer ymyriadau atal salwch gydag unigolion.
Defnyddio fframweithiau cydnabyddedig, megis Gwneud i Bob Cyswllt Gyfrif (MECC), Cyfweld Ysgogiadol, neu gymhorthion cyfoes eraill, i gefnogi pobl i wneud newidiadau mewn modd perthnasol ac effeithiol.	Cymorth ac adnoddau i nyrsys gofal sylfaenol a chymunedol i ddysgu am fframweithiau cydnabyddedig sy'n helpu pobl i wneud newidiadau sy'n ymwneud ag iechyd, ffordd o fyw neu rai eraill, a defnyddio'r fframweithiau hynny.
Sicrhau y caiff adnoddau ac asedau lleol a chymunedol eu defnyddio yn y ffordd orau er budd anghenion cyfannol pob dinesydd.	Adnoddau penodol i alluogi nyrsys gofal sylfaenol a chymunedol i ddefnyddio cyfeiriaduron gwybodaeth megis DEWIS, fel mater o drefn yn y eu gweithgareddau clinigol.
Gweithio ar cyd ag amrywiaeth eang o weithwyr iechyd a gofal proffesiynol a/neu eu cydgysylltu, i wella'r cymorth unigol sydd ar gael i bobl.	Hwyluso amgylcheddau sy'n ysgogi gwaith tîm, gan gynnwys systemau TG ar y cyd, cydleoli ardaloedd gweithio a thrwy ddulliau eraill o gyfathrebu ar unwaith.

MAE NYRSYS GOFAL SYLFAENOL A NYRSYS CYMUNEDOL YN YMRWYMO I...	MAE'R GOFYNION ATEGOL I GYFLAWNI'R YMRWYMIADAU YN CYNNWYS...
Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy geisio deall eu canfyddiadau a'u safbwyntiau o ran eu hamgylchiadau iechyd.	Addysg mewn brysbennu clinigol a llywio gofal, i sicrhau y caiff pobl eu cyfeirio'n ddiogel ac yn effeithiol ar y pwynt cyswllt cyntaf i'r cymorth iechyd a'r gofal mwyaf priodol.
Sicrhau y datblygir timau nyrsio gofal sylfaenol a chymunedol cytbwys fel bod gofal diogel a chymwys ar gael i bobl gan staff ar bob lefel o sgil unigol, o lefel 3 i 8. Cyfrannu arbenigedd a chynorthwyo datblygiad llwybrau gyrfa ar gyfer timau nyrsio gofal sylfaenol a chymunedol, i alluogi canlyniadau iechyd cydradd i bobl sy'n derbyn gofal gan gymysgedd sgiliau hyddysg iawn a chyson, a disgrifiadau swydd safonol.	Addysg benodol â phwyslais a fframwaith gyrfa ar gyfer timau nyrsio gofal sylfaenol yn unol ag ymrwymiad Ysgrifennydd y Cabinet dros Iechyd Gwasanaethau Cymdeithasol yng Nghymru.
Sicrhau bod o leiaf un nyrs sy'n rhagnodi'n annibynnol ym mhob tîm nyrsio gofal sylfaenol a chymunedol yng Nghymru.	Cyllido, cymorth addysgol a chynllunio penodol i ddatblygu o leiaf un nyrs sy'n rhagnodi'n annibynnol ym mhob tîm nyrsio gofal sylfaenol a chymunedol yng Nghymru.
Darparu gofal nyrsio sensitif ac unigol i bobl, gan gynorthwyo â'u dymuniadau o ran eu dewis o le i farw.	• Addysg gydgysylltiedig o ddulliau seicolegol o gefnogi iechyd, llesiant a phenderfyniadau. • Addysg gydgysylltiedig ar gyfer gofal diwedd oes a thystysgrif marwolaeth.
Arwain, cefnogi a chyfrannu at ddatblygiad arfer gorau 'safon aur' ym mhob maes nyrsio gofal sylfaenol a chymunedol.	Parhad systemau iechyd a gofal i sicrhau dulliau cyson cydgysylltiedig.
Defnyddio'r profiadau a'r gwersi a ddysgwyd o raglenni treialu a mentrau newydd mewn gofal sylfaenol a nyrsio cymunedol i lunio timau sy'n helpu pobl i gael gofal diogel a pherthnasol yn y gymuned, lle byddai'r ysbyty yn unig ateb fel arall.	Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio gwerthusiadau o effaith arfer nyrsio; gan gynnwys defnyddio fframweithiau megis Amser a Dreulir Gartref, Dadansoddiad Economaidd, Mesurau Canlyniadau a Adroddwyd gan Gleifion (PROM), Mesurau Profiadau a Adroddwyd gan Gleifion (PREM).
Parhau i ffurfio, arwain a darparu gofal nyrsio unigol, sensitif ac effeithlon sy'n seiliedig ar y boblogaeth ac wedi'i arwain gan dystiolaeth, i ddiwallu anghenion cyfoes cleifion a'r GIG yng Nghymru sy'n canolbwyntio ar y gymuned.	• Cynllun Cymrodoriaeth Hyfforddiant Arweinyddiaeth Glinigol Cymru i ddatblygu arweinwyr clinigol o safon mewn nyrsio gofal sylfaenol a chymunedol. • Datblygiad penodol o swyddi arweinyddiaeth glinigol gofal sylfaenol, i sicrhau bod gan fwy o nyrsys yr wybodaeth, y sgiliau a'r profiad i gyflawni swyddi Arweinwyr Clystyrau Gofal Sylfaenol. • Recriwtio un Nyrs Ymgynghorol ym maes Gofal Sylfaenol a Chymunedol o fewn pob Clwstwr Gofal Sylfaenol yng Nghymru.

Cyflwyniad

Mae'r adroddiad hwn yn nodi barn yr RCN a chlinigwyr arbenigol ar Nyrsio Gofal Sylfaenol a Chymunedol yng Nghymru.

Mae'r adroddiad yn tynnu sylw at ymateb Nyrsio Gofal Sylfaenol a Chymunedol i 'Cymru Iachach' (2018) a'r Rhaglen Strategol ar gyfer Gofal Sylfaenol a Chymunedol (2018) Mae'n diffinio'r cyfraniad sydd ei angen gan Nyrsio Gofal Sylfaenol a Chymunedol i gyrraedd nodau trawsnewid Gofal yn Nes at y Cartref yng Nghymru. Mae'r adroddiad yn ffrwyth ymgynghoriad eang â nyrsys a rheolwyr gofal sylfaenol a chymunedol ledled Cymru; y nod yw llywio a chynorthwyo'r rhanddeiliaid dan sylw i ddarparu a chefnogi iechyd a gofal yng Nghymru.

Mae gwireddu'r uchelgeisiau a nodir yn yr adroddiad hwn yn gofyn am weithio'n strategol mewn partneriaeth, i gefnogi addewidion a wnaed gan nyrsys gofal sylfaenol a chymunedol yng Nghymru. Edrychwn ymlaen at weithio ar yr ymrwymiadau hyn a'u datblygu wrth i bobl gael cymorth gan nyrsys gofal sylfaenol a chymunedol, Llywodraeth Cymru, Byrddau Iechyd GIG Cymru, Addysg a Gwella Iechyd Cymru, darparwyr Addysg a'r holl randdeiliaid.

Wrth ddiwallu anghenion iechyd a llesiant gyda phobl Cymru ac ar eu cyfer, mae Nyrsys

1. **Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsio; ymyriadau therapiwtig a gofal personol, gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol.**
2. **Gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, ac mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth, yn aml fel cydgysylltydd gofal**
3. **Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol.**
4. **Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.**
5. **Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth**
6. **Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr, triniaeth a chanlyniadau**
7. **Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.**

Gofal Sylfaenol a Chymunedol yn ymrwymo i:
Mae'r ymrwymiadau i ddarparu cymorth nyrsio gofal sylfaenol a chymunedol effeithiol a diogel wedi'u tanategu gan chwe egwyddor sy'n diffinio nyrsio, fel yr amlinellir gan yr RCN (2014):

1. **Diben nyrsio gofal sylfaenol a chymunedol** yw hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd. Pan fo pobl yn mynd yn sâl neu'n datblygu anabledd, diben nyrsio gofal sylfaenol a chymunedol yw lleihau'r gofid a'r dioddefaint gymaint â phosibl a galluogi pobl i ddeall ac ymdopi â'u hafiechyd neu anabledd, y driniaeth a'i chanlyniadau. Pan fo marwolaeth yn anochel, diben nyrsio gofal sylfaenol a chymunedol yw cynnal y safon bywyd gorau posibl tan y diwedd.
2. **Mae ymyriadau nyrsio gofal sylfaenol a chymunedol** yn ymwneud â grymuso pobl a'u helpu i gyflawni, cynnal neu adennill annibyniaeth. Mae nyrsio yn cynnwys nodi anghenion nyrsio; ymyriadau therapiwtig a gofal personol; gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol. Yn ogystal â gofal uniongyrchol i gleifion, mae nyrsio gofal sylfaenol a chymunedol yn cynnwys rheoli, addysgu, gwella ansawdd ac ymchwil.
3. **Parth penodol nyrsio gofal sylfaenol a chymunedol** yw ymatebion unigryw pobl i iechyd, salwch, eiddilwch, anabledd a digwyddiadau sy'n ymwneud ag iechyd, a phrofiad pobl o'r pethau hyn beth bynnag fo'u hamgylchedd neu eu hamgylchiadau. Gall ymatebion pobl fod yn fiolegol, seicolegol, cymdeithasol, diwylliannol neu

ysbrydol ac maent yn aml yn gyfuniad o'r rhain. Mae'r term pobl yn cynnwys unigolion o bob oedran, teuluoedd a chymunedau, drwy'r rhychwant bywyd cyfan.

4. **Mae pwyslais nyrsio gofal sylfaenol a chymunedol** ar y person cyfan a'r ymateb dynol, yn hytrach nag agwedd benodol ar y person neu gyflwr patholegol penodol.
5. **Mae nyrsio gofal sylfaenol a chymunedol yn seiliedig ar werthoedd moesegol** sy'n parchu urddas, ymreolaeth ac unigrwydd bodau dynol, y berthynas freintieig rhwng y nyrs a'r claf, a derbyn atebolrwydd personol am benderfyniadau a gweithredoedd. Mynegir y gwerthoedd hyn mewn codau ysgrifenedig moeseg a'u cefnogi gan system o reoleiddio proffesiynol.
6. **Mae nyrsys gofal sylfaenol a chymunedol yn gweithio mewn partneriaeth** â chleifion, eu perthnasau a gofalwyr eraill, mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth. Pan fo'n briodol maent yn arwain tîm, yn rhagnodi, dirprwyo a goruchwylio gwaith eraill; ar adegau eraill byddant yn cymryd rhan dan arweinyddiaeth eraill. Fodd bynnag, maent yn atebol yn bersonol ac yn broffesiynol am eu penderfyniadau a'u gweithredoedd eu hunain bob amser.

(O Defining Nursing; RCN, 2014)

Cefndir

Mae gofal iechyd sylfaenol yn darparu'r pwynt cyswllt cyntaf a'r prif bwynt cyswllt pan fo gofal yn parhau i gleifion yn y system iechyd a gofal. Mae ymarferwyr gofal iechyd sylfaenol yn cydgysylltu gofal arbenigol i gleifion â phryderon biolegol, seicolegol a chymdeithasol lluosog. Mae cleifion fel arfer yn derbyn gofal sylfaenol gan weithwyr proffesiynol megis meddygon teulu, nyrsys practis neu ardal a nyrsys cymunedol. Yn y GIG yng Nghymru y brif ffynhonnell o ofal iechyd sylfaenol yw trwy'r meddyg teulu (SB 25/2016. StatsCymru, 2016).

Mae gweledigaeth Llywodraeth Cymru o "Cymru Iachach" wedi rhoi mwy o bwyslais ar wasanaethau iechyd a gofal ar lefel gofal sylfaenol a chymunedol, ac mae'r Rhaglen Strategol ar gyfer Gofal Sylfaenol a Chymunedol yn nodi'r ffyrdd y caiff dyheadau Cymru Iachach a Gofal yn Nes at y Cartref eu cyflawni.

Mae Cymru Iachach (2018) yn nodi'r dyheadau canlynol:

- **Dylai pawb yng Nghymru gael bywydau hirach, iachach a hapusach, a dylent allu parhau i gadw'n brysur a bod yn annibynnol yn eu cartrefi eu hunain gyhyd â phosib.**
- **Byddwn yn edrych ar iechyd a gofal cymdeithasol fel system gyfan, gyda'r gwasanaethau yn un elfen yn unig wrth gefnogi pobl i fwynhau gwell iechyd a llesiant drwy gydol eu bywydau.**
- **Bydd yna system 'iachusrwydd' sy'n ceisio cefnogi a rhagweld anghenion iechyd, atal salwch a lleihau effaith iechyd gwael.**
- **Bydd y system gyfan yn deg. Bydd gwasanaethau a chymorth yn darparu'r un gofal o ansawdd uchel, ac yn cyflawni canlyniadau iechyd cyfartal, i bawb yng Nghymru.**
- **Bydd yn gwella llesiant corfforol a meddyliol pawb, drwy gydol eu bywydau, o'u geni hyd at ddiwedd urddasol.**
- **Pan fydd angen cymorth, gofal neu driniaeth ar bobl, bydd modd iddynt ddefnyddio ystod o wasanaethau di-dor, sy'n cael eu darparu mor agos â phosibl at y cartref.**
- **Bydd gwasanaethau'n cael eu llunio o amgylch yr unigolyn a grwpiau o bobl, ar sail eu hanghenion unigryw a'r hyn sy'n bwysig iddynt, yn ogystal â chanlyniadau ansawdd a diogelwch.**
- **Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny'n hanfodol.**
- **Bydd symud y pwyslais at adnoddau yn y gymuned yn golygu bod modd cyrraedd y gofal mewn ysbyty yn gyflymach pan fo angen hynny.**

Mae Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 yn amlinellu'r pum ffordd o weithio, sy'n cynnwys yr Hirdymor, Atal, Integreiddio, Cydweithredu a Chynnwys; sy'n cyd-fynd yn agos â dyheadau Cymru Iachach.

Mae'r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru yn rhoi camau a gweithgareddau gwasanaethau iechyd yng Nghymru o fewn fframwaith strwythuredig. Mae'r Chwe Phrif Ffrwd Gwaith yn cynnwys:

1. Atal a llesiant
2. Y Model 24/7
3. Data a Thechnoleg Ddigidol
4. Datblygiad Sefydliadol a'r Gweithlu
5. Cyfathrebu, Ymgysylltu
6. Y Rhaglen Drawsnewid a'r Weledigaeth ar gyfer Clystyrau

Mae egwyddorion Gofal Iechyd Darbodus (2016) yn llywio datblygiad gwasanaethau iechyd a gofal yng Nghymru, a'r nod yw:

- Cyflawni iechyd a llesiant gyda'r cyhoedd, cleifion a gweithwyr proffesiynol yn bartneriaid cyfartal yn y broses drwy gyd-gynhyrchu
- Gofalu am y rhai sydd â'r anghenion iechyd mwyaf yn gyntaf, gan wneud y defnydd mwyaf effeithiol o'r holl sgiliau ac adnoddau
- Gwneud dim ond yr hyn sydd angen ei wneud, dim mwy, dim llai; a pheidio ag achosi niwed
- Lleihau amrywiadau amhriodol gan ddefnyddio arferion sy'n seiliedig ar dystiolaeth mewn modd cyson a thryloyw.

Ceir cysoniad clir rhwng sgiliau, arbenigedd a chyfraniad nyrsio a'r cyd-destun polisi cyffredinol yng Nghymru.
Mae nyrsys gofal sylfaenol a chymunedol yn croesawu'r symudiad cyson tuag at ddull integredig a chydweithredol o weithio gyda chydweithwyr o amryw o asiantaethau a grwpiau proffesiynol er mwyn cefnogi iechyd a llesiant i bobl Cymru. Maent yn cydnabod eu swyddogaeth hanfodol wrth wella canlyniadau i bobl Cymru a chyflawni'r nodau cyfoes ar gyfer iechyd a gofal yng Nghymru, bob awr o'r dydd yn ystod oriau gwaith a thu allan i oriau gwaith.

Y diffiniad o nyrsio yw defnyddio barn glinigol wrth ddarparu gofal i alluogi pobl i wella, cynnal neu adfer iechyd, ymdopi â phroblemau iechyd, a chyflawni'r ansawdd bywyd gorau posibl ni waeth beth fo'u hafiechyd neu anabledd, hyd eu marwolaeth (RCN, 2014). Nid yw'r diffiniad hwn yn fwy perthnasol gynhwysfawr na mewn lleoliadau gofal sylfaenol a chymunedol.

Y gweithlu nyrsio gofal sylfaenol a chymunedol yng Nghymru

Mae'r RCN eisoes wedi cofnodi ei bryderon am y diffyg data cywir a chadarn ar y gweithlu nyrsio gofal sylfaenol a chymunedol (RCN Cymru, 2018) ac mae Llywodraeth Cymru wedi ymdrechu i fynd i'r afael â hyn. Fodd bynnag, ceir anawsterau o hyd wrth geisio cael gafael ar wybodaeth ddibynadwy am y gweithlu hwn.

Mae Datganiad Ystadegol Cyntaf Llywodraeth Cymru (SFR 21/2019) yn nodi bod 42% o'r holl staff a gyflogir yn uniongyrchol gan y GIG yng Nghymru yn nyrsys, ymwelwyr iechyd neu fydwragedd. Dengys hyn bod angen mynd i'r afael â chyfraniad nyrsio at 'Cymru Iachach'.

Nid yw'r SFR 21/2019 yn cynnwys nyrsys practis a gyflogir gan y 462 o gontractwyr meddygfeydd meddygon teulu annibynnol yng Nghymru (Bwletin Ystadegol: SB 25/2016). Mae swyddogaethau nyrsio yn cynyddu ym maes ymarfer cyffredinol, oherwydd anawsterau o ran recriwtio a chadw meddygon teulu; felly mae'n synhwyrol tybio bod o leiaf un swydd nyrs ym mhob practis, ond mae fel arfer yn dîm sy'n cynnwys cynorthwywyr gofal iechyd, nyrsys practis cyffredinol ac uwch-ymarferwyr nyrsio.

Mae SFR 21/2019 yn nodi bod 581 o Nyrsys Ardal yng Nghymru. Fodd bynnag, mae'r Prif Swyddog Nyrsio ar gyfer Egwyddorion Nyrsio Ardal Dros Dro Cymru (2017) yn amlinellu y dylai fod gan bob tîm nyrsio ardal nifer o staff heb fod yn fwy na 15 aelod staff/12 cyfwerth ag amser llawn. Bydd y tîm hwn fel arfer yn cynnwys dwy Nyrs Ardal â chymhwyster cydnabyddedig y Cyngor Nyrsio a Bydwreigiaeth (Cymhwyster Ymarferydd Arbenigol) a thîm o ryw 10 o Nyrsys Cymunedol.

Mae'r RCN yn argymell ar gyfer ardal maint cyfartalog â phoblogaeth o 50,000 o blant, bod angen o leiaf 20 o nyrsys cymunedol plant cyfwerth ag amser llawn i ddarparu gwasanaeth nyrsio cymunedol cyfannol i blant, yn ogystal ag unrhyw blentyn unigol y mae angen iddo gael buddsoddiad gofal parhaus penodol. Ar gyfartaledd, mewn tîm Nyrsio Cymunedol Plant ni ddylai'r gymhareb leiaf o nyrsys cofrestredig i staff anghofrestredig fod yn llai na 70:30 y cant, a dylai isafswm o 25 y cant o'r nyrsys cofrestredig fod yn nyrsys cymunedol plant sydd wedi cwblhau rhaglen addysg a datblygiad cymunedol cydnabyddedig (RCN, 2013) Mae adolygiad a gynhaliwyd yn 2017 yn awgrymu bod gennym ryw hanner o'r niferoedd a argymhellir yng Nghymru, sy'n cynnwys cefnogi plant ag anghenion gofal parhaus.

Dulliau

Mae RCN Cymru yn cyflwyno'r adroddiad hwn, sy'n amlinellu llawer o drafodaethau rhwng ymarferwyr arbenigol a sefydliadau sy'n ymwneud â darparu cymorth nyrsio gofal sylfaenol a chymunedol i bobl Cymru. Mae'r Fforwm Nyrsys Ardal Cymru Gyfan a Fforwm Nyrsys Gofal Sylfaenol Cymru Gyfan wedi mynd i'r afael â chyfraniad nyrsys gofal sylfaenol, ardal a chymunedol at 'Cymru Iachach' a'r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru. Cyflwynir eu safbwyntiau ar y cyd yma.

Cynhaliwyd Uwchgynhadledd Nyrsio Gofal Sylfaenol a Chymunedol RCN Cymru ym mis Mehefin 2019. Y nodau oedd:

1. Hwyluso trafodaeth broffesiynol ar gyfraniad presennol nyrsys gofal sylfaenol a chymunedol a'u cyfraniad yn y dyfodol i gyflawni agenda Cymru Iachach a'r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru.
2 Darparu cymorth a chefnogaeth i Lywodraeth Cymru, Addysg a Gwella Iechyd Cymru (AaGIC) a rhanddeiliaid eraill i ddatblygu'r rhaglen i gyflawni'r Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru.

Ymrwymiadau Nyrsio Gofal Sylfaenol a Chymunedol

Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsio; ymyriadau therapiwtig a gofal personol, gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol.

Mae nyrsys cymunedol ac ardal yn disgrifio eu hunain yn "gyffredinolwyr arbenigol". Mae hyn wedi bod yn thema gyffredin mewn trafodaethau yn ystod y broses o lunio'r adroddiad hwn. Cefnogir y thema hon gan Barrett, Latham a Levermore (2007) a awgrymodd fod nyrsys ardal yn cynnig model gofal nyrsio cyffredinol i gleifion â phroblemau iechyd ac anghenion cymdeithasol lluosog trwy lunio darlun cyfannol o'r claf a'u hamgylchiadau personol.

Diffinnir cyffredinolrwydd gan Brindle (2011) fel ymrwymiad i barhad gofal wedi ei gyfuno â'r gallu i reoli gwahanol fathau o ofal a chymorth. At hynny, dywed fod y cyffredinolwr yn ystyried iechyd ac afiechyd yng nghyd-destun bywydau ehangach pobl, gan gydnabod a derbyn amrywiaeth eang yn y ffordd y caiff y bywydau hynny eu byw, ac yng nghyd-destun y person cyfan. (Brindle, 2011, t.4) Mae Coleg Brenhinol yr Ymarferwyr Cyffredinol (RCGP) y DU yn cynnig eu diffiniad nhw o gyffredinoliaeth, sef ystyried y person cyfan ac yng nghyd-destun teulu ac amgylchedd cymdeithasol ehangach y person hwnnw; gweithio gyda'r amrywiaeth ehangaf o gleifion a chyflyrau; ymdrin â pharhad gofal pobl ar draws llawer o gyfnodau o afiechyd a thros amser a chydgysylltu gofal ar draws sefydliadau iechyd a gofal cymdeithasol.

Mae'r RCGP a'r Sefydliad Iechyd (2011) yn tynnu sylw at bwysigrwydd diffinio cyffredinolrwydd gyfoes, er mwyn gallu egluro a chynllunio ar gyfer disgwyliadau'r cyhoedd, rhyngweithio proffesiynol a datblygiadau yn y dyfodol. Mae Reeve (2010b) yn awgrymu dull o weithio gyda chleifion sy'n seiliedig ar ddull archwilio sy'n amlygu'r sgiliau dehongli sy'n rhan annatod o swyddogaeth gyffredinol yr ymarferydd cyffredinol. Mae Reeve yn dadlau bod sgiliau o'r fath yn diffinio disgyblaeth unigryw a deallusol.

O ganlyniad i'r gwaith agos a wna nyrsys ardal gyda chleifion a'u teuluoedd yn y cartref, golyga hyn eu bod yn arbenigwyr mewn asesu yr ystod o ffactorau a all ddylanwadu ar glaf ar unrhyw adeg. Mae canlyniadau'r trafodaethau a adroddir yma yn dangos bod hyn yn wir yn achos nyrsys ardal yng Nghymru.

Yn eu swyddogaeth fel pwynt cyswllt cyntaf i bobl, mae nyrsys practis wedi dweud eu bod yn aml yn 'geidwaid pyrth' i ofal iechyd y tu hwnt i ymarfer cyffredinol. Neilltuwyd y teitl hwn yn flaenorol i feddygon teulu. Fodd bynnag, mae i swyddogaeth y nyrs ymarfer cyffredinol a'r uwch-ymarferydd nyrsio mewn ymarfer cyffredinol yn ehangu, ac yn gynyddol y nhw yw'r pwynt cyswllt cyntaf i'r claf. Felly, mae nyrsys ymarfer cyffredinol ac uwch-ymarferwyr nyrsio mewn ymarfer cyffredinol yn ymgymryd ag atgyfeirio cleifion ymlaen, gan gynnwys fel cydgysylltwyr gofal ac i gael asesiad arbenigol gan gydweithwyr eraill. Mae hyn yn dangos dealltwriaeth newydd o bwynt cyswllt cyntaf a 'cheidwad pyrth'. Trwy gydnabod hyn, mae angen dulliau cyfoes o addysgu a chefnogi nyrsys i gyflawni swyddogaethau yn ddiogel ac yn briodol.

Mae nyrsys sy'n gweithio yn y gwasanaeth Gofal Sylfaenol Brys y Tu Allan i Oriau hefyd yn gyffredinolwyr a gellir eu disgrifio fel 'ceidwaid pyrth' i iechyd pan fo meddygfeydd meddygon teulu ar gau. Mae sgiliau brysbennu, sgiliau mân salwch a swyddogaeth yr uwch-ymarferydd nyrsio i gyd wedi'u hymgorffori yn y dull amlddisgyblaeth o ddarparu gofal i gleifion.

Mae'r adroddiad hwn yn cyflwyno'r achos dros gydnabod y swyddogaethau nyrsio gofal sylfaenol a chymunedol cyffredinol a'r angen wedyn i fuddsoddi mewn addysg a chymorth datblygiadol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Wrth adolygu angen claf am y brechiad ffliw blynyddol, bydd y nyrs ymarfer cyffredinol yn trafod a fydd angen cynnig y brechiad ffliw i aelodau eraill y teulu. Er enghraifft, pan fo claf yn dioddef gwrthimiwnedd trwy ymyriad meddygol, bydd angen i aelodau eraill y teulu sicrhau nad ydynt yn dioddef y ffliw a all roi'r unigolyn mewn perygl o haint.

Gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, ac mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth, yn aml fel cydgysylltydd gofal

Un o'r themâu a fu'n gylchol yw'r nyrsys gofal sylfaenol a'r nyrsys cymunedol i gyd yn cydlynu gofal; un ai'n dilyn atgyfeirio i dimau Nyrsys Ardal neu'n uniongyrchol i dimau nyrsys Ymarfer Cyffredinol.

Diffinnir cydlynydd gofal gan Hickam et al (2013 tud.3) fel asiant y claf, gweithredu dull "person cyfan" o ofal yn hytrach na dull sy'n canolbwyntio ar y clinigol neu'r clefyd yn unig, a phontio rhwng y claf, tîm y practis, y system iechyd, ac adnoddau cymunedol".

Nododd cyfranogwyr yr uwchgynhadledd swyddogaeth gydlynu nyrsys gofal sylfaenol a nyrsys cymunedol o'r pwynt pan ofynnwyd am gymorth. Roedd cydnabyddiaeth o'r sgiliau a briodolir i nyrsys gofal sylfaenol a chymunedol, gan arwain at ystod eang o atgyfeiriadau, gan gynnwys rhyddhau claf o'r ysbyty. Cofnodwyd y cysyniad o "ward heb waliau" eisoes (QNI, 2006; Haycock-Stuart et al, 2008). Fodd bynnag, mae hyn yn adlewyrchu realiti arbenigedd nyrsys gofal sylfaenol a chymunedol fel cydlynwyr gofal ar ran cleifion y maent yn eu cyfarfod ac yn eu cefnogi. Mae cydlynu gofal yn cynnwys rheoli anghenion cymhleth y claf, drwy weithio gyda'r holl bersonél sy'n ymwneud ag iechyd, gofal cymdeithasol, gofalwyr ac asiantaethau gwirfoddol.

Wrth nodi ac ymdrin ag anghenion gofal personol, mae nyrsys ardal yn gweithio'n agos â chydweithwyr o sefydliadau partner megis yr awdurdod lleol, gwasanaethau cymdeithasol a'r trydydd sector, i gydweithredu, cydlynu a chyfeirio i gymorth ac adnoddau addas. Mae'r agwedd hon ar swyddogaeth nyrsys ardal yn cyfrannu at sicrhau iechyd a llesiant pobl yn y cartref, yn enwedig ar ôl iddynt gael eu rhyddhau'n gynnar o'r ysbyty ac yn gyfraniad a werthfawrogwyd ers cryn amser.

Mae nyrsys ardal yn disgrifio'u profiadau cyson o gael ceisiadau i ymweld â chartrefi cleifion a gafodd eu rhyddhau o'r ysbyty y canfuwyd eu bod mewn perygl, yn aml oherwydd ystod gymhleth o resymau bioseicogymdeithasol. Er y deallir bod penderfyniadau i ryddhau cleifion o'r fath i alluogi llif yn yr ysbyty yn cael eu gwneud, mae'n rhaid deall bod angen y gydnabyddiaeth, y gefnogaeth a'r adnoddau ar nyrsys ardal i gydlynu gwasanaethau sy'n osgoi argyfwng ac ailsefydlu diogelwch i unigolion o ran iechyd a llesiant yn y cartref.

Mae gwasanaethau nyrsio gofal sylfaenol a chymunedol yn addas iawn ar gyfer dull o weithredu gofal yn seiliedig ar le, pan fo cysylltiad rhwng gwasanaethau lleol i alluogi pobl i gael gofal yn agos at eu cartrefi a'u cymunedau. Dyma'r ffordd hanesyddol o weithio. Serch hynny, byddai buddsoddi i ddatblygu'r gwasanaethau hyn ymhellach yn arwain at fwy o gyfleoedd i wella gofal y claf yn ei gartref.

Mae nyrsys ardal a nyrsys plant cymunedol yn ddolen gyswllt allweddol rhwng iechyd a gwasanaethau cymdeithasol oedolion a phlant ac mae ganddynt ran bwysig i'w chwarae yn cydlynu gwasanaethau rhwng asiantaethau iechyd a gofal partner sy'n fynych yn ymwneud ag ymateb i anghenion asesedig claf. Nyrsys o'r fath yw'r cydlynwyr gofal delfrydol ar gyfer anghenion bioseicogymdeithasol unigolion o fewn cyd-destun cymunedol gofal yng Nghymru.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae'r nyrs plant gymunedol yn cefnogi'r gwasanaeth oncoleg allgymorth i ddarparu gofal a rennir i blant sydd â diagnosis o ganser. Bydd y nyrs plant gymunedol yn gweld y plentyn a'r teulu yn wythnosol i reoli'r llinell ganolog a thynnu gwaed, cysylltu â'r ganolfan drydyddol a nyrsys arbenigol pan fo angen. Yn achos plant â diagnosis o Lewcemia Lymffoblastig Acíwt, mae hon yn daith hir dros gyfnod o 3-4 blynedd ac mae'r nyrsys plant cymunedol yn meithrin perthynas gref gyda theuluoedd.

Mae nyrsys practis yn defnyddio egwyddorion gofal iechyd darbodus wrth gyfeirio pobl i'r gweithiwr proffesiynol mwyaf perthnasol i gefnogi eu hanghenion. Yn aml bydd hyn i asiantaethau ac adnoddau megis X-pert (diabetes), Rhaglen Cleifion Arbenigol (EPP), podiatreg, iechyd rhywiol, adsefydlu cleifion yr ysgyfaint, adsefydlu cardiaidd, Timau Adnoddau Cymunedol, gwasanaethau eiddilwch, timau ymateb aciwt, 'rhagnodwyr cymdeithasol', 'cysylltwyr cymunedol' a llawer mwy.

Ym maes Gofal Sylfaenol Brys y Tu Allan i Oriau

(OOH) mae nyrsys yn gweithio o fewn tîm amlddisgyblaethol; yn brysbennu cleifion, rhoi cyngor ynghylch hunanofal, cynnal ymgynghoriad wyneb yn wyneb mewn canolfan gofal sylfaenol, trefnu ymweliad cartref, neu atgyfeirio a chyfeirio i'r gweithiwr iechyd gofal proffesiynol mwyaf perthnasol i gefnogi eu hanghenion, gan gynnwys fferyllydd, optegydd neu ofal eilaidd arbenigol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

- **Fel rhan o adolygiad Clefyd Rhwystrol Cronig yr Ysgyfaint (COPD), mae Nyrsys Ymarfer Meddygol sydd wedi eu lleoli yng Nghaerdydd a'r Fro yn asesu sgôr diffyg anadl claf, ac yn seiliedig ar hyn, yn cydlynu cefnogaeth o'r cwrs adsefydlu cleifion yr ysgyfaint lleol. Mae hwn yn gwrs 6 wythnos pan gefnogir y claf gan ffisiotherapyddion, therapyddion galwedigaethol, cynghorwyr rhoi'r gorau i ysmygu a maethegwyr i wella iechyd a llesiant.**
- **Gan gydnabod y gall cael diagnosis o ddiabetes Math 2 fod yn brofiad brawychus, mae nyrsys practis yn cydlynu cefnogaeth o'r rhaglen X-pert. Mae hon yn rhaglen 6 wythnos, sy'n cael ei rhedeg gan ddeietegwyr cymunedol, ac sydd wedi ei chynllunio i roi gwybodaeth a dealltwriaeth ynghylch diabetes i unigolion ac i roi gwybodaeth ynghylch sut i reoli eu hiechyd eu hunain. Yn ardaloedd Caerdydd a'r Fro caiff hyn ei gyflwyno bellach i gynnwys cyfieithwyr ar gyfer y cymunedau ethnig anodd eu cyrraedd a chaiff ei gynnig hefyd mewn cyfarfodydd gyda'r nos i'w gwneud hi'n haws i ddiwallu anghenion y boblogaeth sy'n gweithio**
- **Mae nyrsys practis yng Nghlwstwr De-ddwyrain Caerdydd a'r Fro yn cydlynu cefnogaeth i bobl sy'n ynysig, drwy eu cyflwyno i 'grwpiau garddio lleol'.**

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae nyrsys ardal wedi chwarae rhan allweddol wrth ddatblygu cyfarfod ward rithwir/tîm amlddisgyblaethol wythnosol wedi ei leoli yn y gymdeithas o fewn Casnewydd. Un enghraifft o sut y mae'r ward rithwir wedi cefnogi anghenion claf unigol: Roedd nyrs ardal yn poeni bod iechyd a llesiant unigolyn yn dirywio ac roedd yn credu y byddai adnodd cyfunol y ward rithwir yn helpu i osgoi argyfwng. Yn ogystal ag anawsterau biofeddygol, roedd yn ymddangos bod heriau seicolegol heb eu trin, ynysu cymdeithasol, cartref mewn cyflwr gwael, dim bwyd yn yr oergell, a gwendidau cyffredinol yn effeithio ar allu'r unigolyn i wneud dewisiadau. Canolbwyntiodd y ward rithwir/tîm amlddisgyblaethol ar y ffaith fod yr unigolyn yn cyfranogi llai o ran hunanofal a thriniaethau a awgrymwyd, ac roedd hyn yn arwain at bryderon ynghylch ei allu i aros gartref yn ddiogel.

Yn dilyn asesiad nyrsio a chymdeithasol, cydweithredol, a chymhleth yn feddygol, y prif nod oedd gwella iechyd a llesiant meddygol a seicolegol, ochr yn ochr â gwelliannau i amgylchedd cartref yr unigolyn. Gweithiodd y tîm amlddisgyblaethol gyda'i gilydd i ddatblygu syniadau a chynllun gofal gan gynnwys adolygiad hunan wirfoddol dan arweiniad fferyllydd o feddyginiaeth a chymorth gan bersonél Llwybr Pobl Hŷn.Arweiniodd trafodaeth unigol y ward rithwir/y tîm amlddisgyblaethol at yr unigolyn yn cymryd rhan weithredol unwaith eto mewn cynllun gofal a gytunwyd ar y cyd i gefnogi ei broblemau meddygol a seicolegol, ynghyd â defnyddio dodrefn a chyfarpar i helpu gydag anawsterau symudedd. A'i hwyliau'n well teimlai'r unigolyn y gallai dderbyn cymorth a chwmnïaeth cymydog.

Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol.

Nyrsys ardal a chymunedol yw'r grŵp iechyd proffesiynol sy'n treulio'r amser mwyaf gyda chleifion a'u teuluoedd, cymunedau a rhwydweithiau cymdeithasol. Felly maent yn y sefyllfa orau i ddeall cyd-destun gofal pob unigolyn, wrth fabwysiadu model gofal cyfannol a bioseicogymdeithasol, yn hytrach na model biolegol/meddygol yn unig.

Pwysleisiodd nyrsys ardal a chymunedol eu harbenigedd ym maes asesu claf yn gyfannol. Pwysleisiodd nyrsys ar bob lefel y rhan y maent yn ei chwarae wrth ddiwallu anghenion cymhleth unigolyn drwy gymryd agwedd gyfannol tuag at fywyd ac amgylchiadau'r unigolyn hwnnw. Ystyriwyd bod cael perthynas agos â chleifion, eu teuluoedd a'u gofalwyr yn hanfodol i gefnogi gallu'r unigolyn i aros yn ddiogel gartref. Adroddodd nyrsys gofal sylfaenol a nyrsys cymunedol am eu swyddogaeth fel negodwyr a chyfryngwyr i gleifion, teuluoedd a'r ddynameg sy'n gysylltiedig â bywyd teulu, yn aml drwy ddefnyddio cyfathrebu medrus i gynorthwyo sgyrsiau pwysig a sensitif ynghylch penderfyniadau iechyd a gofal.

Mae nyrsys practis yn canolbwyntio ar gysylltiadau teuluol wrth ddod i gysylltiad â chleifion, sy'n arwain at ystyried anghenion cyfannol. Er enghraifft, ystyried effaith iechyd a llesiant teulu ar gyflwr hirdymor unigolyn, megis asthma neu feddyginiaeth wrthimiwnedd.

Mae hyn yn cyd-fynd â'r term llafar modern "yr hyn sy'n bwysig" i'r unigolyn sydd angen cefnogaeth. Mae'n enghraifft ardderchog o'r sgiliau sy'n bodoli a'r dulliau gweithredu y mae nyrsys gofal sylfaenol a chymunedol yn ymgymryd â nhw, gan, ar yr un pryd, ymdrin â ffordd gyfoes o feddwl am gefnogaeth iechyd a gofal i bobl Cymru. Mae nyrsys gofal sylfaenol a chymunedol eisoes yn ymarfer o fewn y fframwaith hwn ac maent mewn sefyllfa dda i barhau i wneud hynny. Serch hynny, byddai'n gamgymeriad peidio â rhoi'r gydnabyddiaeth ac adnoddau digonol sydd eu hangen i wneud hyn yn iawn, gan gynnwys amser digonol a chefnogaeth addysgol.

Gwasanaethau nyrsys plant cymunedol yw sylfaen llwybrau gofal pob plentyn sydd angen cefnogaeth nyrsio y tu allan i'r ysbyty. Gellir rhannu'r rhain yn bedwar grŵp:

- Plant â chyflyrau acíwt a thymor byr;
- Plant â chyflyrau hirdymor;
- Plant ag anableddau a chyflyrau cymhleth, yn cynnwys y rhai sydd angen gofal parhaus a phlant newydd-anedig; a
- Phlant ag afiechyd sy'n cyfyngu ar fywyd ac afiechyd sy'n bygwth bywyd, gan gynnwys y rhai sydd angen gofal lliniarol a gofal diwedd oes.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae nyrs plant gymunedol yn chwarae rhan ganolog yn y broses o reoli rhyddhau plant ag anghenion meddygol a nyrsio cymhleth. Er enghraifft asesiad o fabi cyfnod llawn yn dilyn trawma sylweddol adeg yr enedigaeth yn dangos bod angen ei fwydo drwy diwb nasogastrig, a bod angen ocsigen a sugnad. Bydd y nyrs plant gymunedol yn bresennol mewn cyfarfodydd cynllunio rhyddhau, dechrau unrhyw asesiadau gofal parhaus, cysylltu â gwasanaethau cymdeithasol a chefnogi anghenion hyfforddi'r rhieni. At ôl i'r plentyn gael ei ryddhau bydd y nyrs plant gymunedol yn ymweld mor aml ag sydd ei angen i sicrhau bod anghenion y plentyn yn cael eu diwallu a bod y rhieni yn cael cefnogaeth. Mae hyn i gyd yn erbyn cefndir o gefnogi proses alaru'r rhieni sy'n gorfod dygymod â realiti cefnogi babi ag anghenion sylweddol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Gan ddefnyddio dull o weithredu Care Aims (Malcomess, 2005) "rhesymu, gwneud penderfyniadau, rheoli risg ac ymarfer myfyriol", mae nyrsys ardal yng Nghasnewydd wedi nodi cynnydd medwn hyder ac effeithiolrwydd wrth weithio gyda chleifion unigol tuag at hunanreoli lle bo'n bosibl. Mae defnyddio fframwaith Care Aims yn helpu i hwyluso sgyrsiau am yr hyn sy'n bwysig i gleifion unigol a'u teuluoedd/gofalwyr, mewn ffyrdd na chawsant eu harchwilio o'r blaen.

Mae nyrsys ardal yn nodi bod hyn yn helpu i ganfod disgwyliadau, boddhad a'r rhan y mae cleifion a theuluoedd yn ei chwarae o ran gofal a chefnogaeth, O'r blaen byddai dibyniaeth ar gefnogaeth broffesiynol wedi ei rhagdybio a'i derbyn. Cafodd cyflwyno'r ffordd newydd hon o weithio ei disgrifio fel "y peth gorau imi ei ddysgu erioed yn ystod fy holl yrfa nyrsio", ac mae wedi helpu i gynyddu sgiliau ac ehangu gwybodaeth er mwyn gweithio'n wahanol gyda phobl yn eu cartrefi eu hunain. Mae hon yn enghraifft weithredol o wireddu nyrsio cymunedol cyfoes Gofal Iechyd Darbodus i gyflawni iechyd a llesiant, gyda'r cyhoedd a'r cleifion yn bartneriaid cyfartal.

Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.

Mae nyrsys gofal sylfaenol a chymunedol yn helpu pobl i reoli eu cyflyrau aciwt a hirdymor, gan gynnwys canser, asthma, diabetes, clefyd rhwystrol cronig yr ysgyfaint, wlseri ar y goes a phroblemau iechyd meddwl. Gwyddys bod cydafiachedd o'r fath yn gysylltiedig â chanlyniadau iechyd gwaeth a chostau gofal iechyd uwch yn ogystal â rheoli neu ofalu mwy cymhleth (Valderas, 2009). Drwy ryngweithio gyda chleifion, mae nyrsys practis yn darparu agweddau mawr ar y contract ar gyfer gwasanaethau meddygol cyffredinol

Mae'r ystod o ffyrdd y mae nyrsys practis yn rhan o'r broses rheoli cyflyrau hirdymor yn amrywio Mae'n cynnwys adolygu cyflwr, helpu gyda thechneg cyfarpar, cynlluniau hunanreoli, dechrau cymryd meddyginiaeth, optimeiddio ac addasu, rhoi addysg i bobl allu rheoli meddyginiaethau gartref megis 'pecynnau achub' ar gyfer clefyd rhwystrol cronig yr ysgyfaint.

Caiff plant â chyflyrau hirdymor eu cefnogi'n aml gan nyrs glinigol arbenigol (fel yn achos diabetes, cyflyrau anadlol, epilepsi, cyflyrau endocrin ac ymataliaeth) ynghyd â nyrs plant mewn lleoliad cartref neu gymunedol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

- **Mae nyrsys diabetes arbenigol yn gweithio gyda nyrsys practis i helpu i ddarparu gofal arbenigol i bobl â diabetes a fyddai o'r blaen yn gorfod mynd i'r ysbyty i gael therapi inswlin. Mae hyn yn golygu nad oes raid i bobl deithio i ysbyty prysur ac aros mewn clinig cleifion allanol i gael gofal arbenigol. Mae hefyd yn golygu y gall pobl elwa ar gymysgedd o ddulliau arbenigol a chyffredinol o ran eu hiechyd a'u llesiant, yng nghyd-destun eu bywyd, teulu a chymuned.**
- **Mae nyrsys practis yn cysylltu â'r gwasanaeth gwella clwyfau lleol am asesiad arbenigol a chynllunio gofal ar gyfer clwyfau cymhleth cyn i'r unigolyn ddychwelyd at gefnogaeth a gofal o dan ymarfer cyffredinol. Mae'r dysgu ar y cyd hwn gyda nyrsys hyfywedd meinwe yn golygu bod nyrsys practis yn cynnal cynllun gofal unigol ar gyfer clwyf cymhleth, gyda mwy o hyder a chymhwysedd, ac ar yr un pryd yn sicrhau dilyniant gofal ar draws y Tîm Amlddisgyblaethol.**

Tabl 2: Swyddogaeth y tîm nyrsio ymarfer cyffredinol (GPN) wrth gyflawni elfennau Gwasanaethau Meddygol Cyffredinol (GMS) Contract Ymarferydd Cyffredinol (GP)

Gwasanaethau hanfodol a ddarperir gan ymarfer meddygol (GMS)	Enghraifft o swyddogaeth GPN
Rheoli cleifion sy'n wael neu'n sy'n credu eu bod yn wael gyda chyflyrau y disgwylir yn gyffredinol y ceir adferiad ohonynt	Gwasanaethau mân anhwylderau a mân anafiadau dan arweiniad GPN, yn enwedig nyrs sy'n rhagnodi'n annibynnol ac Uwch Ymarferydd Nyrsio
Rheoli afiechyd cronig	Gwasanaeth dan arweiniad GPN, yn enwedig nyrs sy'n rhagnodi'n annibynnol
Gwasanaethau sgrinio	Gwasanaeth dan arweiniad GPN ar gyfer sytoleg serfigol. GPN yn cynorthwyo ar gyfer gwasanaethau sgrinio cenedlaethol am ganser y coluddyn a chanser y fron, retinopathi diabetig, ymlediad aortaidd
Brechu ac imiwneiddio	Gwasanaethau dan arweiniad GPN ar gyfer rhaglenni imiwneiddio cenedlaethol (targed haen 1), yn cynnwys y ffliw, yr eryr, niwmococol, llid yr ymennydd, pertwsis adeg beichiogrwydd, a'r amserlen brechu plant. Mae hefyd yn cynnwys imiwneiddio cyn teithio ar gyfer hepatitis A, DTP a Teiffoid
Arolygu iechyd plant	GPN yn cyfeirio i'r Tîm Gofal Sylfaenol (PHCT)
Gwasanaethau atal cenhedlu	Dan arweiniad neu gyda chymorth GPN e.e. gosod dyfais atal cenhedlu yn y groth (IUCD), gosod a thynnu Nexplanon, Depo-Provera, pils atal cenhedlu trwy'r geg, yn enwedig nyrs sy'n rhagnodi'n annibynnol
Gwasanaethau mân lawdriniaeth	Gyda chymorth GPN
Mae meysydd y QOF/Fframwaith Sicrwydd Ansawdd a Gwelliant (QAIF) yn cynnwys:	
Clinigol – mae gan y maes hwn ddangosyddion ar draws gwahanol feysydd clinigol e.e. Clefyd Coronaidd y Galon (CHD), methiant y galon, asthma, COPD a phwysedd gwaed uchel.	Fel arfer dan arweiniad GPN

Mae Tabl 2 yn dangos sut y mae cyflawni 2 ardal graidd contract y gwasanaethau meddygol cyffredinol (gwasanaethau hanfodol a'r Fframwaith Ansawdd a Chanlyniadau (QOF) yn ddibynnol ar gyfraniad nyrsys sy'n gweithio mewn ymarfer cyffredinol.

Dywedodd adolygiad Cochrane (Laurant et al, 2018) "ar gyfer cyflyrau cronig (hirdymor), yn ôl pob tebyg mae nyrsys hyfforddedig, megis ymarferwyr nyrsio, nyrsys practis, a nyrsys cofrestredig, yn darparu ansawdd gofal cydradd neu o bosibl, gofal o ansawdd gwell hyd yn oed o'i gymharu â meddygon gofal sylfaenol, ac yn ôl pob tebyg yn cyflawni canlyniadau iechyd cydradd neu well ar gyfer cleifion".

Nid oes raid i hyn gael ei gyfyngu i gyswllt ar sail llawdriniaeth. Er enghraifft, mae nifer cynyddol o nyrsys practis yn cefnogi pobl â chyflyrau hirdymor sy'n methu â mynd i'r feddygfa, drwy ymweld â nhw. Mae hyn yn sicrhau tegwch o ran darparu gwasanaethau i bobl sy'n gaeth i'r tŷ, pobl nad ydynt yn cael gwasanaethau nyrsys ardal, ac a fyddent fel arall ar eu colled gan nad ydynt yn gallu manteisio ar y ddarpariaeth o wasanaethau sydd eisoes ar gael.

Yn aml caiff plant â chyflyrau hirdymor eu rheoli gan nyrs glinigol arbenigol ynghyd â'r nyrs plant gymunedol (CCN) yn y lleoliad cymunedol.

Mae plant a phobl ifanc â chyflyrau hirdymor eisiau byw bywyd sydd mor normal â phosibl; fodd bynnag, yn aml mae rhywbeth yn tarfu ar eu bywyd bob dydd, yn enwedig colli ysgol ar gyfer apwyntiad ysbyty neu oherwydd bod eu cyflwr yn gwaethygu. Mae gofal iechyd lle mae'r unigolyn yn ganolog yn helpu plant a phobl ifanc i gyflawni eu nodau a diwallu eu hanghenion ehangach. Er enghraifft, drwy gael gwasanaeth nyrs plant gymunedol mewn cydweithrediad â thîm nyrsio'r ysgol, gall plentyn gael cynllun iechyd unigol. Mae hyn yn ei alluogi i ddysgu sut i reoli ei salwch a'r driniaeth, er mwyn adnabod arwyddion cynnar

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae Nyrs Ymarfer Cyffredin yn ymgymryd ag adolygiad blynyddol o ofal a rennir ar gyfer pobl sy'n byw ag Arthritis Gwynegol. Mae hyn yn cynnwys; ymgymryd â Sgoriau Gweithgaredd Clefyd a sgorio Osteoporosis; adolygu a thrafod rheoli meddyginiaeth ar bresgripsiwn; sicrhau bod lefelau gwaed DMARD yn cael eu monitro ar gyfnodau a argymhellir; cyfeirio at sgan DEXA pan fo'n briodol; cynnig cyngor hybu iechyd ynghylch lleihau'r risg o anhwylderau cardiofasgwlaidd.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Y Nyrs Ymarfer Cyffredin yw'r gweithwyr iechyd proffesiynol sydd fel arfer yn cynnal profion sbirometreg yn y gymuned fel prawf diagnostig ar gyfer COPD. Fel arfer y Nyrs Ymarfer Cyffredin sy'n gyfrifol am ddehongli canlyniadau prawf sbirometreg ac yna cyfleu'r canlyniadau i bobl ac egluro'r cyflwr hirdymor hwn sy'n ddiwrthdro. O gychwyn siwrne'r claf, mae'r Nyrs Ymarfer Cyffredin yn cydlynu ac yn hwyluso; diagnosis; rheoli meddyginiaethau; dewis anadlydd; atgyfeirio i ofal eilaidd ac adsefydlu cleifion yr ysgyfaint; cefnogi rhoi'r gorau i ysmygu; cefnogaeth bersonol ac emosiynol; adnabod dirywiad yn iechyd yr ysgyfaint, trefnu gwasanaethau trydydd sector; a chynnal trafodaethau ynghylch diwedd oes gyda phobl a'u teuluoedd.

Nid yw'r gwasanaeth hwn sy'n hygyrch yn lleol yn cael ei ddarparu mor hyblyg mewn lleoliadau gofal eilaidd ac mae'n hanfodol bod y cleifion hyn yn cael eu cefnogi yn eu cymunedau eu hunain cyhyd â phosibl. Mae pobl â COPD yn cael canlyniadau gwaeth ar ôl cael eu derbyn i'r ysbyty. Felly mae hwyluso gofal di-dor, lleol a chyfannol yn y gymuned yn helpu cleifion i fyw bywyd iachach, gartref, cyhyd â phosib.

Mae'r Nyrs Ymarfer Cyffredin yn darparu amrywiaeth eang o wasanaethau atal cenhedlu i fenywod, drwy bractis cyffredinol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Dangosodd data poblogaeth llawer o achosion o feichiogrwydd anfwriadol ymysg pobl ifanc yn eu harddegau o fewn practis meddyg teulu. I ehangu'r dewisiadau ar gyfer atal cenhedlu hirdymor, cafodd Nyrsys Ymarfer Cyffredin hyfforddiant achrededig er mwyn cynnig gwasanaeth gosod a thynnu dyfeisiadau IUD/IUS a Nexplanon. Mae'r Nyrsys Ymarfer Cyffredin nawr yn cynnig apwyntiadau wythnosol yn y practis ac maent wedi diwallu anghenion cleifion yn llwyddiannus sydd wedi arwain at lai o alw am wasanaethau bydwreigiaeth. Yn bwysicach, mae'r fenter hon, sydd wedi ei lleoli yn y practis, wedi cynnig gwell dewis a gwasanaethau atal cenhedlu sy'n hawdd cael gafael arnynt.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Gan gydnabod bod 30% o apwyntiadau ym maes ymarfer cyffredinol yn ymwneud â phryderon ynghylch iechyd meddwl, mae gwasanaeth newydd yn cael ei gyflwyno i bob practis meddyg teulu Bwrdd Iechyd Prifysgol Caerdydd a'r Fro, er mwyn i gleifion ei chael hi'n hawdd mynd at nyrsys iechyd meddwl ar gyfer nifer o bryderon, sy'n amrywio o fethu cysgu i gefnogaeth adeg galar. Mae cleifion yn gallu cael gwasanaeth nyrsys iechyd meddwl drwy eu dewis nhw fel y pwynt cyswllt cyntaf, yn hytrach na gweld meddyg teulu yn gyntaf. Mae hyn yn helpu i wella'r dewis o ran cael gafael ar aelodau priodol o'r tîm gofal sylfaenol.

Mae nyrsys yn adnodd allweddol a ddefnyddir yn y gwasanaeth Gofal Sylfaenol Brys y Tu Allan i Oriau. Maent yn gweithio yn rhan o dîm amlddisgyblaethol (MDT) yn darparu gofal i gleifion ag anghenion gofal iechyd brys pryd nad ellir aros i'w practis meddyg teulu ailagor. Yn ystod y blynyddoedd diweddar mae Gwasanaeth Gofal Sylfaenol Brys y Tu Allan i Oriau wedi symud o weithlu ymarfer cyffredinol yn unig i ddull tîm amlddisgyblaethol. Mae ymarferion gallu a galw diweddar wedi dangos mai model 60:40 mwy cynaliadwy (60% MDT, 40% GP) y mae angen i'r gwasanaethau y Tu Allan i Oriau anelu ato yn eu cynlluniau gweithlu.

Ymarferydd Brysbennu y Tu Allan i Oriau:

Mae'r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at o leiaf lefel BSc (gradd) ac fel arfer mae ganddyn nhw gefndir o weithio yn un neu fwy o'r meysydd gofal canlynol: ymarfer meddygol, cymunedol, gwasanaeth ambiwlans Cymru neu adran Damweiniau ac Achosion Brys (A+E). Maent yn ymgymryd â brysbennu dros y ffôn gan ddefnyddio templedi gwneud penderfyniadau sy'n helpu i frysbennu cleifion yn ddiogel drwy ymgynghoriad dros y ffôn. Gallant roi cyngor ar hunanofal, cyfeirio i wasanaethau amgen (yn cynnwys ambiwlans, A+E, eu meddyg teulu) neu gyfeirio cleifion i'r canolfannau gofal sylfaenol ar gyfer ymgynghoriad clinigol a fydd yn cael ei gynnal gan feddyg teulu, Ymarferydd Clinigol neu Ymarferydd Mân Salwch Gallant weithio ar eu pen eu hunain ond cânt eu cefnogi o fewn y gwasanaeth y tu allan i oriau gan yr Ymarferwyr Clinigol neu Feddygon Teulu. Mae pob un o'r ymarferwyr hyn yn brysbennu cleifion sy'n 3 oed a hŷn.

Ymarferydd Mân Salwch y Tu Allan i Oriau:

Mae'r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at o leiaf lefel BSc (gradd) ac wedi cwblhau cymhwyster diploma ychwanegol mewn Mân Salwch. Gallant gynnal ymgynghoriadau gyda chleifion â symptomau mân salwch yn unig. Gallant weithio ar eu pen eu hunain ond cânt eu cefnogi yn y gwasanaeth y tu allan i oriau gan Ymarferwyr Clinigol neu Feddygon Teulu. Mae pob un o'r ymarferwyr hyn yn gweld cleifion 5 oed a hŷn. Mae gan rai o'r nyrsys hyn gymhwyster Rhagnodi Annibynnol, sy'n eu galluogi i gynhyrchu a llofnodi presgripsiynau; tra bo'r rhai nad ydynt yn Rhagnodi Annibynnol yn defnyddio Cyfarwyddiadau Grwpiau Cleifion (PGD) i'w galluogi i weinyddu o'r fferyllfa y tu allan i oriau.

Ymarferydd Clinigol y Tu Allan i Oriau:

Mae'r nyrsys neu barafeddygon hyn wedi eu hyfforddi hyd at lefel MSc (Meistr) ac maent naill ai'n Uwch-ymarferydd Nyrsio neu'n Uwch-ymarferydd Parafeddygol. Gallant gynnal ymgynghoriadau awtonomaidd a gallant asesu, rhoi diagnosis, trin/rhagnodi a chyfeirio ymlaen i weithwyr gofal iechyd proffesiynol eraill fel y bo'r galw. Mae ganddyn nhw hawliau derbyn sy'n eu galluogi i gyfeirio i'r system gofal eilaidd gan gynnwys meddygaeth, llawdriniaeth, Clust, Trwyn a Gwddf (ENT), uned asesu plant (dros 5 oed), ac A+E. Os oes angen cefnogaeth gallent alw un o'u cydweithwyr ymarfer cyffredinol y tu allan i oriau. Mae pob un o'r ymarferwyr hyn yn gweld cleifion 5 oed a hŷn. Mae gan rai o'r nyrsys gymhwyster Rhagnodi Annibynnol sy'n eu galluogi i gynhyrchu a llofnodi presgripsiynau ac mae'r parafeddygon ar hyn o bryd yn defnyddio PGD i'w galluogi i weinyddu o'r fferyllfa y tu allan i oriau.

Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth
Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr, triniaeth a chanlyniadau

Gan ddefnyddio dealltwriaeth fioseicogymdeithasol o iechyd, mae **cyflyrau cymhleth** yn cyfeirio at bresenoldeb anhwylderau iechyd lluosog neu'r ymadwaith rhwng dau anhwylder iechyd neu fwy. **Diffinnir angen cymhleth** fel rhywbeth sy'n ymwneud â chleifion y mae eu hanghenion yn amlffactoraidd, yn gorgyffwrdd ac yn amrywio o ran symptomau o unigolyn i unigolyn. Mae ffactorau cyfrannol yn fiolegol, seicolegol neu'n gymdeithasegol o ran natur; gan gynnwys cyflyrau hirdymor (cronig), cydafiachedd, heneiddio, eiddilwch, yn ymwneud ag iechyd seicolegol neu feddyliol, ac amgylchiadau cymdeithasol neu deuluol. Gall fod yn ofynnol i unigolyn ag angen cymhleth gael cefnogaeth gwasanaethau iechyd a gwasanaethau cymdeithasol.

Ynghyd â'r newid yng ngofal sylfaenol a newidiadau demograffig ym mhroffil oedran a chlefyd, dywedir fod cleifion bellach angen gofal am gyflyrau cymhleth gartref (Sefydliad Nyrsio'r Frenhines, 2011) neu fod gan gleifion gartref fwy o angen gofal cymhleth (Coleman, 2003; Cronfa'r Brenin, 2012a; Yr Adran Iechyd, 2013). Felly, bydd yn fwy tebygol y bydd cleifion wedi eu lleoli yn y gymuned ag anghenion cymhleth (Cronfa'r Brenin, 2012b).

Mae angen i luosogrwydd a chymhlethdod anghenion cleifion wedi eu lleoli yn y gymuned gael ei ddisgrifio fel "care quake" (Yr Adran Iechyd, 2010) ac mae nyrsys gofal sylfaenol a nyrsys cymunedol yn ganolog er mwyn diwallu anghenion o'r fath. Hefyd, mae amgylchedd iechyd a gofal cymdeithasol cyfoes yn gymhleth, sydd yn gofyn am wybodaeth, sgiliau a hyder i negodi er lles cleifion a theuluoedd.

Mae nyrsys gofal sylfaenol a chymdeithasol yn adrodd am yr angen i gynnal cyfres eang ac amrywiol o sgiliau i gyflawni gofal clinigol arbenigol a lleihau derbyniadau ysbytai y gellir eu hosgoi. Mae cymysgfa gynyddol o gyfarpar meddygol sydd hefyd yn gynyddol soffistigedig yn cael ei defnyddio yn y cartref, ac mae angen i nyrsys ardal a nyrsys cymunedol fod yn gyfarwydd â'r rhain a bod yn brofiadol wrth eu defnyddio. Mae'r arbenigedd hon yn galluogi cleifion cymhleth i aros gartref neu i gael eu rhyddhau o'r ysbyty yn gynt na'r hyn a fuasai'n bosibl o'r blaen.

Mae'r broses o adnabod sepsis yn digwydd drwy ddefnyddio'r asesiad NEWS sydd wedi ei leoli yn y gymuned , sy'n golygu bod modd adnabod unigolion sy'n dangos arwyddion clinigol o sepsis.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae ymddangosiad Uwch-ymarferwyr Nyrsio ymarfer cyffredinol neu swyddi nyrsio eiddilwch yn galluogi cleifion i gael eu cynorthwyo yn eu cartrefi eu hunain, gan eu bod yn gaeth i'r tŷ ond nad oes angen cymorth iechyd na chymdeithasol dwys arnynt. Mae hyn yn sicrhau ffyrdd newydd o gyrraedd pobl sydd y tu allan i fodelau darparu gofal traddodiadol, megis gan y Meddyg Teulu neu ei ddarparu gan nyrsys ardal. Mae Uwch-ymarferwyr Nyrsio Ymarfer Cyffredinol a nyrsys eiddilwch yn achub ar y cyfle i adolygu a chefnogi'r modd o reoli cyflyrau hirdymor, drwy gamau megis gwirio techneg anadlydd, gwirio'r defnydd o feddyginiaeth a'u heffeithiolrwydd, trafod dewisiadau ffordd o fyw, asesu'r risg o gael codwm yn y cartref a rhoi brechiad blynyddol yn erbyn y ffliw, drwy ddefnyddio dull bio-seico-gymdeithasol cyffredinol.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Gwasanaeth a arweinir gan nyrsys yw'r Tîm Ymateb Acíwt sy'n darparu gofal i'r boblogaeth leol. Eu nod yw atal pobl rhag cael eu derbyn i ysbyty a chyflymu'r broses o ryddhau pobl o ysbytai. Eu prif arbenigeddau yw: rhoi meddyginiaeth fewnwythiennol yn yr ysbyty cymunedol neu yng nghartref y claf, os yw'n gaeth i'r tŷ; monitro therapi gwrthgeulo ar ôl cyfnod mewn ysbyty; pontio cyn ac ar ôl llawdriniaeth; a chwnsela Therapi Gwrthgeulo Trwy'r Geg/llwytho warfarin ar ôl diagnosis o thromboemboledd gwythiennol newydd. Gellir gwneud atgyfeiriadau gan unrhyw ysbyty neu weithiwr proffesiynol yn y gymuned, gan gynnwys cartrefi gofal.

Mae nyrsys ardal a chymuned yn rhagori ar asesiadau cyfannol, gan fynd i'r afael â hyn trwy gydbwyso'r elfennau rhyng-gysylltiedig sydd ar waith ar gyfer claf unigol. Gan i nyrsys ardal a chymuned yng Nghymru adrodd bod symud gwasanaethau iechyd i ffwrdd o ysbytai tuag at leoliadau gofal yn y gymuned, a ysgogir gan bolisïau, yn gymhleth, yn ogystal â newid anghenion iechyd o fewn y boblogaeth o gleifion yn y gymuned a nod Llywodraeth Cymru i "alluogi nyrsys i asesu pa mor ddifrifol yw cyflwr cleifion, a ydynt yn debygol o ddirywio, a beth fydd eu hanghenion parhaus", cynhaliwyd astudiaeth ymchwil yng Nghymru i ystyried gwaith asesu nyrsys ardal ar gyfer cleifion yn y gymuned ag anghenion cymhleth.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Nod astudiaeth PhD a ariannwyd gan Cydweithrediad Cynyddu Gwaith Ymchwil Cymru oedd datblygu a dilysu offeryn i nodi a mesur anghenion cymhleth ar gyfer cleifion yn gymuned. Aeth yr ymchwiliad i'r afael â asesiadau nyrsys ardal ar gyfer cleifion yn y gymuned ag anghenion cymhleth a nod Llywodraeth Cymru i "alluogi nyrsys i asesu pa mor ddifrifol yw cyflwr cleifion, a ydynt yn debygol o ddirywio, a beth fydd eu hanghenion parhaus".

Roedd y gwaith o ddatblygu'r Offeryn Cymhlethdod Cleifion (PCI) yn cynnwys cyfranogiad eang gan randdeiliaid ac ymgynghori parhaus. Trwy gael cytundeb Cymru gyfan o amrywiaeth eang o safbwyntiau, roedd eitemau'r offeryn yn targedu'r meysydd y mae clinigwyr nyrsys ardal, rheolwyr a chynllunwyr strategol yn eu hystyried yn gydrannau hanfodol o gymhlethdod ar gyfer cleifion yn y gymuned. Profwyd y PCI yn ymarferol gan nyrsys ardal, yn ystod asesiadau o anghenion cleifion yn y gymuned. Sefydlwyd dilysrwydd a dibynadwyedd yr offeryn yn ei gyd-destun cymhwysol.

Mae'r canlyniadau yn dangos y problemau, a nodwyd gan nyrsys ardal, sy'n gysylltiedig â gofal cymhleth yn y gymuned, gan gynnwys: ymgysylltu â chleifion, cyswllt cymdeithasol, angen clinigol, teulu a gofalwyr, adnoddau a diogelwch, a allai wneud claf sy'n oedolyn yn fwy tebygol o fod â mwy o anghenion cymhleth.

Mae'n fwy pwysig nag erioed o'r blaen i nodi, cydnabod, deall a chefnogi gofynion addysgol nyrsys gofal sylfaenol a chymunedol sy'n cynorthwyo pobl 24 awr y dydd, 7 diwrnod yr wythnos, er mwyn gallu rhoi egwyddorion gofal iechyd darbodus ar waith i sicrhau yr eir i'r afael ag anghenion cyfannol a chymhleth cleifion yn ddiogel a gan yr unigolyn sydd yn y sefyllfa orau i gefnogi dilyniant ac arbenigedd.

Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.

Gan fod y boblogaeth yn gynyddol heneiddio, cyflyrau hirdymor di-rif, triniaeth well i reoli symptomau ac ymestyn bywyd a mwy o bwyslais ar ofal yn y gymuned i bobl sy'n byw gyda chyflyrau hirdymor a/neu sy'n cyfyngu ar eu bywydau, mae angen cynyddol i ddarparu gofal lliniarol a diwedd oes di-dor sydd wedi'i drefnu'n dda, yn y gymuned ac yn y cartref i bobl, gan gynnwys plant.

Diffiniad Sefydliad Nyrsio'r Frenhines (QNI) o ofal lliniarol yw gofal cyfannol gweithredol i gleifion â salwch datblygedig sy'n gwaethygu. *Mae rheoli symptomau, a darparu cymorth seicolegol, cymdeithasol ac ysbrydol yn hollbwysig. Nod allweddol gofal lliniarol yw cyflawni'r ansawdd bywyd gorau ar gyfer cleifion a'u teuluoedd.*

Mae'r materion allweddol ar gyfer nyrsio gofal sylfaenol a nyrsio cymunedol yn cynnwys; darparu cymorth i gleifion â chyflyrau sy'n cyfyngu ar eu bywydau heblaw am ganser, cynllunio gofal uwch i bennu beth yw anghenion a dewisiadau pobl, gwella'r cymorth i ofalwyr a hunanofal, rheolaeth a darpariaeth gwasanaeth clinigol 24 awr y dydd o ansawdd uchel, cyflawni disgwyliadau safon aur a chyfathrebu da ar draws ffiniau iechyd, gofal a'r trydydd sector.

Mae timau nyrsio gofal sylfaenol a chymunedol yn darparu gofal lliniarol rhagorol i gleifion ar ddiwedd eu hoes ac mae'n galluogi cleifion i gael marwolaeth dda lle bynnag y maent yn dewis, wrth gael eu cefnogi gan gymorth ac arbenigedd arbenigol prydlon ac agored sydd ar gael yn rhwydd. Mae timau Nyrsio Ardal yn ganolog i gefnogi anghenion cleifion, teuluoedd a gofalwyr am ofal lliniarol yn y gymuned, lle treulir tua 40% o amser nyrsio ardal yn y modd hwn.

I gydnabod pwysigrwydd swyddogaeth nyrsio wrth gefnogi anghenion pobl am ofal lliniarol a diwedd oes, mae RCN (2015) yn argymell y dylid galluogi nyrsys i:

- drin pobl â thosturi
- gwrando ar bobl
- cyfathrebu'n glir ac yn sensitif
- nodi a diwallu anghenion cyfathrebu pob unigolyn
- cydnabod poen a thrallod a chymryd camau gweithredu
- cydnabod pan fo rhywun o bosibl yn ychydig ddyddiau ac oriau olaf ei fywyd
- cynnwys pobl mewn penderfyniadau am eu gofal a pharchu eu dymuniadau
- rhoi'r wybodaeth ddiweddaraf i'r unigolyn sy'n cyrraedd diwedd ei oes, a'r bobl hynny sy'n bwysig iddo, am unrhyw newid yn y cyflwr
- cofnodi crynodeb o'r sgyrsiau a phenderfyniadau
- gofyn am ragor o gymorth os oes angen
- gofalu am eu hunain a'u cydweithwyr a gofyn am gymorth os oes angen

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae Nyrsys Ymarfer Cyffredinol yn cymryd rhan mewn materion diwedd gofal ar ran y cleifion, eu teuluoedd a'u gofalwyr. Er enghraifft, trwy eu gwybodaeth barhaus am gleifion a'u teuluoedd, mae dim ond tynnu cleifion oddi ar restrau gwahodd am apwyntiadau yn y practis wedi osgoi trallod.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae nyrsys sy'n arbenigo mewn methiant y galon yn gweithio gyda Nyrsys Ymarfer Cyffredin yn y practis i ddiweddaru gwybodaeth Nyrsys Ymarfer Cyffredin am fethiant y galon. Yn sgil hyn, mae Nyrsys Ymarfer Cyffredin yn fwy hyderus a chymwys i gefnogi unigolion ag agweddau allweddol ar ofal methiant y galon, gan gynnwys; y defnydd o feddyginiaeth a'i effeithiolrwydd, cynnal pwysau gwaed iach, dewisiadau ffordd o fyw. Mae hefyd yn galluogi unigolion i drafod agweddau ar eu cynllun gofal, gan gynnwys gofal diwedd oes.

Gwnaeth nyrsys ardal a nyrsys cymunedol helpu pobl i aros yn eu cartrefi, derbyn gofal lle maent yn dewis a lle bynnag mae eu cartref, gan gynnwys mewn cartref gofal.

ASTUDIAETH ACHOS ENGHREIFFTIOL

I wella'r daith ofal i bobl sy'n byw mewn cartrefi gofal lleol, mae nyrsys ardal yng Nghasnewydd wedi gweithio gyda chydweithwyr yn y cartrefi gofal i lunio cynlluniau gofal uwch gyda thrigolion a'u teuluoedd. Nod y fenter hon yw sicrhau y caiff anghenion preswylwyr eu bodloni, o ganlyniad i drafodaethau a hwyluswyd rhwng preswylwyr unigol, eu teulu, gofalwyr a'r holl staff sy'n dod i gysylltiad â'r preswylydd yn ystod y dydd a'r nos.

Mae gweithio yn y modd hwn wedi cynyddu hyder staff cartrefi gofal i ddarparu'r cymorth a'r gofal mewn unrhyw gyfnod pan fo anghenion gofal yn newid, er enghraifft pan fo iechyd yn dirywio dros dro neu yn y tymor hirach. Mae'n galluogi nyrsys ardal a staff cartrefi gofal i weithio fel tîm cydgysylltiedig i ddarparu'r gofal cyfannol sydd ei angen ar unigolyn, gan fod sgyrsiau eisoes wedi eu rhannu a chynlluniau wedi eu gwneud ar gyfer yr hyn a ragwelir a allai ddigwydd. Mae trafodaeth o'r fath yn galluogi gofal wedi'i gynllunio yng nghartref yr unigolyn ei hun, yn hytrach na orfod ei dderbyn i ysbyty os a phan y bydd yn dirywio.

I wella'r profiad gofal ymhellach, mae nyrsys ardal hefyd wedi dilyn hyfforddiant mewn cadarnhau marwolaeth, er mwyn cynnal dilyniant gofal a chymorth i breswylwyr a theuluoedd pan fydd marwolaeth.

Mae Nyrsys Plant Cymunedol yn cymryd rhan weithredol wrth gefnogi anghenion gofal lliniarol a diwedd oes plant.

ASTUDIAETH ACHOS ENGHREIFFTIOL

Mae cyfran fawr o lwyth achosion Nyrsys Plant Cymunedol yn blant a phobl ifanc â chyflyrau sy'n byrhau eu bywydau ac sydd angen gofal lliniarol. Mae'r Nyrsys Plant Cymunedol yn gyfrifol am ddarparu gofal iechyd mewn dull partneriaeth, gan weithio'n agos a gweithwyr proffesiynol eraill a Gwasanaethau Anabledd Plant yn yr Awdurdod Lleol; gan weithredu fel y gweithiwr allweddol pan fo hynny'n briodol. Mae'r dull hwn wedi achosi symudiad i ffwrdd o'r model meddygol o ofal tuag at ddulliau sy'n canolbwyntio ar yr unigolyn a'r pwyslais ar lais y plentyn a chynlluniau wedi'u cyd-gynhyrchu. Caiff taith y plentyn trwy lefelau anghenion gofal ei fonitro ac mae gan y Nyrsys Plant Cymunedol swyddogaeth ar y cyd â'r gweithiwr cymdeithasol i sicrhau y nodir gwasanaethau cymorth ac y nodir angen cynyddol yn gynnar a bod y symudiad i ofal parhaus a/neu ofal diwedd oes yn cael ei wneud yn briodol. Mae'r Nyrsys Plant Cymunedol yn darparu gofal diwedd oes uniongyrchol gan gydgysylltu â'r arbenigwyr nyrsio clinigol gofal lliniarol plant a'r Hosbis Plant i gefnogi teuluoedd yn y cyfnod diwedd oes.

Heriau ar gyfer datblygu nyrsio gofal sylfaenol a chymunedol yng Nghymru

Nododd y gweithdy heriau darparu'r lefelau presennol o ofal a chymorth, a'r lefelau cynyddol a rhagwelir, heb nifer y gweithlu sy'n ofynnol. **Nodwyd mai recriwtio a chadw nyrsys oedd yr heriau mwyaf** ar gyfer gofal sylfaenol a chymunedol.

Nododd cydweithwyr nyrsio gofal sylfaenol a chymunedol amrywiaeth o ran darpariaeth gwasanaeth ledled Cymru, gan gynnwys mewn amgylcheddau GIG ac ymarfer cyffredinol. Er bod hyn yn galluogi rhoi cymorth a gofal unigol i gleifion a theuluoedd, mae perygl o beidio bod â '**safonau aur**' ledled Cymru. Er enghraifft, wrth ddatblygu swyddi newydd er enghraifft gweithwyr cymorth iechyd nyrsio cymunedol ar fand 4 ac uwch-ymarferwyr nyrsio mewn ymarfer cyffredinol.

Mae amrywiaeth y ddarpariaeth gwasanaeth o fewn ymarfer cyffredinol yn cael ei ddathlu am ei allu i fodloni anghenion y boblogaeth leol, a hefyd ei werthfawrogi fel ffactor sy'n cyfyngu wrth gyflawni safonau cyson a datblygiad swyddogaeth ledled Cymru. Er enghraifft, byddai polisi Cymru gyfan ar gyfer **pob tîm nyrsio gofal sylfaenol a nyrsio cymunedol i gynnwys o leiaf un nyrs sy'n rhagnodi'n annibynnol** yn gwella yn drawiadol gallu nyrsys gofal sylfaenol a nyrsys cymunedol i ddarparu achosion o gymorth ar gyfer pobl â chyflyrau hirdymor. Dylid bod pwyslais o'r newydd gan Lywodraeth Cymru ar **gyflwyno nyrsys sy'n rhagnodi'n annibynnol mewn gofal sylfaenol.**

Nid yw arweinyddiaeth nyrsio gofal sylfaenol wedi'i ffurfioli na'i safoni yng Nghymru, er gwaethaf cyfeiriad y polisi. Byddai polisi Cymru gyfan i **bob Clwstwr gynnwys Ymgynghorydd Nyrsio mewn Gofal Sylfaenol a Chymunedol** yn sicrhau arweinyddiaeth leol ar gyfer datblygiad clinigol, addysg ac ymchwil, yn seiliedig ar anghenion cymunedau lleol (gweler disgrifyddion swyddi yn atodiad 1).

Mae cydweithwyr gofal sylfaenol a nyrsio cymunedol yn cydnabod lle Clystyrau Gofal Sylfaenol fel y cyfryngau ar gyfer newid gweddnewidiol. Fodd bynnag, gall fod yn **anodd i nyrsys gofal sylfaenol a nyrsys cymunedol gymryd rhan mewn gweithgareddau Clwstwr**, yn enwedig pan fo'r pwyslais cryfaf ar ymarfer cyffredinol a'r model busnes o ofal sylfaenol annibynnol yn seiliedig ar gontractwr. Mae nyrsys gofal sylfaenol a nyrsys cymunedol yn bartneriaid allweddol wrth gyflawni dyheadau strategol a dyheadau a arweinir gan bolisïau sy'n cael eu datblygu drwy waith Clwstwr a galwad i arweinwyr nyrsio elwa i'r eithaf ar y gallu i gyfrannu arbenigedd a gwaith mewn partneriaethau agosach drwy'r model hwn.

Gan ddathlu'r dulliau unigryw o weithio y mae nyrsio ymarfer cyffredin yn ei gynnig mewn partneriaeth â thimau ymarfer cyffredin, cynigiodd **Nyrsys Ymarfer Cyffredin y gellid gwella cyfleoedd drwy gysylltedd uniongyrchol ag arweinwyr nyrsio ar lefel Bwrdd Iechyd**, gan gynnwys Cyfarwyddwyr Nyrsio. Roedd rhai cyfranogwyr yn y gweithdy yn dadlau y byddai cael eu cyflogi gan y Bwrdd Iechyd o fudd i ofal cleifion, drwy'r gallu i fynd i'r afael â safonau, addysg, datblygiad proffesiynol parhaus a materion proffesiynol eraill ar sail ehangach nag y mae cyflogaeth gan bractisiau contractwyr annibynnol, unigol yn ei ganiatáu.

Adroddir, gan fod **gwasanaethau a thimau nyrsio plant cymunedol yn aml yn cael ei ariannu yn rhan o ofal eilaidd**, bod hyn yn effeithio ar sicrhau cydweithrediad llawn nyrsys plant cymunedol mewn gofal sylfaenol a gofal cymunedol. Gellid ystyried hyn wrth chwilio am ffyrdd o wella gofal a chymorth ar gyfer iechyd a lles plant a phobl ifanc yn y gymuned, ac ar sail lle.

Gofynion ar gyfer cynaliadwyedd a thwf nyrsio gofal sylfaenol a nyrsio cymunedol yng Nghymru

- Mae nyrsys gofal sylfaenol a chymunedol yn ymwybodol o'r angen am **ddealltwriaeth gyfoes o ystod a chwmpas eu swyddogaethau**, i alluogi ymatebion hyblyg sy'n bodloni anghenion cleifion.
- Mae angen am **ddarpariaeth a chyfleoedd addysg parhaus a phriodol sy'n addas** i'r cyd-destun gofal cyfoes.
- Ceir cydnabyddiaeth o werth **diwylliant hyfforddi ar y cyd**, i gefnogi rhannu a dysgu mewn tîm amlddisgyblaethol.
- Amlygir yr angen am **gymorth technolegol** fel mater parhaus, i alluogi dilyniant a diogelwch drwy'r gallu weld gwybodaeth am gleifion, casglu a rhannu gwybodaeth.
- Mae angen **buddsoddi mewn strwythurau a phrosesau cynllunio gweithlu**, megis llwybr gyrfa a fframwaith addysg o fewn nyrsio ymarfer cyffredinol. Mae hwn yn ofyniad amlwg sy'n berthnasol i weithlu sydd y tu allan i delerau ac amodau cyflogaeth y GIG.
- Nodir bod **llwybr gyrfa a fframwaith addysg sy'n canolbwyntio yn benodol ar nyrsio ymarfer cyffredin** yn ganolog i gyflawni lefelau cyson, diogel o ofal a chymorth nyrsio o fewn ymarfer cyffredin.
- Mae angen a nodwyd am fuddsoddiad mewn swyddi arweinyddiaeth **nyrsio gofal sylfaenol a chymunedol** yn ogystal â datblygiad a chynllunio olyniaeth, gan gynnwys ar lefel Nyrs Ymgynghorol ac Arweinydd Clwstwr.
- Ceir angen a nodwyd i gefnogi **diwylliant o ymholi a dysgu drwy ddull yn seiliedig ar ymchwil o fewn ymarfer clinigol nyrsio gofal sylfaenol a chymunedol**, na eir i'r afael ag ef ar hyn o bryd drwy strwythurau neu brosesau presennol. Byddai swydd Nyrs **Ymgynghorol o fewn y Clystyrau** yn galluogi pwyslais a arweinir gan weithwyr proffesiynol drwy ddefnyddio dulliau empirig o ymchwilio a gwerthuso (gweler y disgrifyddion yn atodiad 1).
- Ceir cyfleoedd i Nyrsio Gofal Sylfaenol a Chymunedol wella dilyniant gofal iechyd ar gyfer pobl Cymru. Er enghraifft, byddai lleiafswm o un **nyrs sy'n rhagnodi'n annibynnol ym mhob tîm Nyrsio Gofal Sylfaenol a Chymunedol** yn golygu y byddai'n bosibl cwblhau achosion gofal yn y cartref neu yn y syrjeri heb yr angen i gynnwys gweithiwr iechyd meddygol proffesiynol. Byddai hyn hefyd yn lleihau pwysau amser ar feddygon teulu, gan felly wella'r gallu i gael gafael ar adnoddau meddygon teulu.

Darlun o'r cysylltiad rhwng Cymru Iachach, cyfraniad ac ymrwymiad nyrsio gofal sylfaenol a chymunedol, a'r gofynion cefnogol i gyflawni'r ymrwymiad

Cymru Iachach	Nyrsys gofal sylfaenol a chymunedol ...	Mae nyrsys gofal sylfaenol a nyrsys cymunedol yn ymrwymo i...	I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...
Bydd gwasanaethau'n cael eu llunio o amgylch yr unigolyn a grwpiau o bobl, ar sail eu hanghenion unigryw a'r hyn sy'n bwysig iddynt, yn ogystal â chanlyniadau ansawdd a diogelwch.	Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol.	**Deall anghenion iechyd a gofal poblogaethau lleol ac unigolion ar sail yr wybodaeth, data a thystiolaeth sydd ar gael.** **Cynnal asesiad unigol a chyfannol o anghenion biolegol, seicolegol, cymdeithasegol, diwylliannol ac ysbrydol, gan ddechrau gyda'r cwestiwn o 'beth sy'n bwysig i chi?'** **Deall elfennau canlyniadau ansawdd a diogelwch a'r hyn sy'n bwysig i'r cleifion a'u gofal trwy greu, casglu a defnyddio ymchwil a thystiolaeth.**	**Adnabod yr angen am amser ac adnoddau (gan gynnwys systemau TG cysylltiedig) i gynnal asesiadau iechyd a gofal ystyrlon a phenodol.** **Cydnabod yr angen am amser ac adnoddau i gynnal asesiadau cyfannol unigol ystyrlon sy'n llunio cynlluniau gofal cydweithredol** **Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud â chanlyniadau ansawdd a diogelwch a'r hyn sy'n bwysig i gleifion.**
Dylai pawb yng Nghymru gael bywydau hirach, iachach a hapusach, a dylent allu parhau i gadw'n brysur a bod yn annibynnol yn eu cartrefi eu hunain gyhyd â phosib.	Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth	**Neilltuo amser i weithio gydag unigolion a theuluoedd i ddeall dymuniadau a gallu unigolyn i fod yn annibynnol.** **Neilltuo amser i gytuno ar gynllun gofal sy'n meithrin annibyniaeth ac yn cefnogi'r anghenion a fynegwyd.** **Adolygu effaith gofal nyrsio ar weithgarwch ac annibyniaeth yr unigolyn.**	**Adnabod yr angen am amser ac adnoddau i gynnal asesiadau ystyrlon o ddymuniadau a gallu unigolyn i fod yn annibynnol.** **Adnabod yr angen am amser i gytuno ar gynllun gofal sy'n meithrin annibyniaeth a chefnogi'r cynllun hwnnw.** **Cymorth ac adnoddau penodol er mwyn i nyrsys gofal sylfaenol a chymunedol lunio ymchwil empirig yn ymwneud ag effaith gofal nyrsio ar weithgarwch ac annibyniaeth unigolyn.**
Bydd yna system 'iachusrwydd' sy'n ceisio cefnogi a rhagweld anghenion iechyd, atal salwch a lleihau effaith iechyd gwael.	Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.	**Defnyddio gwybodaeth a sgiliau i greu'r cyfleoedd gorau posibl ar gyfer ymyriadau atal salwch gydag unigolyn neu grwpiau o bobl.** **Defnyddio fframweithiau cydnabyddedig, megis Gwneud i Bob Cyswllt Gyfrif (MECC), Cyfweld Ysgogiadol, neu gymhorthion cyfoes eraill, i gefnogi pobl i wneud newidiadau mewn modd perthnasol ac effeithiol.**	**Adnabod yr angen am amser i greu'r cyfleoedd gorau posibl ar gyfer ymyriadau atal salwch gydag unigolion.** **Cymorth ac adnoddau i nyrsys gofal sylfaenol a chymunedol i ddysgu am fframweithiau cydnabyddedig sy'n helpu pobl i wneud newidiadau sy'n ymwneud ag iechyd, ffordd o fyw neu rai eraill, a defnyddio'r fframweithiau hynny.**
Byddwn yn edrych ar iechyd a gofal cymdeithasol fel system gyfan, gyda'r gwasanaethau yn un elfen yn unig wrth gefnogi pobl i fwynhau gwell iechyd a llesiant drwy gydol eu bywydau.	Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsio; ymyriadau therapiwtig a gofal personol, gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol.	**Sicrhau y caiff adnoddau ac asedau lleol a chymunedol eu defnyddio yn y ffordd orau er budd anghenion cyfannol pob dinesydd.** **Gweithio ar cyd ag amrywiaeth eang o weithwyr iechyd a gofal proffesiynol a/neu eu cydgysylltu, i wella'r cymorth unigol sydd ar gael i bobl.**	**Adnoddau penodol i alluogi nyrsys gofal sylfaenol a chymunedol i ddefnyddio cyfeiriaduron gwybodaeth megis DEWIS, fel mater o drefn yn y eu gweithgareddau clinigol.** **Hwyluso amgylcheddau sy'n ysgogi gwaith tîm, gan gynnwys systemau TG ar y cyd, cydleoli ardaloedd gweithio a thrwy ddulliau eraill o gyfathrebu ar unwaith.**

Cymru Iachach	Nyrsys gofal sylfaenol a chymunedol ...	Mae nyrsys gofal sylfaenol a nyrsys cymunedol yn ymrwymo i...	I gyflawni hyn, bydd ar nyrsio gofal sylfaenol a chymunedol angen ...
Pan fydd angen cymorth, gofal neu driniaeth ar bobl, bydd modd iddynt ddefnyddio ystod o wasanaethau di-dor, sy'n cael eu darparu mor agos â phosibl at y cartref.	Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr, triniaeth a chanlyniadau	**Sicrhau nad yw pobl yn destun niwed neu ofid corfforol, seicolegol neu arall trwy geisio deall eu canfyddiadau a'u safbwyntiau o ran eu hamgylchiadau iechyd.**	**Addysg mewn brysbennu clinigol a llywio gofal, i sicrhau y caiff pobl eu cyfeirio'n ddiogel ac yn effeithiol ar y pwynt cyswllt cyntaf i'r cymorth iechyd a'r gofal mwyaf priodol.**
Bydd pobl yn mynd i ysbyty cyffredinol dim ond os yw hynny'n hanfodol.		**Sicrhau y datblygir timau nyrsio gofal sylfaenol a chymunedol cytbwys fel bod gofal diogel a chymwys ar gael i bobl gan staff ar bob lefel o sgil unigol, o lefel 3 i 8.** **Sicrhau bod o leiaf un nyrs sy'n rhagnodi'n annibynnol ym mhob tîm nyrsio gofal sylfaenol a chymunedol yng Nghymru.**	**Cynllunio, ariannu a chymorth ariannol â phwyslais ar gyfer datblygu rhagnodwyr annibynnol mewn timau nyrsio gofal sylfaenol a chymunedol ledled Cymru.**
Gwella lles corfforol a meddwl pawb, trwy gydol eu bywydau, o'u genedigaeth i ddiwedd eu hoes yn urddasol.	Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.	**Darparu gofal nyrsio sensitif ac unigol i bobl, gan gynorthwyo â'u dymuniadau o ran eu dewis o le i farw.**	**Addysg gydgysylltiedig o ddulliau seicolegol o gefnogi iechyd, llesiant a phenderfyniadau.** **Addysg gydgysylltiedig ar gyfer gofal diwedd oes a thystysgrif marwolaeth.**
Bydd y system gyfan yn deg. Bydd gwasanaethau a chymorth yn darparu'r un gofal o ansawdd uchel, ac yn cyflawni canlyniadau iechyd cyfartal, i bawb yng Nghymru.	Gwaith mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, a gofalwyr eraill, ac mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaethol, yn aml fel cydgysylltydd gofal yn y gymuned	**Cyfrannu arbenigedd a chynorthwyo datblygiad llwybrau gyrfa ar gyfer timau nyrsio gofal sylfaenol a chymunedol, i alluogi canlyniadau iechyd cydradd i bobl sy'n derbyn gofal gan gymysgedd sgiliau hyddysg iawn a chyson, a disgrifiadau swydd safonol.** **Arwain, cefnogi a chyfrannu at a ddatblygiad arfer gorau 'safon aur' ym mhob maes nyrsio gofal sylfaenol a chymunedol.**	**Fframwaith addysg a gyrfa â phwyslais ar gyfer timau nyrsio gofal sylfaenol, fel yr ymrwymwyd gan Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol yng Nghymru.** **Parhad systemau iechyd a gofal i sicrhau dulliau cyson cydgysylltiedig.**
Bydd symud y pwyslais at adnoddau yn y gymuned yn golygu bod modd cyrraedd y gofal mewn ysbyty yn gyflymach pan fo angen hynny.		**Defnyddio'r profiadau a'r gwersi a ddysgwyd o raglenni treialu a mentrau newydd mewn gofal sylfaenol a nyrsio cymunedol i lunio timau sy'n helpu pobl i gael gofal diogel a pherthnasol yn y gymuned, lle byddai'r ysbyty yn unig ateb fel arall.** **Parhau i ffurfio, arwain a darparu gofal nyrsio unigol, sensitif ac effeithlon sy'n seiliedig ar y boblogaeth ac wedi'i arwain gan dystiolaeth, i ddiwallu anghenion cyfoes cleifion a'r GIG yng Nghymru sy'n canolbwyntio ar y gymuned.**	**Cymorth ac adnoddau â phwyslais ar gyfer nyrsys gofal sylfaenol a chymunedol i greu gwerthusiadau o effaith ymarfer nyrsio, gan gynnwys y defnydd o fframweithiau er enghraifft Amser a Dreuliwyd Gartref, dadansoddiad Economaidd, Mesurau Canlyniadau a Adroddwyd gan Gleifion (PROMs), Mesurau Profiad a Adroddwyd gan Gleifion (PREMs).** **Cynllun Cymrodoriaeth Hyfforddiant Arweinyddiaeth Glinigol Cymru i ddatblygu arweinwyr clinigol o safon mewn nyrsio gofal sylfaenol a chymunedol.** **Datblygiad penodol o swyddi arweinyddiaeth glinigol gofal sylfaenol, i sicrhau bod gan fwy o nyrsys yr wybodaeth, y sgiliau a'r profiad i gyflawni swyddi Arweinwyr Clystyrau Gofal Sylfaenol.** **Recriwtio un Nyrs Ymgynghorol mewn Gofal Sylfaenol a Chymunedol ym mhob un o'r Clystyrau Gofal Sylfaenol yng Nghymru (gweler y disgrifyddion swydd yn atodiad 1).**

Crynodeb

Wrth barhau i fodloni anghenion iechyd a lles pobl Cymru, bydd nyrsys gofal sylfaenol a chymunedol yn ...

1. Gweithio gydag unigolion, eu teuluoedd a'u gofalwyr i nodi anghenion nyrsio; ymyriadau therapiwtig a gofal personol, gwybodaeth, addysg, cyngor ac eiriolaeth; a chymorth corfforol, emosiynol ac ysbrydol.
2. Ystyried y person cyfan a'i anghenion biolegol, seicolegol, cymdeithasol, diwylliannol neu ysbrydol.
3. Hyrwyddo iechyd, gwellhad, twf a datblygiad, ac atal afiechyd, salwch, anaf ac anabledd.
4. Grymuso pobl i gyflawni, cynnal neu adfer annibyniaeth
5. Lleihau gofid a dioddefaint a galluogi pobl i ddeall ac ymdopi â'u cyflwr, triniaeth a chanlyniadau
6. Pan fo marwolaeth yn anochel, helpu i gynnal y safon bywyd gorau posibl tan y diwedd.
7. Gweithio mewn partneriaeth â chleifion, eu perthnasau a gofalwyr eraill, ac mewn cydweithrediad ag aelodau eraill o dîm amlddisgyblaeth, yn aml fel cydgysylltydd gofal

Atodiadau

Atodiad 1: Detholiad o Ddisgrifyddion Swyddogaethau Gofal Sylfaenol a Nyrsio Cymunedol (wedi eu cymryd oddi wrth RCN Cymru, 2017)

Nyrs Ymarfer Cyffredinol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofrestradwy arbenigol ychwanegol)

- Ymarferydd annibynnol
- Gweithio'n agos gyda'r tîm ymarfer cyffredinol er mwyn diwallu anghenion cleifion, wrth gefnogi'r gwaith o gyflwyno polisïau a gweithdrefnau, gan ddarparu arweinyddiaeth i nyrsys
- Asesu, cynllunio, datblygu, gweithredu a gwerthuso rhaglenni lles
- Gweithredu a gwerthuso cynlluniau triniaeth unigol ar gyfer cleifion â chyflyrau hirdymor
- Ymgymryd â nifer o ddyletswyddau nyrs practis gan gynnwys rheoli cyflyrau hirdymor, gofal am glwyfau, sytoleg serfigol, brechiadau teithio a brechiadau ar gyfer plant, cynnal profion diagnostig perthnasol
- Blaenoriaethu problemau iechyd ac ymyrryd yn briodol i gynorthwyo cleifion mewn sefyllfaoedd cymhleth, brys neu argyfyngol, gan gynnwys dechrau gofal brys effeithiol
- Hybu lechyd y Cyhoedd gan gynnwys rhaglenni sgrinio cenedlaethol

Uwch Ymarferydd Nyrsio (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofrestradwy arbenigol ychwanegol, cyfle i fod yn nyrs y RCN cymeradwy)

- Annibynnol, ymarfer uwch, gyda chwmpas ymarfer estynedig sy'n darparu gofal o fewn arbenigedd perthnasol yn sgil atgyfeiriadau
- Darparu asesiadau arbenigol, diagnosisau, triniaethau a gwerthusiadau gofal
- Lefel uchel o sgiliau diagnostig/rhesymu clinigol, sy'n cynnig ystod eang o raglenni adsefydlu/triniaeth i gleifion ag anghenion cymhleth iawn
- Darparu pwynt cyswllt cyntaf yn y Practis i gleifion sy'n cael problemau diwahaniaeth nad ydynt wedi eu diagnosio, gwneud defnydd o sgiliau wrth gymryd hanes, archwilio corfforol, datrys problemau a gwneud penderfyniadau clinigol er mwyn sefydlu cynllun rheoli a diagnosis
- Dechrau, arwain a datblygu gwaith ymchwil rheolaidd, archwilio, gwerthuso a gweithredu arferion sy'n seiliedig ar dystiolaeth a chefnogi eraill sy'n ymgymryd â phrosiectau ymchwil
- Dangos sgiliau meddwl beirniadol a dadansoddol uwch gan weithredu fel ffynhonnell arbenigedd a gwybodaeth glinigol i weithwyr proffesiynol eraill
- Cynghori ar y rheolaeth a argymhellir ar draws y llwybr cleifion cyfan, sy'n cynnwys atal, a gofal cymunedol, hirdymor ac ar ddiwedd bywyd
- Gorchymyn, dehongli a gweithredu ar ymchwiliadau meddygol a hwyluso mynediad i staff meddygol priodol

Nyrs Ymgynghorol mewn Gofal Sylfaenol a Chymunedol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster arbenigol ychwanegol y gellir ei gofrestru / cofnodi)

- Ymarferydd annibynnol sy'n darparu o leiaf 50% o'r gofal yn uniongyrchol
- Ymarfer arbenigol uwch, yn gweithio gyda chleifion, cleientiaid a/neu gymunedau gan wneud dyfarniadau a phenderfyniadau clinigol hanfodol lle na fydd cynsail yn bodoli o bosibl
- Yn gyfrifol am reoli llwyth achosion cymhleth gan ddarparu a rheoli gwasanaeth cynghori clinigol arbenigol
- Sicrhau y glynir wrth ddimensiynau ymarfer moesegol a moesol
- Cyflawni swyddogaeth mewn rheolaeth glinigol, gan ddarparu mewnbwn arbenigol a gweithio i sicrhau gwelliant ansawdd ar draws sbectrwm eang o ddarpariaeth gofal
- Cyfrannu at gynllunio strategol a gweithredu polisïau cenedlaethol yn lleol
- Gwerthuso gwasanaethau clinigol, arwain ar ddatblygu a/neu ailgynllunio gwasanaethau newydd
- Cymryd yr awenau wrth gychwn a datblygu gwasanaethau trawsddisgyblaethol a gweithio rhyngasiantaethol sy'n cyfrannu at safonau a chanllawiau amlbroffesiynol

- Gwneud a derbyn atgyfeiriadau uniongyrchol gan gleifion/cleientiaid; cynnal asesiad o anghenion unigol a manteisio ar gydweithrediad ac arbenigedd priodol rhwng asiantaethau ac ar draws ffiniau er mwyn diwallu anghenion cleifion/cleient orau.
- Darparu arweiniad ac esiampl effeithiol sy'n ysbrydoli ac yn cynnal ymrwymiad cydweithwyr ac yn hwyluso'r broses o rymuso eraill
- Cyhoeddi gwaith ymchwil neu fod wedi, neu'n gweithio tuag at ddoethuriaeth
- Cyfrannu at ddatblygu a gwerthuso rhaglenni addysgol
- Arwain gwaith ymchwil ac archwilio a chyfrannu at yr agenda ymchwil ehangach, gan sefydlu partneriaethau ymchwil gyda Sefydliadau Addysg Uwch a chymunedau ymchwil eraill.

Gweithiwr Cymorth Gofal Iechyd Ymarfer Cyffredinol (Nad yw wedi cofrestru)

- Darparu gofal nyrsio yn rhan o dîm nyrsio o dan oruchwyliaeth uniongyrchol neu anuniongyrchol o fewn fframwaith cytunedig, a rhoi gwybod am unrhyw newidiadau ar unwaith
- Cynorthwyo i gyfathrebu a chyfeirio tuag at hunanofal a'r broses o hybu iechyd
- Gweithio o fewn canllawiau, cyflawni gweithgareddau dirprwyedig gan gynnwys rheoli stoc, brechlynnau tymheredd cyson, hebrwng cleifion a rheoli heintiau
- Gweithio o fewn canllawiau, darparu gofal megis sbirometreg, archwiliadau iechyd, mesuriadau gwythïen-bigiadau a ffisiolegol, cofnodi canlyniadau i'r nyrs gofrestredig

Arweinydd Tîm Nyrsio y Cylch (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth gyda chymhwyster arbenigol ychwanegol cofrestradwy) ⟨ Ymarferydd annibynnol

- Darparu arbenigedd a chymorth clinigol gwell i gleifion yn yr ardal sy'n ymweld â thimau amlddisgyblaethol cymhleth yn yr ysbyty ac mewn lleoliadau cymunedol
- Cydgysylltu rhwng deiliaid llwythi achosion, gwasanaethau adnoddau cymunedol, wardiau gofal eilaidd a nyrsys arbenigol er mwyn sicrhau y caiff cleifion eu rhyddhau yn ddiogel ac yn effeithiol, ac ymyriadau ataliol rhagweithiol er mwyn cynnal pobl yn eu hamgylchedd cartref
- Arwain ar safonau ac arferion proffesiynol er mwyn cefnogi staff mewn ffyrdd newydd o weithio
- Gweithio'n agos gyda thimau gofal sylfaenol yn y rhwydweithiau, sicrhau bod cyfathrebiadau yn effeithiol a bod llwybrau gofal diogel ac effeithiol yn y rhwydweithiau, gan gynnwys asesu ac atgyfeirio er mwyn atal cleifion rhag cael eu derbyn i'r ysbyty yn ddiangen
- Gwella gweithrediadau a chynlluniau gofal diwedd oes
- Arwain y tîm nyrsio cymunedol yn broffesiynol a bod yn rheolwr llinell gweithredol iddynt

Nyrs Gymunedol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth)

- Cymryd cyfrifoldeb am bob agwedd ar ofal nyrsio parhaus a darparu pecynnau cynhwysfawr o ofal nyrsio yng nghartrefi pobl o dan oruchwyliaeth anuniongyrchol Deiliad y Llwyth Achosion
- Sicrhau bod cydweithrediad agos â'r tîm amlddisgyblaethol sy'n cymryd rhan yn nhrafodaethau'r tîm amlddisgyblaethol mewn cysylltiad ag asesiadau risg er mwyn sicrhau diogelwch unigolion, eu cyd-gleifion a'r staff
- Cynnal yr ymweliad/cyswllt cyntaf dros dro â chlaf, a fydd yn cael ei ailasesu gan ddeiliad y Llwyth Achosion o fewn 24 awr. Cyfeirio unigolion at wasanaethau cymunedol priodol er mwyn diwallu eu hanghenion parhaus Cyfeirio unigolion i wasanaethau cymunedol priodol i ddiwallu eu hanghenion parhaus
- Adrodd unrhyw risgiau neu beryglon a helpu i ddatblygu a sefydlu dulliau a gweithdrefn er mwyn atal/lleihau'r risg
- Sicrhau iechyd, diogelwch a lles eich hun, eich cydweithwyr, cleifion/cleientiaid, gofalwyr a phob unigolyn arall sy'n gysylltiedig â'r maes ymarfer
- Gwneud newidiadau i gynlluniau gofal yn sgil adolygiadau, gan eu hadrodd i'r Uwch-nyrs

Nyrs Iechyd Galwedigaethol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofrestradwy arbenigol ychwanegol)

- Ymarferydd annibynnol
- Gweithio gydag unigolion a thimau i atal problemau iechyd, hybu amodau byw a gweithio'n iach gyda gwybodaeth a sgiliau penodol o ran deall effeithiau gwaith ar iechyd ac iechyd yn y gweithle.
- Cynnal profion sgrinio iechyd, gan gynnwys monitro'r gweithlu a'r gweithle ac asesu anghenion iechyd a hybu iechyd; addysg a hyfforddiant a phan fo hynny'n briodol cwnsela a chymorth ac asesu risg a rheoli risg.
- Rheoli tîm amlddisgyblaethol o weithwyr iechyd proffesiynol

Nyrs Plant Cymunedol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofnodadwy arbenigol ychwanegol)

- Cefnogi'r plentyn, y teulu a'r gofalwyr, mewn ymateb i wneud y gorau o annibyniaeth ac ansawdd bywyd y plentyn neu'r person ifanc
- Darparu gofal nyrsio i blant a phobl ifanc sydd ag anghenion gofal cymhleth, gan gynnwys cymorth meddygol cymhleth fel rhan o ofal bob dydd neu ddiwedd oes
- Cefnogi plant a phobl ifanc sy'n cael pecynnau Gofal Parhaus a gofal diwedd oes 24/7, gan gynnwys penwythnosau a gwyliau banc
- Darparu asesiadau clinigol a chymorth i blant mewn lleoliadau cymunedol sydd ag anghenion gofal iechyd yn rhan o weithio gyda gwasanaethau gofal sylfaenol er mwyn atal derbyniadau diangen i'r ysbyty a hwyluso'r broses o ryddhau cleifion yn gynnar
- Cynnal ymyriadau neu asesiadau gofal iechyd penodol mewn lleoliadau cymunedol
- Cynllunio gofal i blant sydd ag anghenion iechyd acíwt ar gyfer adolygiadau gydag uwch aelodau o'r staff fel sy'n briodol, adrodd ar newidiadau yng nghyflwr y plant neu ganlyniadau ymyriadau
- Cymryd rhan yn y gwaith o roi meddyginiaethau, gan gynnwys therapi mewnwythiennol a bod yn ymwybodol o gyffuriau/therapïau cyfredol wrth drin poen a symptomau eraill.

Arbenigwr Nyrs Glinigol Gymunedol (wedi cofrestru â'r Cyngor Nyrsio a Bydwreigiaeth â chymhwyster cofnodadwy arbenigol ychwanegol)

- Yn gweithio'n annibynnol ac yn chwarae swyddogaeth ganolog wrth arwain ymarferion clinigol a gwella safonau gofal, hybu gwasanaeth di-dor drwy weithgareddau proffesiynol, archwiliadau, gwaith ymchwil, addysg, rheolaeth ac ymarfer clinigol
- Gweithio yn rhan o dîm, datblygu gwasanaethau dan arweiniad nyrsys a darparu sylwadau nyrsio arbenigol yn ystod pob cam o gyfnod gofal y claf
- Arwain gofal clinigol drwy reoli llwyth achosion diffiniedig i gleifion, darparu asesiad, cynllun a gwerthusiad arbenigol, hwyluso addysg ar gyfer cleifion a'u teuluoedd
- Darparu Clinigau Mynediad Cyflym nad oes angen goruchwyliaeth Ymgynghorydd arnynt
- Archebu, dadansoddi a dehongli ymchwiliadau patholeg, radioleg a microbioleg
- Gweithredu fel pwynt cyfeirio ar gyfer cleifion yn y gymuned y mae problemau'n deillio o'u cyflwr a/neu ei driniaeth, drwy ddarparu gwasanaeth llinell gymorth dros y ffôn

Atodiad 2:
Y Rhaglen, Uwchgynhadledd Nyrsio Gymunedol a Gofal Sylfaenol RCN Cymru: 12 Mehefin 2019

AMSER	Uwchgynhadledd Nyrsio Gymunedol a Gofal Sylfaenol RCN Cymru: 'Bodloni'r Agenda ar gyfer Cymru Iachach' 12 Mehefin 2019 Y RHAGLEN
12.00 – 13:00	**Cofrestru a Chinio**
13:00 – 13:10	**Croeso** Nicola Davis-Job, Cyfarwyddwr Cyswllt Dros Dro (Ymarfer Proffesiynol) RCN Cymru
13:10 – 13:15	**Cyflwyniad y Cadeirydd i'r Uwchgynhadledd** Dr Sue Thomas, Ymgynghorydd Gofal Sylfaenol, Y Sector Gymunedol ac Annibynnol, RCN Cymru
13:15 – 13:35	**Y Rhaglen Strategol ar gyfer Gofal Sylfaenol yng Nghymru** Sue Morgan, Cyfarwyddwr Cenedlaethol ac Arweinydd Rhaglen Strategol ar gyfer Gofal Sylfaenol
	Cwestiynau
13.40 – 14.05	**Y Darlun Cyfoes ar gyfer Gofal Sylfaenol a Nyrsio Cymunedol** Dr Crystal Oldman, Cyfarwyddwr, Queen's Nursing Institute, y DU
	Cwestiynau
14.10 – 14.30	**Swyddogaeth Addysg a Gwella Iechyd Cymru a Gofal Sylfaenol a Nyrsio Cymunedol** Stephen Griffiths, Cyfarwyddwr Nyrsio, Addysg a Gwella Iechyd Cymru
	Cwestiynau
14:40 – 15:00	**Te a Choffi**
15:00 – 16:30	**Gweithdai** Gwahoddir cynrychiolwyr i weithio gyda chydweithwyr i fynd i'r afael â chwestiynau allweddolHwyluswyr: Sue Thomas, Diane Powles, Lisa Turnbull
16:30 – 16:50	**Sylwadau, Casgliadau Cynnar, Argymhellion a'r Ffordd Ymlaen**
16:50 – 17:00	**Crynodeb a Sylwadau i Gloi** Stephen Griffiths, Cyfarwyddwr Nyrsio, Addysg a Gwella Iechyd Cymru
17:00	**Gorffen**

Cyfeiriadau

Coleman E (2003) Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. Journal of the American Geriatrics Society. Cyf. 51(4), 549–555

Yr Adran Iechyd (2010) Front Line Care: the future of nursing and midwifery in England. Yr Adran Iechyd, Nyrsio mewn Iechyd Cyhoeddus, Leeds

Yr Adran Iechyd (2013) Care in local communities: *A new vision and model for district nursing.* Yr Adran Iechyd, Nyrsio mewn Iechyd Cyhoeddus, Leeds

Comisiynydd Cenedlaethau'r Dyfodol Cymru (2015) Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) https://futuregenerations.wales/about-us/future-generations-act/ Swyddfa Comisiynydd Cenedlaethau'r Dyfodol Cymru, Caerdydd

King's Fund (2012a) Transforming the Delivery of Health and Social Care: *The case for fundamental change.* King's Fund, Llundain

King's Fund (2012b) The care of frail older people with complex needs: time for a revolution. Uwchgynhadledd Iechyd Sir Roger Bannister, Castell Leeds. King's Fund, Llundain

Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E a van Vught A (2018) Nurses as substitutes for doctors in primary care. Cronfa Ddata Adolygiadau Systematig Cochrane

Malcomess K (2005) The Care Aims Model. Yn Anderson C a van der Gaag (2005) Speech and Language Therapy: Issues in Professional Practice. Whurr Publishers, Llundain

NHS Cymru (2018) Strategic Programme for Primary Care in Wales. Ar gael yn http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Strategic%20Programme%20for%20Primary%20Care.pdf (gwelwyd 30 Gorffennaf 2019)

Prudent Healthcare Wales (2016) Prudent Healthcare Securing Health and Well-being for Future Generations. Ar gael yn http://www.prudenthealthcare.org.uk/wp-content/uploads/2016/02/Securing-Health-and-Wellbeing-for-Future-Generations1.pdf (accessed on 30 July 2019)

Queen's Nursing Institute (2011) Nursing People at Home: *The issues, the stories, the actions.* Queen's Nursing Institute, Llundain

RCN (2013) Defining staffing levels for children and young people's services: *RCN standards for clinical professionals and service managers.* RCN, Llundain

RCN (2014) Defining Nursing. RCN, Llundain

RCN (2015) Getting it Right Every Time: fundamentals of nursing care at the end of life. Ar gael yn http://rcnendoflife.org.uk/my-role/ (gwelwyd 30 Gorffennaf 2019)

RCN Cymru (2017) Role Descriptors: *The unique contribution of primary and community nursing throughout the life course*. RCN Cymru, Caerdydd

RCN Cymru (2018) Nursing Numbers in Wales. RCN Cymru, Caerdydd

Unsworth J, Tuffnell C a Platt A (2011) Safer care at home: use of simulation training to improve standards. British Journal of Community Nursing. Cyf. 16(7), 334-9

Llywodraeth Cymru (2017) Interim District Nurse Guiding Staffing Principles. Ar gael yn https://gweddill.gov.wales/docs/phhs/publications/171004letteren.pdf (gwelwyd 30 Gorffennaf 2019)

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