

# COMMUNITY AND DISTRICT NURSING SERVICE MODELS

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## Literature Search for innovative and integrated models of care

This report is prepared for the Community Nursing Service Level Alliance Team, Bay of Plenty District Health Board.

The purpose of this report is to summarise the relevant New Zealand and international community/ district nursing service models through a literature search and review.

In addition, most relevant NZ and Australian exemplars are supplied as identified through telephone interviews and personal experience.

The information provided here is not a systemic review of the evidence available on community and district nursing service models. However, much care and diligence has been applied to present an up-to-date report based on literature search, interviews and personal experience.

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# Community and District Nursing Service Models

## LITERATURE SEARCH FOR INNOVATIVE AND INTEGRATED MODELS OF CARE

### SUMMARY

This report is prepared for the Community Nursing Service Level Alliance Team, Bay of Plenty District Health Board. The purpose of this report is to summarise the relevant New Zealand and international community/district nursing service models through a literature search and review.

The examples show cased in this report as innovative or integrated community nursing services show the following themes:

- Increased use of nurse led specialist clinics for ambulatory clients with a range of specialties including complex wound care, continence management, infusion and diabetic clinics.
- Increased use of smart technologies supporting evidence based practice, tele health care, shared care records and plans and mobile technologies for nurses on the road
- Strong education, training and research support for the nursing workforce
- Increased focus on multi-disciplinary team approach and intense case management for complex clients care
- Increasingly working through specifically established network of services alongside general practice/primary care.
- Care coordination provided at varying levels of care
- 24/7 customer contact center or telephone support for patients, referrers and staff
- Increased use of generalist nursing functions wrapped around specialist care where communities are seen as corridors of health and social services

Integration of community and district nursing is not only focused on integrating with primary and secondary care but also focused on integrating with community services.

### RECOMMENDATIONS

The following sites in New Zealand are recommended for site visits by SLAT.

Site	Topic
1. Midland Health Network pilot, Waikato	Community nursing and primary care integration
2. The Nurse Maude Association, Christchurch	Integration within community services and innovative services
3. Canterbury Clinical Network, Christchurch	Primary care integration
4. Capital and Coast District Health Board, Wellington	Canons Creek clinic and Island Bay Pilot

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## NEW ZEALAND INTEGRATION AND INNOVATIVE MODELS

In 2011, the Ministry of Health (MoH) commissioned a report on *District Nursing Services Developments in NZ*. ('The MoH 2011 Report') This report summarises the findings of a comprehensive survey of 59 district nursing service (DNS) innovations in New Zealand and draws together themes from selected case studies. Four innovations were selected for detailed case study and profiled in the 2011 report.

A copy can be accessed on the Ministry's website through this following link:

[https://www.health.govt.nz/system/files/documents/publications/district-nursing-service-development-in-nz\\_0.pdf](https://www.health.govt.nz/system/files/documents/publications/district-nursing-service-development-in-nz_0.pdf)

The MoH 2011 report provided details of New Zealand DNS models as at 2011. This report and literature search largely focused on innovations and new service developments in New Zealand since 2011. In addition, two of the four innovative DNS service were also interviewed to gain an update since 2011 on new service developments.

### Nurse Maude District Nursing Service

Information relating to this section was collected from a mixed sources of websites, phone interview with CE of Nurse Maude and Programme Manager of Canterbury Clinical Care Network and personal experience as a former General Manager of Nurse Maude. The links to the website are provided below:

<http://www.nursemaude.org.nz/nursing/nursing-services>

Hammond, C. E., & Nixon, M. A. (2011, May/June). The reliability of a Handheld Wound Measurement and Documentation Device in Clinical Practice. *Wound, Ostomy and COntinence Nurses Society*, pp. 260 - 264.

Manchester, A. (2014, August Vol 20, No 7). Nurse Maude Champions Community Care. *Kai Tiaki Nursing New Zealand*.

### Background

Established in 1896 by Matron Sybilla Maude, the Nurse Maude Association (NM) is the oldest and largest district nursing service in New Zealand. Sybilla pioneered district nursing service in New Zealand and left the Christchurch hospital and set on foot to care for the sick and poor in their homes.

The governance and structure of NM is unique in New Zealand as it the Association is established under its own Act of parliament. The core focus of NM remains the same which is to support people to stay out of hospital and remain living as independently as possible in their own homes, with an emphasis on self-care.

NM structure and model is one that is both independent but integrated with a wide range of community services. NM employs more than 1100 staff including 100 district nurses and 600 support workers providing a range of services which includes district nursing, community allied health services, restorative home based support care, palliative care services, 11 bed hospice, 40 bed dementia residential care facilities, nurse led clinics, clinical equipment and supply shops, meals on wheels, laundry services, care coordination, independent care management and assessment services. . Each year, NM staff provide care to about 14,000 patients a year through 700,000 episodes of care. Forty percent of patients are aged 85 and over with more than half having multiple co-morbidities. Nearly a third of NM patients access more than three NM services.

## Community Nursing

NM claims to have developed a more comprehensive spectrum of community nursing services in New Zealand with service collaboration at the heart of its service model. A broad range of community nursing including district nursing, palliative nursing, school nursing, and specialist nursing on diabetes, stomal, wound care and continence is provided at home, schools, aged care facilities, and clinic settings. The RNs & ENs provide clinical assessment and care and are part of a larger multi-disciplinary team consisting of CNS, allied health, Health Care Assistants and home based support workers. ENs & HCAs provide ongoing care and support. About a third of the district nursing clients receive palliative care.

The following section provides an overview of the range of services and models provided through community nursing services.

### PAEDIATRIC PALLIATIVE CARE

Child's doctor can refer to the NM Specialist Palliative Care team and care is provided in collaboration with child's primary paediatrician. Services provided include pain/symptom relief, communication with different doctors and other health professionals, providing information that can help to make treatment decisions, identifying other professionals who can help. Care is provided in various settings ranging from home visits, hospice or hospital, support through telephone & video conferencing if the child lives in a remote community.

### STOMAL SERVICE

Visits in hospital, and at home after discharge, arranging for ostomy equipment, clinics for regular checks and assessments, access to other health professionals and agencies and prescriptions for ostomy appliances.

### COMPLEX WOUND SERVICES

Specialist wound care clinics where nurses can assess, manage and advise on chronic or complex wounds, or leg ulcers. Provide care plans and follow-up programmes aimed at preventing wounds, including compression hosiery for leg ulcers. Clients are referred by their GP, Practice Nurse, District Nurse, hospital or specialist, or may contact the Wound Management Service themselves. The CNSs also provide consultation and advice on wound management to GP's, community and practice nurses, rest homes and private hospitals.

For over 15 years, NM has provided innovative use of technologies and products available and participated in various national and international trials. These include the successful use of manukau honey dressings, SYFT technology to identify and isolate specific bacteria in long-term wounds and handheld wound measurement and documentation device. The complex wound service is supported through a nurse-led clinic that is supported by a MDT including scheduled visits from the Christchurch based vascular surgeon. The MDT provides support to patients with diabetes, physiotherapy and self-management plans providing a sustainable care plan.

### CONTINENCE SERVICE

This service is based on a MDT approach as well with continence advisor consultations (RN or physiotherapist), education in the specialist area of continence management for patients and other health professionals, confidential support, assessment, treatment, and continence products for anyone over 4yrs of age. This service is provided in home, community and clinic settings.

### ACUTE DEMAND NURSING

A high level specialist nursing care enabling patients to stay own home rather than be admitted to, or remain in, hospital referred by doctor or hospital specialist and assessed and cared for by the Acute Community Team over a period of one to five days. After that care will be referred back to the GP for follow-up.

## INFUSION SERVICES

The GPs and medical specialist refer patients to NM Infusion Centre and if the Infusion Centre is not the best place an alternative arrangement is made.

NM sees the Infusion Centre as an expansion on its district nursing services. It is staffed by four nurses providing arrange of services including antibiotics, frusmide for end-stage heart failure and blood transfusion for palliative care patients. Patient profile of those who access the Infusion Centre are:

- Oncology patients (approx. 60%) total numbers
- General Medicine patients with PICC's requiring blood sampling, intravenous medications, on-going specialist oversight
- Patients with acute infections requiring longer term IVAB's ie. Septic Arthritis, Osteomyelitis, Endocarditis, Cellulitis generally require 2-6week IVAB treatment
- Chronic infective conditions, i.e. Bronchiectasis, recurrent prosthetic infections

## HOME DIALYSIS SERVICE

For patients assessed as able to receive dialysis at home the Home Dialysis Coordinator meets with the patient at hospital to discuss the care plan working closely with the Dialysis Department at the Hospital. Personalised care plan is developed by RN who formally admits patient to NM Home Dialysis Service and ensures that patient and family/carer understand how the care is provided, by whom and when. A nurse will visit the patient at home to deliver the Community Dialysis Programme which includes assessment, cannulation, equipment set-up, monitoring during dialysis treatment and the takedown and cleaning of equipment.

## DIABETES SERVICE

Diabetes service provide assistance, support and information for people newly diagnosed with diabetes and families in their own home or workplace from Monday to Friday 8am - 5pm, assistance with the start of insulin or changes in medication. Community nursing gives ongoing support to diabetics via a 24/7 service.

## DIETITIAN SERVICE

This service is primarily for wound and palliative care patients and is provided by NZ-registered dietitian. The Dietitian Service provides an assessment of dietary needs for a wide range of medical conditions and support to caregivers. Dietary information to promote wellbeing, and monitoring and adjustment of nutritional programmes for people with life-limiting illnesses, is also available either in clients' homes, (if they are unable to travel), or at the dietitians clinic at NM.

## SCHOOL BASED NURSING SERVICE

The NM School Based Nursing Service provides access to youth focused health services in decile 1 and 2 secondary schools, alternative education facilities and teen parent units in Christchurch. The team of RNs are skilled in youth health and development. The service is provided in conjunction with other primary and secondary services. The nurses provide universal health, disability and youth development checks which includes the HEADSSS assessment, screening of hearing, vision, chronic illnesses and symptoms of illness providing a proactive promotional health campaigns and individual health services.

## CREST

NM has two rapid response team operating under the Community Rehabilitation Enabled Support Team (CREST) model. Bulk funding of community services has provided the flexibility to re-design the traditional home based support services to enable early supported discharge or admission avoidance. CREST liaison

nursing team, based in the hospital identify people who would be suitable for this service. This service is also accessed by GPs referring relevant patients.

NM's CREST (each) team employs 12 full-time equivalent (FTE) support workers working rostered and rotating shifts. Each team includes a registered and enrolled nurse case manager.

### **Canterbury Clinical Network (CCN)**

CCN supports a range of integration work in the primary and community setting. The 2011 earthquake has accelerated the work in particular the shared electronic patient record. The network allows care to be coordinated across the sector enabling providers to map out pathways especially for those whose needs are not met (COPD). Patients with complex needs have a single care plan that all providers have access to.

### **Integration with General Practice**

DN service is focused on developing a shared care approach for the most complex clients. The focus of integration is within the community and the approach taken is to build a network of community services around the enrolled population of general practices. DHB-employed care coordinators work within nine of these general practices and use NM as a preferred provider for community services. NM district nurses have joint practice meetings and agree on a joint care plan.

### **Information Systems Management**

Since late 2014, NM has developed an in-house electronic patient record system called CRISTA (community record information system, team approach). CRISTA enables DNs to have access on point of care to client records, visit schedules, emails, patient interventions and outcomes, link to CDHB e-SCRV (shared care record view) and the NM intranet.

### **NM New Zealand Institute of Community Healthcare**

NM community nurses and other staff are supported with on-going professional development, education, training, research and clinical trials through its own Institute for Community Healthcare.

## Capital and Coast District Nursing Service

The following information was collected through an interview with the Project Manager, Medicine, Cancer and Community who implemented the specialist leg ulcer clinic and is currently working on frail elderly and district nursing projects. Additional information is supplied from personal experience.

### **Background**

The MoH 2011 report profiled a case study on Capital and Coast District Health Board's (CCDDHB) DNS specialist leg ulcer/wound pilot clinic within an urban PHO (Ora Toa Medical Centre in Cannons Creek). This service was part CCDHB's 2010 District Nursing project" that sought to enhance the district nursing service in the region.

In 2005, CCDHB publicly consulted 'an integrated home and community health service' model for the district. Three stages of changes were identified and proposed as follows:

- Care Coordination Centre (since July 2005):

A single point of entry for all community health referrals including district nursing, community allied health services, home based support services and entry into Aged Residential Care facilities. This Care

Coordination Centre (CCC) also took over the Needs Assessment Service Coordination (NASC) function for people aged 65. A request for proposal (RFP) process was carried out with Nurse Maude Association selected as the contracted provider. 12 FTE Care Managers were either employed or re-deployed from NASC and introduced InterRAI MDS-HC and Contact Assessment tools. The Care Managers are registered nurses or allied health professionals and were fully trained on InterRAI and restorative models of care. The Care Managers were 'assigned' to a general practice or PHO and established stronger communication. A summary care plan was shared with the patients' GP.

- Restorative home based packages of care (since late 2005)

Following a RFP process, existing home based support service providers were selected to implement a restorative packages of care services working with CCC to change the traditional home care service provision. The packages of care also was expanded to include 'routine' nursing and community allied health service delivery however the very few packages of care in fact delivered nursing and allied health services resulting in no change to existing district nursing service provision. The introduction of home based packages of care resulted in significant changes to home based support service delivery based on clinical and social needs rather than the entitlement model. In 2011, a subsequent RFP was issued which included in addition to existing packages the non-complex assessment with rationalisation of providers to two and a casemix based bulk funding methodology.

- Community Nursing and Allied Health Re-design

The final part of the change was to include the re-design of community (district) nursing and allied health services. The CCDHB publicly consulted its options in 2007 and concluded that it will look for enhancement to current services through an internal process which is the context to the development of the '2010 District Nursing' project.

## **2010 District Nursing Project Update**

An update on the 2010 District Nursing project including the specialist leg ulcer clinic is provided in this section. The project focused on the philosophy that community nursing should focus on delivering care autonomously in the community and then then look to wrap around specialist care around this.

### **SPECIALIST LEG ULCER CLINIC**

The specialist leg ulcer clinic at Cannons Creek is now operating as a business as usual service having developed tool which assess the risk of non-healing leg ulcers and to relate the tool's use to wound healing rates after specialist nursing intervention. Detailed wound care guideline are in place with 30% of wounds healed within 2 weeks and if not a referral to Clinical Nurse Specialist is made. The patient outcome is positive with reduced VAC. A second clinic at Strathmore was unsuccessful and is now closed. This is mainly due to poor access to the clinic in that area. The 3 bases treat about 60 patients a day. There is the need to provide for compression hosiery. The district nursing service currently provides one set at no cost to patients however a VAC surgeon can prescribe five. It is anticipated that Pharmac, through CCDHB lobbying with the Maori Unit, are expected to fund this within the next six months. The District Nursing service have trained the Practice Nurses to perform Doppler assessment.

### **SPECIALIST LEG ULCER CLINIC**

PHO out-reach nursing is funded through SLA and LT funding. It is unclear how this is practically delivered in the community. It appears to be largely providing follow up visits in parallel to district nursing from an acute event of older persons.

### **DATA AND WORKFORCE**



A stock take of district nursing activities was carried out with measured activities. High level retrospective data is available. The following changes have been made based on information collected:

- District Nurses are employed to the service not physical location
- Weekend rotation established, previously specific staff recruited to weekend roster
- Greater focus on establishing 'generalist nursing' role supported by health care assistants, Clinical Nurse Specialist (continence, stoma, respiratory, palliative, wound) and RN with special interest. Previously the CNS and Charge Nurse Manager roles were inter changeable which no longer is the case with CNS expected to maintain high level of clinical service intervention and Charge Nurse Managers have a greater focus on clinical screening, support and allocation of work flow.
- Employed CNS Hospital Avoidance Admission who has an ED nurse background. This nurse visit the hospital, and wards and pull patients.

### PROMOTION

District Nursing Service was profiled and marketed to the referrers and patients alike. A 'big card' containing introductory information regarding the district nursing service is provided to patients especially ahead of discharge.

### LOOKING AHEAD

The following list provides the top of mind areas for improvement or enhancement to current service delivery.

- Referrals comes through CCC which is then re-processed by DNS mainly due to limited information provided by referrers in the first place. There are opportunities to eliminate this duplication.
- CNS Older Adult is sitting with Community Allied Health who are co-located on other part of the building but are not integrated in the DNS service model.
- DN don't attend MDT, the DN liaison nurse attends the MDT however she does not provide clinical care and is focused on assessment and care planning.
- The DN are assigned' to GPs and currently in process to enable DN to meet with GPs each month.'
- DN identified area of focus is heart failure in addition to the current focus on diabetes and renal services.

### **Pilot Project – Integrated Community Services (July 2014)**

In July 2014, Waikane and Island Bay General Practices were identified to working with DNS to run a pilot project on integrating community services. The following list provides key project information:

- Aim to integrate community Allied Health and CNS with DNS service
- The service is co-designed with patients, one patient already involved and others are being interviewed at present.
- Health Quality New Zealand (HQNZ) is supportive of this project and provided training in August on design methodology focused on 'what does a user want?'. Prototype is now being finalised.
- Leutz model of integration is used as a basis to guide the integration work noting the following
  - a cohort of patients who require full integration
    - DN & Allied Health staff to have access to MedTech
    - Shared care plan (similar to health passport)
    - Geriatrician involvement in the MDT
  - a cohort of patients identified as emerging high needs
    - Identify who will case manage and who will coordinate care
    - Ensuring EPOA, vaccination, medication etc. are up to date

- PHO based pharmacist home visit to 'high risk' patients discharged from hospital to review medication.
- A cohort of patients classified as general needs
  - Ensuring that GP knows who in DNS and Allied Health team to contact and being able to directly liaise with them
- The main challenge to date is around funding the GP to attend MDT meetings.
- Currently focused on developing risk stratification tool and outcome measurements however the project outcome is reduction to ED' which is not seen as ideal from stakeholders.

### **Self-Care Management focus**

The DNS is taking a greater focus on self-care management with younger generation seeking support with self-care. Main area of interest is IV cannulation in a home setting and DNS are on rotation in order to keep up to date with training. The DN are engaging the patients at the outset on admission to DNS about self-care management and support which has seen the biggest change in how the services is received.

Since 2008, the DNS has not had any additional staffing however are seeing about 30% increase in patients.

### **Healthcare Hawke's Bay DHB pilot**

Information accessed through the following site:

<http://www.hawkesbay.health.nz/news/pageid/2145884215>

#### **Background**

This is a pilot programme involving DHB District Nurses, Health Hawke's Bay (PHO) and three General Practices with the aim of breaking new ground in patient care through closer integration of district nursing and primary care practices.

District Nurses are employed and resourced by HBDHB, structured within the Oral, Rural and Community Service, but also closely aligned to the practice - at times physically basing themselves there when not visiting patients in their home.

Previously GPs and District Nurses worked in relative isolation, and there were difficulties in communicating patient information even though both may have been involved in providing care for the same patient.

DNs have access to the General Practices MedTech 32 PMS system, now see their patient's history online, even when on the road via laptop. They can add to the file any actions they have taken, note anything they have observed when visiting the patient in their home, and express any concerns. They can also schedule doctor's appointments.

DN skills are being used by General Practice – wound assessment, advice, management of wounds failing to progress or developing complications, catheter and bowel management, administration of prescribed medications and support with management of other health issues.

DNs are in effect one of the team, to be referred to, and to pass on information to the appropriate practice when a patient is referred to them directly from hospital services.

The pilot has been running for 15 months and the service model is expected to be finalised by April 2015. Other General Practices will be invited to participate prior to that date.

## Desired Outcome

Improvement of patient experience by bringing key stakeholder services closer together, eliminating duplication and waste, and ensuring patients have direct access to services closer to their medical home.

## Key features, learnings and feedback

- Rolled out at Hastings Health Centre, Totara Health and Te Mata Peak Practice
- District Nurses aligned to General Practices and given remote access to their clinical records.
- DNs can access overall histories of patients they are treating at home and contribute to shared patient records through their clinical notes
- Initial teething problems included poor knowledge of roles, incompatibility with each other's methodology and way of practising
- Resounding message from all stakeholders is that the partnership is one of the most significant moves so far towards integrating services and putting patient at centre of care.
- Alan Wright, GP Hastings Health Centre says, development of closer ties with district nursing staff was "long overdue" and has led to "one of the best integrated programmes that's happened in years".  
*"GPs will learn quickly, as I have, that these District Nurses are at the coalface of health care, working with patients in their own homes. Giving them unrestricted access to our files can only benefit General Practice. The inputting of their case notes can only advance our knowledge of our patients. Previously we might not have even known that a patient had been seen by a District Nurse, and more importantly, what for."*
- One of Dr Wright's patients, 86-year-old Rex Hay has had much involvement with DNs due to circulation problems in his legs leading to multiple operations and ultimately the loss of his left leg in 2010.  
*"While they're here they just sit down on the floor and punch everything through to my doctor, and if there's any sort of trouble my doctor comes around to see me. "When I go to the doctor, he brings up everything the DNs have told him. "It's marvellous care."*
- Rachael Prenter, Acting manager Hastings Health Centre says she believes the collaboration is the only example of its kind in the country. *"We are trying to move from a model which can provide fragmented, duplicated and disorganised care to one that merges activity around the patient. e.g. Prior to this programme, we in General Practice received results for tests ordered by DNs that we knew nothing about but were expected to follow up. That clearly is not best practice."*
- HBDHB Clinical Nurse Manager Community Nursing Maree Gladstone said the pilot is at the stage where opportunities to develop the concept of integration were becoming clearer including:
  - possibility of clinics within the practice setting for DN patients,
  - streamlining the referral process and
  - Investigating alternative nursing models to improve both the patient and nurse experience in line with the philosophy of integration, and DHB strategic direction.

## Midland Health Network Pilot

The following documents were accessed and available via Sarah Davey:

- *Integrated Family Health services a gift for primary nursing – Helen Parker – Midlands Health Network 30/5/2014*
- *FAQ documents 1-3*

Practice nurses and DNs work together to identify opportunities to integrate services, also includes DHB RNs where integration is indicated.

- All referrals for DNs is through Community Referral Centre which negates the need for referrals between primary care and DNs
- Core nursing functions are shared – if a patient is eligible for DNS no charge is made regardless of which RN role provides the service, if charge indicated for primary service, charge applies regardless of which RN role provides the service
- Regular nursing meetings to share information plus web based forum
- Development programme – pre and post pilot workshops, MedTech basic training for DNs, Coach/Mentor (skilled in integrated care) for each team of nurses, Technical support
- Measures identified and information is collected
- Team approach – patients have personalised care plan and are under a team
- Shared care record
- GP triage and same day appointments

## Counties Manukau DHB Localities Model – Community Health Service Integration

Information accessed through the following site and personal experience:

<http://www.countiesmanukau.health.nz/AchievingBalance/System-Integration/system-integration-home.htm>

CMH has ambitious plans to integrate primary and community care at a locality level. Multidisciplinary community teams are being formed around general practice clusters in each locality to better support primary care as the central focus and coordinating mechanism of healthcare ('the healthcare home'). Primary Care's role is expanding with a focus on delivering proactive and coordinated care. Locality leadership groups and community and clinical networks have been established to provide engagement and governance over the development and implementation of new models of care.

The Home Healthcare (district nursing and community allied health) and Needs Assessment and Service Coordination (NASC) teams have already begun this transition to the locality model as part of a 'whole of system' approach to improving services for older people, under the direction of the four locality General Managers. Over time, most community services, except those that are highly specialised, will work in these integrated, multi-disciplinary locality-based clusters.

Since July 2014, an At Risk Individual (ARI) programme is being rolled out by primary care practices to identify and manage clients at risk of hospitalisation. Patients enrolled in the ARI programme have a named

care coordinator assigned to them, have an electronic summary health record which is able to be viewed across health care providers and have a patient centered, goal based care plan which is shared with their care team.

The localities are working together in setting the direction for further integration of community health services. The focus is on creating a seamless and connected care and support for the service users. The following are the main objectives that guides the development of an integrated Community Health Services:

- develop current services towards an integrated model of reablement
- services are closely integrated with 'the healthcare home'
- enable funding to support the primary care to deliver to the integrated model of reablement
- use of technologies to enable more productive and better clinical care
- commissioning with providers of service for shared outcome
- maximise the use of skilled workforce and support work satisfaction
- support the delivery of care plan developed by programmes such as ARI in order to respond rapidly to the needs of the service users

The community health service integration is similar to the Northern Ireland's regional redesign of community nursing.

## West coast DHB – Neighbourhood Nurse Project

Information accessed through the following site:

[http://www.westcoastdhb.org.nz/about\\_us/projects/neighbourhood\\_nurses/](http://www.westcoastdhb.org.nz/about_us/projects/neighbourhood_nurses/)

### Background

This is a project carried out from project 2003-2006 with a report produced in January 2007.

Primary aim was to trial a new primary health care nursing role focused on new ways of working with clients, families, and colleagues.

The secondary aim was to explore success factors (or otherwise) in implementing the role.

A more 'generic' role "*the Neighbourhood Nurse*" was proposed. The idea is that the nurses would be free to 'do what needs to be done' in response to client and community need, instead of service delivery being shaped by contracted work streams.

The patients' needs were expected to be wide ranging from actual health problems, to education and support. The role focused on facilitating the patients and families to take responsibility for maintaining their own health, wellness and capability. It was anticipated that health gains would follow from increased emphasis on health promotion and strengthening clients in self-management.

The nurses were expected to be supported to expand their knowledge and skills to develop a broader, more generalist orientation than required in traditional community-based nursing roles.

Geographically based caseload was expected to present diverse health needs across the age range, and also thought to go some way to rationalising the travel involved in servicing a sparsely distributed outlying rural population

### **Key outcomes**

Demonstrated new role was able to deliver the service intended, and overall, stakeholders believed it should be implemented through a considered process.

- mapping a more generic primary health care nursing role through development of a position description and related set of competencies
- framework of development and support for nurses transitioning to a new role and new way of working
- benchmarking to monitor role development and service delivery
- tool to obtain in-depth client feedback on service
- set of Project Files which give full details to assist future planning.

### **Key learnings**

- nurses needed to feel they were making a free & informed choice when taking up a new role
- ongoing communication with stakeholders is critical
- development and support is necessary for transition to a new role
- flexibility is needed in the position description to enable the role to be 'fitted' against a given community's needs, other service provision and individual competency profiles
- Change requires management and leadership support close to the action.

### **Implications**

- Trialing the new primary health care nursing role in several localities surfaced important principles for role and service development that might not have become apparent had the project continued in one locality
- Nursing role development is a dynamic process responsive to health needs in particular communities, which means that a new role may develop differently in different localities
- Agreement needed on the rationale for change, and a shared ownership of service development between professionals, providers and the community.

The challenge identified for the DHB in planning primary health care nursing services for a given locality is to obtain the right mix of nursing roles according to four factors:

- community profile
- other service provision or service gaps
- the team's readiness to explore new ways of working
- the competency profiles of individual nurses within the team

## AUSTRALIAN DISTRICT NURSING SERVICE MODELS

In Australia primary care developments are trailing behind New Zealand with the formation of primary care networks currently underway. District Nursing Services are operated through various structures across the country. The three largest district nursing providers are all not-for-profit entities who have well established district and community nursing and healthcare services. The three services have for long time (70 – 120 years) operated in their local state. The last decade has seen them expand nationally and also merge and acquire other community health care providers.

### SilverChain Group

Information accessed through the following site:

<http://www.silverchain.org.au/>

#### **Background**

In September 2011, Silver Chain in Western Australia and RDNS in South Australia, two large not-for profit organisations, merged to become one of the largest in-home health and care providers in Australia. With over 3,000 staff and 400 volunteers, the Group assists over 83,000 people to remain living in their homes and community every year providing in excess of 2.5 million occasion of service and 1.7M hours of care.

Both Silver Chain and RDNS South Australia were established over 100 years and specialises in delivering care in the community to assist people in their homes. The Group's coverage now includes Western Australia, South Australia, Queensland and New South Wales.

A broad range of services are provided to people including specialist nursing, palliative care, home care and support services, home hospital and home therapy/allied services, such as physiotherapy, podiatry and speech pathology, personal alarms, 24/7 customer service center and other technology based support to assist clients of all ages.

Description of relevant service offerings are described below.

#### **Telehealth**

The following section is a direct write up from the SilverChain annual report 2013/14.

Silver Chain took part in a ground breaking Telehealth pilot in Geraldton, Western Australia, to help improve rural access to healthcare by delivering services in the home using technology supported by the National Broadband Network.

The pilot commenced on 30 June 2013 and involved the use of video-enabled Samsung tablets to deliver Telehealth monitoring and video consultations to 86 elderly clients living in their own homes.

Clients monitored their conditions from their home by entering data such as their blood pressure, temperature, pulse and weight on to their tablet each day which was in turn sent to a Silver Chain nurse for assessment.

When there was an anomaly, an alert was sent to our nurse via email or mobile phone and as the nurse already had a comprehensive view of their client's immediate health issues, could make an informed decisions about what action to be taken.

#### **Specialist Wound care Clinic**

Technology is helping to improve the quality of life for clients suffering from chronic long-term wounds.

Nurse practitioners provide Silver Chain's Advanced Wound Assessment Service and use technical interventions to heal wounds supported by their extensive wound knowledge and experience. Long suffering clients with chronic wounds that have failed to show healing after six weeks of evidence based treatment are typically referred to this service. Low frequency ultrasonic debridement machines are the new form of technology used to assist in the healing of persistent wounds by providing a relatively painless method of removing non-viable tissue, reducing bacteria and accelerating healing.

### **Customer centre**

Two Customer Centres based in Perth and Adelaide support the organisation nationally providing 24 hours a day, seven days a week, supporting to clients, providers and referrers. The two Centres handle about 775,000 client calls during a year and processed 72,500 referrals.

The Referrals teams operate as the front door to the organisation for all new clients, processing referrals and preparing them for care delivery. The service teams play a collaboration role between clients, their families and operational staff, ensuring vital information passes between these stakeholders seamlessly with minimal disruption to client care.

The direction of these Centres is likely to lead to onboarding new clients, helping clients navigate the aged care environment and assisting them in making key choices about the right packages and organisation for their care goals.

### **Registered Training Organisation (RTO)**

The SilverChain group operates a RTO offering training and education to staff and general public in Western and South Australia.

The range of training offered include:

- Certificate III in Aged Care to students in several regions in and around Perth
- Diploma of Nursing course
- Traineeships in Certificate III Aged Care and Home and Community Care
- Wound Management Master Class program that attracted participants from across Australia.
- National online palliative care course and a face-to-face workshop program in Tasmania. The online course is offered to more than 13,500 learners from 22 different countries. The Tasmanian workshop program is anticipated to reach over 800 participants.

### **Royal District Nursing Service (RDNS)**

Information accessed through the following site and personal experience.

<http://www.rdns.com.au/>

#### **Background**

RDNS is the oldest and largest district nursing provider in Australasia. For over 124 years, RDNS provided nursing and home based care in metropolitan Melbourne. In 2008, it looked to expand its services in Australia and introduced care coordination and customer services in Tasmania. In 2009, it launched a New Zealand subsidiary providing predominantly restorative home based support care in Auckland, Otago and Southern. Today RDNS provides services across Australia in Victoria, New South Wales, Queensland, Tasmania and New Zealand and China.



RDNS on a typical day provide home nursing and healthcare to more than 9,500 people throughout Greater Melbourne, parts of regional Victoria, New South Wales, Western Australia, Queensland, China and New Zealand. In a year, over 1 200 nurses make more than 2.7 million client visits to over 40,000 people, mainly in their own homes travelling in excess of 10 million kilometers on a 24/7 basis.

### **Spectrum of services**

RDNS offers a broad spectrum of services in home, school, aged care, corporate and other settings including for those who are homeless. The services includes community nursing, specialist nursing, home care packages, palliative care, dementia care, HIV aids allied health, education and tele health care. Key service features includes:

- MDT team approach
- Intense case management to coordination
- Use of tele health care
- Use of evidence based care
- Specialist Nurse Led Clinics
- Unique service models supporting vulnerable individuals' with HIV aids and homeless people
- Active Service (restorative) Model focus on reablement and wellness, goal directed care and dementia
- Consumer Directed Care
- Rapid Response and reablement focus
- Hospital in the home programmes with care provided at home while still under while the primary care responsibility with hospital medical/ surgical specialist
- Use of mobile computing technologies since late 1990s by District Nurses who operate paperless

In 2014, RDNS introduced home-based peritoneal dialysis providing consumers nurse-supervised

### **Customer Service Centre**

The service delivery is supported by the RDNS Customer Service Centre (CSC) on a 24/7 basis and aims to resolve on a first contact basis most of the 267,000+ inbound calls a year. The CSC is staffed by registered nurses who can perform clinical screening, triage and assessment and coordination of services over the phone. The CSC also manages the National Pregnancy Birth and Baby (PBB) helpline on behalf of Healthdirect Australia and plans for video consultations. The service's target population groups include culturally and Linguistically Diverse Communities (CALD), disabled women, indigenous people and teenage mothers.

### **Tele health care**

Following three years of development, research and evaluation, RDNS is now planning to implement Telehealth as part of its medicines management service for consumers. La Trobe University carried out an evaluation of the major Broadband Enabled Innovation Project (BEIP) and RDNS trailed a cohort of consumers in 2012 which now continues on to business as usual. Early this year, another major project with funding of A\$3.3 million Telehealth initiative funded by the Federal Government Department of Health involves RDNS as one of the partners with more than 200 RDNS clients. Telehealth care involves an RDNS nurse attending to a client remotely, via a videoconference link into the living room. Easy-to-use technology ensures that each client is monitored daily for medicines compliance. It includes a weekly in-home visit. The furthest tele health appointment was with a client over 16,000 km away.

### **Consumer Directed Care (CDC)**

CDC aim is to deliver services in a way that allows consumers to have greater control and say over their own lives and the care they receive. These included people from culturally and linguistically diverse backgrounds

(CALD); lesbian, gay, bisexual, transsexual and intersex groups (LGBTI); veterans; financially and socially disadvantaged people; and people at risk of homelessness.

### **Homeless**

Partnerships and collaboration underpin RDNS Homeless Persons Program (HPP) success which has been recognised with many state and national awards over the years. Currently RDNS HPP partners with 25 service providers in order to co-locate staff in areas of need. A key factor in successful co-location is to find like-minded services that work with homeless people, thereby adding value to both services. Currently RDNS HPP co-locations span – community health, public hospitals, crisis accommodation, day-centres, community housing and services targeting street-based people. The district nurses under the HPP provide services in an unmarked care and no uniform. Due to the trust established between the nurses and the homeless person, the nurse often acts as the case manager/ social worker to access main stream health and social services. The HPP nurses provide care and support to people from all walks of life including some who are fifth generation homeless person.

### **RDNS Institute**

RDNS established its Institute to support its workforce with education, evidence based practice and research over 15 years ago. It provides support to the nurses the use of evidence into practice through an innovative research program. In 2014, it focused on three strategic areas; of research – dementia care, medicines management and wound care – ongoing collaborations have fostered exceptional outcomes, often directly influencing RDNS policy changes and informing new standards of clinical best practice.

RDNS Institute also provides consumer led research with wider community in key projects, including diverse groups and multi-disciplinary teams.

The following is a list of publication by RDNS staff in 2013/14 fiscal year alone.

#### **DEMENTIA**

Goeman, D. (2014). RDNS Nurse led dementia trial. Aged Care Insite.

Koch, S., Goeman, D., Beanland, C. & Duane, F. (2013). The essential role of the dementia specialist. Nursing Review.

Duane, F., Goeman, D., Beanland, C., & Koch, S. (2013). The role of a clinical nurse consultant dementia specialist: a qualitative study. Dementia (in press).

Keady, J., Jones, L., Ward, R., Koch, S., Swarbrick, C., Hellstrom, I., Davies-Quarrell, V. & Williams, S. (2013). Introducing the bio-psychosocial-physical model of dementia through a collective case study design. Journal of Clinical Nursing, 22(19-20): 2768-2777 doi: 10.1111/j.1365- 2702.2012.04292.x.

#### **MEDICINES MANAGEMENT**

Elliott, R., Goeman, D., Beanland, C. & Koch, S. (2014). Medicines Management and assessment of capacity in older people with dementia. Current Clinical Pharmacology Journal.

#### **WOUND CARE**

Kapp, S., Miller, C. & Rist, G. (2014). The experiences of self-management following venous leg ulcer healing. Journal of Clinical Nursing.

Kapp, S. (2014). Simpson, K. & Santamaria, N. (2014). Perspectives on living with and self-treating venous leg ulcers: A person's story and a health care perspective. Wound Practice and Research, 22 (2), 98-101.

Ogrin, R. (2014). We have the evidence to improve venous leg ulcer outcomes: How do we get this evidence into practice? *Wound Practice and Research* (in press).

Kapp, S. (2014). Clinical Practice: Getting stockings on and off. *Nursing Review*.

Miller, C., Kapp, S. & Donohue, L. (2014). Examining factors that influence the adoption of health-promoting behaviours among people with venous disease. *International Wound Journal*, 11(2), 138-146.

Kapp, S. (2014). Preventing leg ulcers by enabling people to apply and remove their compression stockings. *Aged Care Insite*.

Kapp, S. (2014). Wound management study to help seniors. *The Heidelberg Leader*. 4th March, general news.

Kapp, S., Miller, C. & Donohue, L. (2013). The use and acceptability of devices for compression stocking application and removal. *Wound Practice and Research*.

Santamaria, N. & Kapp, S. (2013). TeleWound care – providing remote wound assessment and treatment in the home care setting: current status and future directions. *Journal of Smart Homecare Technology and Telehealth*.

#### MISCELLANEOUS

Wong, P., Liamputtong, P., Koch, S. & Rawson, H. (2014). Families' experiences of their interactions with staff in an Australian intensive care unit (ICU): a qualitative study. *Intensive & Critical Care Nursing*. Article (in press).

Slegers, C., Zion, D., Glass, D., Kelsall, H., Fritschi, L., Brown, N. & Loff, B. (2014). Why do people participate in epidemiological research? *Journal of Bioethical Inquiry*.

Crane, M., Douglass, J., Goeman, D. & Jenkins, C. (2014). Device technique can be improved in older adults through tailored education. *Primary Care Respiratory Journal*.

Ibrahim, J., Chadwick, L., MacPhail, A., McAuliffe, L., Koch, S. & Wells, Y. (2014). Use of quality indicators in nursing homes in Victoria, Australia: A cross-sectional descriptive survey. *Journal of Aging and Health*, DOI: 10.1177/0898264314531619.

Goeman, D. (2014). A journey – but where is the start line? *ANMJ*, 21(7), 36–37.

Goeman, D. (2014). RDNS Institute – relevant and focussed. *PHCRIS Infonet*, 18(3), 2.

Adams, T., Orchard, C., Houghton, P.E., & Ogrin, R. (2014). The metamorphosis of a collaborative team: From creation to operation. *Journal of Inter professional Care*. E-publication 0 (0):1-6. PubMed PMID: 24593331. doi:10.3109/ 13561820.2014.891571.

Michael, J., Ayles, T., & Ogrin, R. (2013). The development of a translation standard to support the improvement of health literacy and provide consistent high quality information. *Australian Health Review*, 37, 547-551.

Pandur R. (2013). Square peg in a round hole – infection control in home health care. *Australian Nursing & Midwifery Journal*; 20(10):42.

## INTERNATIONAL COMMUNITY AND DISTRICT NURSING SERVICE MODELS

There are many international models of care identified through the literature search on innovative and integrated community nursing. In general, they support the following concepts;

- Supports Leutz integration theory in providing community based case management for some - very high needs clients
- Increased use of MDT and IDT approaches to case manage complex client care including use of support assistants
- Increased use of tele health care and mobile computing technologies
- Support for 24/7 community nursing
- Reaffirms the generalist and broad service scope of community and district nursing services
- Confirms that community nursing plays a significant role within the primary care team in alleviating pressures on secondary care by treating more patients in primary care settings

### Nurse employment in primary care – UK and New Zealand

NZFP 2008 Hoare et al

<https://www.rnzcgp.org.nz/assets/documents/Publications/Archive-NZFP/Feb-2008-NZFP-Vol-35-No-1/HoareFeb08.pdf>

#### Conclusion

It wasn't the employment of nurses which changed to facilitate practice nurse development in the UK. Practice nurses organised themselves into peer groups, general practices were remunerated for the attainment of patient health outcomes and a statutory duty of clinical governance at organisational and individual level was applied. Nurse-led clinics and integrated community and practice nurse teams are not part of the New Zealand primary health care culture. Focusing on the employment structures of nurses may be of little relevance in addressing the inequalities in health and achieving the goals of the PHCS in New Zealand. The barriers to full implementation of the PHCS need to be explored. Solutions would include innovative use of nursing skills and integrating primary care and community nursing teams.

Table 1 of this paper provides a useful comparison between UK and New Zealand.

### Care in local communities – a new vision and model for district nursing, UK

NHS/Dept. of Health UK 2013, p13 DN Service Model

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213363/vision-district-nursing-04012013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-district-nursing-04012013.pdf)

District nurse led team providing care and support in the community, including people's homes:

- Population and Case load management:  
Managing and accountable for an active caseload and providing population interventions to improve community health and wellbeing. Surveillance of caseload and local population needs. Working with a range of health and social care partners (including GPs, voluntary sector and community services) for health protection and improvement for adults and their carers, at home and in other community settings. For example, flu immunisation, falls screening and early intervention.

- Support and care for patients who are unwell, recovering at home and at end of life:  
Delivering a swift response from the district nursing service when specific expert health intervention is needed e.g. with short-term health issues, or sudden health crises or when patients are discharged from hospital, or have a sudden deterioration in a health condition. Providing interventions within the home including chemotherapy and intravenous therapy.  
Working with community specialist nurses including community matrons, to deliver specialist care including palliative and end of life care.
- Support and care for independence:  
Providing leadership and prioritisation of supportive care to help patients stay well and can manage their independence at home. For example, wound care management, advice on nutrition; help to avoid falls or to manage medicines, advice on 'assistive technology' such as telehealth and telecare, working with patients and their families to help them care for themselves.  
Leading and delivering ongoing support from the district nursing team and a range of local services (e.g. GP, voluntary and community organisations, or local authority). Working together with patients to deal with more complex issues over a period of time. For example, to meet continuing and long-term health needs

P25 Annex 1 has examples of innovative care related to:

- supporting people to die – MDT w GPs and use of same notes system
- tele health to monitor patients and also for patients to first self-manage exacerbations
- exploration of use of skype
- patient refusal of other agencies except GP and DNs – DNs took on diabetes management, referred to specialists in heart and Mental Health nursing, regular MDT meetings
- Facilitation of care package review
- Roll out of tablets/laptops with ability to view appointments and schedule/push same

## Regional Redesign of Community Nursing – Northern Ireland

Department of Health, Social Services and Public Safety, Belfast, Northern Ireland

[http://www.dhsspsni.gov.uk/regional\\_redesign\\_of\\_community\\_nursing\\_project-4.pdf](http://www.dhsspsni.gov.uk/regional_redesign_of_community_nursing_project-4.pdf)

In 2003, a position paper on 'Strategic Direction in Community Nursing in Northern Ireland' (DHSSPS 2003) was published that set the strategic direction for community nursing. The principles identified in the Position Paper stated that Northern Ireland will have a nursing service for primary and community care that:

- Is increasingly the first point of contact for patients and clients;
- Is flexible to work across boundaries, in new settings and take on new demands;
- Has a wider range of competencies and a greater variety of roles in dealing with identified communities of need;
- Is client/patient centred – focusing on assessment of need and client/patient pathways;
- Has devolved power and decision making to teams of nurses and
- multi-disciplinary teams locally, with increased opportunities for leadership roles at local level;
- Is underpinned by public health principles and thinking;
- Is 'connected' across disciplines, professions and sectors.

The overarching aim is to develop a community nursing workforce that is equipped to respond to the increasing demands of:

1. first contact care – assessment diagnosis, treatment and discharge for patients when they first enter a point of access to Health and Social Services
2. continuing care– ongoing care and chronic disease management
3. while always underpinning this with a public health approach – organized social and political effort and health promotion for the benefit of populations, families and individuals. (Rooney & Gribben, 2006)

The regional redesign of community nursing project examine new ways of working through the funding of eight pilot projects across Northern Ireland. The project included nurses who deliver care in both community and primary care settings including district nurses, specialist community public health nurses, health visitors, school nurses and occupational health nurses, community mental health and learning disability nurses, treatment room nurses, practice nurses and nurse practitioners and community children's nurses.

The outcomes of the eight pilots were in the majority supportive of redesigning the services and teams to deliver to the three elements of care; fist contact care, continuing care with a public health approach. This requires a fundamental role shift in defining nursing by titles to patient needs. The First Contact Care has a rapid response approach in responding to the patients' needs at the point of entry. The Continuing Care has a proactive case management of chronic disease, specialist support and prevention strategies as key features. The public health approach is seen as fundamental to the way that community nursing care is delivered with a strong emphasis on prevention and self-management.