



West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

The Neighbourhood Nurse Project

**A Primary Health Care Nursing Innovation funded
by Ministry of Health: July 2003-December 2006**

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Contents

EXECUTIVE SUMMARY	1
Recommendations for the way forward	4
Recommendations related to outcomes to take forward	4
Recommendations related to approaches to change	4
CHAPTER 1 INTRODUCTION AND OVERVIEW OF THE PROJECT	6
1 The Neighbourhood Nurse Proposal	6
2 Defining the new role in Reefton July 2003 - December 2004	8
3 Trialling the new role in several localities June 2005 - December 2006	9
4 Project structures and processes	11
Management of the project	11
Accountability and reporting	12
Professional and role development	13
Benchmarking activities	14
Evaluation activities	14
CHAPTER 2 WHAT WAS ACHIEVED: THE SERVICE DELIVERED	16
1 Demographic features of the three localities	16
2 The range of services delivered	16
3 Referral patterns and caseload profile	17
4 Feedback on the service from referrers and colleagues	19
5 Feedback from clients	19
6 The nurses' perspective	22
7 How the service met challenges for primary health care	24
CHAPTER 3 WHAT WAS LEARNED	
1 Choice is critical in role development and transition	27
2 Ongoing communication with stakeholders is key	29
3 Role development requires upskilling and support	31
4 Primary health care nursing roles need to be flexible	33
Types of primary health care nurse	34
A framework for use in each locality	35
5 Change management and leadership are needed close to the action	36
6 Benchmarking and client feedback are useful	38
BIBLIOGRAPHY	
AUTHORS AND ACKNOWLEDGEMENTS	
APPENDICES	

LIST OF APPENDICES

- A Steering Group terms of reference and membership
- B Demographic profiles for the three localities
- C Benchmarking for the Neighbourhood Nurse service : Key features
- D Annotated position descriptions
- E Position description with related competencies
- F Competency self-assessment tool
- G Comparison of learning needs before and after
- H Professional development undertaken
- I Development for Whanau Nurse
- J Recommended professional development programme
- K Colleague referral leaflet
- L Client information leaflet
- M Feedback from colleagues and referrers: Information for focus group participants
- N Feedback from clients: Consumer satisfaction survey tool
- O Feedback from project participants: Outline for focus group and review of learning
- P List of Project Files held by Director of Nursing and Midwifery

Executive summary

Background The West Coast DHB was successful in an application for Primary Health Care Nursing Innovations funding offered by the Ministry of Health. Innovations were required to align with the Primary Health Care Strategy, and the funding was intended to allow the development of new models of nursing practice in order to reduce current fragmentation and duplication of services.

The Proposal had a primary aim of trialling a new primary health care nursing role which would involve new ways of working with clients, families, and colleagues. A secondary aim was to explore the success factors (or otherwise) in implementing the role.

A more 'generic' role - the Neighbourhood Nurse - was proposed, in which 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.

- Needs would be understood to range from actual health problems, to the education and support people need to take responsibility for maintaining their own health, wellness and capability. It was anticipated that health gains would follow from an increased emphasis on health promotion and strengthening clients in self-management.
- Nurses would be supported to expand their knowledge and skills to develop a broader, more generalist orientation than required in traditional community-based nursing roles.
- A geographically based caseload would present diverse health needs across the age range, and was also thought to go some way to rationalising the travel involved in servicing a sparsely distributed outlying rural population.

Project development and implementation A Project Team began the 'Neighbourhood Nurses in Reefton' project in July 2003, working with the community-based team of primary health care nurses, Reefton Medical Centre (as project partner) and the local community. After making good progress on a community profile for the wider Reefton area and defining the new role in a working version of position description, the project lost momentum towards the end of 2004.

A Steering Group was formed in early 2005 to refocus the project and guide its future direction. After ascertaining the commitment in Reefton to project goals and trialling the new role, a decision was made to widen the opportunity, with the possibility that the role would be developed in several communities. Applications for fixed-term positions were sought and four nurses were appointed to fixed-term positions in three localities in September 2005. One position was identified as a Whanau Nurse with a brief to focus on the needs of the local Maori community. The Ministry granted an extension to the project period to allow for a 15-month trial, and the project concluded in December 2006.

Project processes in the implementation period included:

- project management and oversight through a Steering Group and Project Team which included a contracted Project Manager
- reporting as required by the funder and within the DHB
- support for professional and role development through individual learning plans based on needs analysis, a workshop programme and clinical supervision

- benchmarking through monthly statistical reporting to ascertain the nature and progress of nursing role development in the three localities
- evaluation activities which involved clients, colleagues and project participants.

The service delivered Those appointed into the Neighbourhood Nurse positions quickly established or extended their caseloads, enabling the progress towards the project's primary aim - an exploration of the nature of the service that could be delivered from the new role.

Monthly statistical reporting showed:

- that the nurses delivered services according to the project Proposal, i.e. across a broad range of client needs and ages
- variations in service delivery across the three localities of Reefton, Dobson and Hokitika, which reflected differences in community profile, health need, and referring patterns
- the number of clients identifying as Maori accessing the service increased in all localities over the trial period
- that the range of new referrals demonstrated that the role integrated all community nursing contracts (ACC, District and Public Health Nursing).

Client feedback on the new service was obtained through a postal survey. While clients mentioned specific aspects of nursing care amongst 'the three most important things' the nurses had assisted them with, two thirds identified the advice and support they received as important. Clients described the flexibility of the service and the nurses' approachability and caring attitude as 'most helpful aspects', along with what it meant to them to receive care at home.

Key outcomes Overall, the project demonstrated that the new role was able to deliver the service intended, and overall, stakeholders believed it should be implemented through a considered process. Key pieces of work undertaken in the course of the project provide a platform for the DHB to take the role forward:

- the mapping of a more generic primary health care nursing role through development of a position description and related set of competencies
- an 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
- a tool to obtain indepth client feedback on service
- a set of Project Files which give full details to assist future planning.

Key learnings The secondary aim of the project was to learn what would support the implementation of a new role and new ways of working. Important learning in the project was that:

- nurses needed to feel that they were making a free and 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 Trialling a 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
- there needs to be agreement 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.

Recommendations for the way forward

The overall recommendation is for West Coast DHB to take learning from the project forward in an evolutionary way, meshed with the many other reviews and improvements planned and underway for primary health care service provision. The project has contributed useful tools and processes for developing primary health care nursing on the West Coast, and provided valuable learning around change processes.

Recommendations related to outcomes to take forward

Primary health care nursing roles need to be flexible (3.4) That the position description developed and refined for the Neighbourhood Nurse role is adopted as a framework for future generalist community-based nursing roles, as it outlines a range of competencies, not all of which may be required in every appointment, but may be developed according to the range of needs presenting in a particular community and the presence or availability of other nursing roles within a given team.

That the framework discussed and refined by Steering Group members is used in a locality by locality review of primary health care nursing services to determine configuration of local teams and implementation of the new role.

Role development requires upskilling and support (3.3) That a programme of professional development activities/opportunities is provided from which nurses may 'pick and mix' a personal programme according to their learning needs in order to develop a broader set of skills (per Appendix J).

That coordination of this programme is undertaken by a workforce and practice development coordinator for primary health care nursing (PHCN).

That the above be supported from the balance of the Innovation funding.

Seeking client feedback on the service received (3.6) That benchmarking data derived from monthly statistical reporting is further developed to enable ongoing assessment of progress and activities related to development of a generalist primary health care nursing role.

That the client feedback tool developed in the project is reviewed as to its potential for modification and use on an ongoing basis within Community and Primary Health Care Services.

Recommendations related to approaches to change

Choice is critical in role development and transition (3.1) That nurses are free to decide to take up the new role and requisite development or not, and are respected in their choice.

That there are information resources and opportunities to discuss what transition into the new role and new way of working means.

Ongoing communication with stakeholders is critical (3.2) That the proposed PHCN workforce and practice development coordinator work with line managers, the DONM and Communications Manager to formulate and implement a communication plan which includes

- formal communication through newsletters and primary health care forums
- ensuring that team members are well-informed as change is anticipated and implemented
- using available communication opportunities (e.g. monthly District Nurse meeting) for giving and receiving information.

Change management and leadership are needed close to the action (3.5) That the proposed PHCN workforce and practice development coordinator works directly with line managers and nursing teams to facilitate change and provide support in an ongoing roll out phase.

1 The Neighbourhood Nurse Proposal

Funding for innovations in primary health care nursing was offered

The vision set out in the Primary Health Care Strategy is that

- people will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care
- primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups¹.

As primary health care nursing roles hold great potential for meeting these broad goals, yet are often under-utilised, in mid-2002 the Ministry of Health put up funding for nursing innovations in primary health care. The intent was to

- support the development of innovative models of primary health care nursing practice to deliver on the objectives of the Primary Health Care Strategy
- allow for new models of nursing practice to develop and reduce current fragmentation and duplication of services
- assist in the transition of primary health care delivery to Primary Health Organisations².

From 139 registrations of interest, a shortlist of 15 were asked to submit a full proposal. WCDHB's Proposal - 'Neighbourhood Nurses in Reefton' - was announced in early 2003 as one of eleven innovations to be awarded funding, and the only South Island Innovation.

Key points in the Neighbourhood Nurse Proposal

The Proposal outlined a service offered by a team of 'Neighbourhood Nurses' working with geographically defined caseloads of individuals and families in Reefton and the surrounding district. Important points were:

- The new Neighbourhood Nurse role referenced WCDHB's Rural Nurse Specialist role³, which had been implemented in smaller rural communities to provide a primary health service across a range of age and health need.
- The Neighbourhood 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.
- Needs addressed would range from actual health problems, to the education and support people require to take responsibility for maintaining their own health, wellness and capability.
- It was anticipated that health gains would follow from an increased emphasis on health promotion and strengthening clients' skills in self-management.
- Nurses would be supported in expanding their knowledge and skills to develop a broader, more generalist orientation than required in traditional community-based nursing roles.

¹ Minister of Health (Feb 2001), page 2.

² Feek & Hughes (June 2002).

³ The Neighbourhood Nurse role differed from the Rural Nurse Specialist on two counts: it did not include the provision of 'on-call' cover or the PRIME training required for that. For an overview of the RNS role, see Williams (2001).

- A more-or-less geographically based caseload would present diverse health needs across the age range, and also was thought to go some way to rationalising the travel involved in servicing a sparsely distributed outlying rural population.

Two goals were defined The project's primary goal was to trial a new primary health care nursing role - which would involve new ways of working with clients, families, and colleagues - in a discrete community, in order to improve the health outcomes for that community.

A secondary goal was to explore factors impacting on the success (or otherwise) in introducing a new primary healthcare nursing model.

Reasons for locating the project in Reefton Reefton was proposed as the project's location on the basis of these inter-related factors:

- project implementation and evaluation would be simplified in a discrete community
- DHB management, the community-based nursing team and the medical centre had previously explored questions around the provision of primary health care nursing services in Reefton
- rural areas can be at risk of GP services becoming 'fragile', and there was a positive response to the proposed role from the local GP as the intended project partner.

2 Defining the new role in Reefton July 2003-December 2004

Activities pre-implementation When funding was announced in February 2003, a number of activities were undertaken:

- a meeting of hospital, community and medical centre staff in Reefton was called by the GM Primary Care Services to discuss the project Proposal and its implications, news of the funding being well-received
- a press release appeared in the local newspaper
- a Project Team was formed, consisting of the Director of Nursing/GM of Primary Care Services as Project Sponsor, Nurse Manager (Community and Primary Health Care Services) and a Project Consultant.
- an Overview Document (Feb 2003) was prepared and made available on the WCDHB website.

The Project Team met with the community-based nurses in Reefton in June 2003 prior to the project's commencement to review the Neighbourhood Nurse concept and expectations of how the project would proceed.

Project activities and progress The project began in July 2003 and made good progress in that year, achieving the following:

- appointment of a part-time Project Leader
- consultation with the Reefton community
- consultation with relevant union representatives (NZNO and PSA)
- ongoing consultation with WCDHB HR advisers on implications around role change
- individual learning plans for the Reefton nurses, based on identified learning needs
- a programme of monthly workshops, a number of which were open to a wider group.

Through this period and into 2004 the Neighbourhood Nurse project worked collaboratively with the DHB-approved Healthy Inangahua Project being implemented in Reefton by Community and Public Health. The two projects took a joint approach to developing a community profile, community consultation and working through their respective projects' programme logic.

Several presentations to primary health care forums were given nationally and locally, and project progress was reported on a Neighbourhood Nurse webpage on the WCDHB website.

Workshops in 2004 focused on defining the new role, and by May a provisional position description for a 'Primary Health Care Nurse (Neighbourhood Nurse)' (Appendix D) had been completed. A negotiation process around the position description and transition arrangements between the DHB Human Resource Manager and union organisers began. While it had been expected that the nurses who chose to do so could trial the new role from September 2004, delays and difficulties meant this process stalled and little progress had been made by the end of the year.

Outcomes There were useful foundations achieved in this period:

- the development of a community profile for the wider Reefton area was underway in conjunction with the Healthy Inangahua Project
- issues related to a single patient file, MedTech and other IT capability had been explored
- a position description and requisite competencies had been developed and were to become a platform for the next phase of the project.

3 Trialling the new role in several localities June 2005-December 2006

By early 2005, key people were no longer available to the Project Team. A new Project Sponsor (the Acting GM Community and Primary Health Services) formed a Steering Group in late April to refocus the project.

The opportunity to try the new role was opened up By May it had been established that not all members of the Reefton community-based nursing team could see themselves trialling the new role. The Steering Group determined that it was critical that nurses trialling the new role actively chose to do so. In deciding to offer the opportunity across the Coast, the Steering Group had also allowed for the possibility that nurses choosing to try the new role could be located in different areas, rather in a team working together.

Human Resource advice was for fixed term positions as the employment mechanism, and NZNO was informed of these developments in the project. The DHB negotiated with the Ministry to extend the project term to December 2006, which would allow the nurses appointed 15 months to develop and consolidate the role.

Nurses were appointed in three localities A process to widely promote and advertise 'an opportunity in primary health care nursing' included a local roadshow and the option for applicants to be briefed about the role. Allocation of the positions was based on the location of the applicants, available funding and the need to continue services. Representatives of local communities and health service providers were involved in the interview process and four Registered Nurses working locally were appointed.

Hokitika Two experienced District Nurses based at the Hokitika Health Centre, Mary Marr and Fiona Goodwin, made a joint application.

The DHB considered that the Neighbourhood Nurses' caseload would include clients normally referred to District Nursing, and also include new 'non-traditional' clients. To ensure that there would be time to work with 'District Nurse referred' clients in a different way, and new types of client need, the staffing level in the District Nurse team was increased (though it is fair to say that staffing levels proved to require further adjustment).

Mary was to complete a Post Graduate Certificate in palliative care offered jointly by Whitireia Community Polytechnic and Hospice New Zealand, and Fiona was underway in a rural health care focussed Post Graduate Diploma in Health Science (Advanced Nursing) through Auckland University.

Dobson The DHB made available Practice Nurse funding for a position based at Dobson Medical Centre, as it would help address unmet need in this community and give the project a 'greenfields' example.

Christine Beadle, with Plunket and paediatric nursing experience, and recently a Senior Coordinator in Access Homehealth (a service supporting disabled and elderly people in their homes) was appointed to Dobson. Her post-graduate study was to lead on to enrolment in the Master of Nursing degree through Auckland University.

Reefton The Innovation Proposal had provided for a 0.5 FTE position to be identified as a 'Whanau Nurse' with a specific brief of '*...a particular (but not exclusive) focus*

on the needs of the local Maori community⁴. As the community-based nursing team in Reefton was well-established, and the funding for this 0.5 FTE position was provided from the project, it was hoped that the new role would be able to identify and respond to unmet need locally.

Karen Davidson, an experienced Enrolled Nurse who had gained a Bachelor of Nursing in 2000, applied from her Staff Nurse position at Reefton Hospital. She was to work from the Neighbourhood Nurse framework as a Whanau Nurse based at the Reefton Medical Centre. As Chair of the Komiti of the Inangahua Manaaki Mo Te Whanau (a pan-Maori group in Reefton), and a Trustee of Reefton Area School, she already held several leadership roles in this community.

The new Neighbourhood Nurses quickly established their role and caseload The nurses began an orientation and induction programme in September 2005. By December that year, they had established their caseloads, and were confident enough that the new roles were enabling them to practice differently to give examples in a presentation about the project and the new role. The whole-hearted commitment the nurses made to their positions and their early progress in a new way of working was impressive.

The ‘freedom to practice’ inherent in the new role meant that the nurses could offer nursing services ranging from health promotion to personal care in post-hospitalization, chronic and palliative care situations. They were to find the most useful learning experiences for direct application with clients:

- effective brief intervention around smoking cessation, diet and exercise
- adult health assessment
- self-management in chronic conditions (Flinders model)
- and additionally for the Whanau Nurse, visits with a youth health service and Maori health services.

A pattern of service related to community profile and need emerged in each locality⁵. The nature and range of services, and variations by locality, are discussed in Chapter 2, along with consumer and colleague feedback.

⁴ Position Description: Primary Health Care Nurse (0.5 ‘Whanau Nurse’) 18 June 2005.

⁵ One of the nurses based in Hokitika (Fiona Goodwin) found that family commitments needed to take priority, and resigned her Neighbourhood Nurse position in October 2006, however, this did not affect the pattern of service.

4 Project structures and processes

The Proposal had identified several streams of support and monitoring, which had been implemented as the role was explored with the Reefton nurses. Project processes were reviewed when the project was refocussed, and to support the development and evaluation of the new role, some new processes were added.

This section gives a brief overview of project structures and processes, with an emphasis on the period from mid-2005 (full details can be found in the Appendices and Project Files), and covers

- management of the project
- accountability and reporting
- professional and role development
- evaluation activities.

MANAGEMENT OF THE PROJECT

Steering Group A Steering Group was formed in April 2005, and met regularly to provide direction and oversight of the refocused project. Early 2006 saw a decision to broaden representation and review the Group's purpose as the project entered a phase of consolidation and began to anticipate completion and evaluation. The Steering Group's terms of reference and membership are in Appendix A.

Project Team This smaller team was responsible for the operational aspects, meeting monthly to support and advise on the day to day functioning of the project, members liaising with each other to manage any urgent issues. At its core was line management for the Neighbourhood Nurses, which nevertheless had a number of people in the direct line management position during this period.

Membership from October 2005 was:

Project Sponsor/General Manager Primary Care Services (Hecta Williams)
 Nurse Manager, Community and Primary Health Care Services (Hellen Bygate, Janet Hogan, Maureen Frankpitt)
 Director of Nursing and Midwifery (Dr Jane O'Malley)
 Project Manager (Dr Chris Hendry)
 Project Nurse Consultant (Shelley Jones).

The Project Team were also members of the Steering Group, as was the Professional Practice Coordinator and former Project Leader (Michele Barber), who was called on to support the Project Team at key points.

Project management The Proposal recognised a need for specific project management input to support line management in project implementation. The Project Leader initially appointed had been seconded to another position, and a Project Manager was contracted in late September 2005. To ensure that the project delivered according to MOH contracted specifications, her immediate priorities were to

- modify existing service delivery data gathering systems, coach the nurses in their use and ensure the necessary data processing parameters were in place
- review available data on patterns of health need on the Coast and help the nurses relate this to their service priorities

- review the project budget.

The Project Manager also

- continued preparation of quarterly reports to the Ministry
- instituted a monthly report for project participants from May 2005
- as its coordinator, reviewed the membership and purpose of the Steering Group
- further refined monthly statistical reporting processes to enable service delivery monitoring and evaluation
- oversaw project evaluation processes that enabled stakeholders to give feedback on the project and direction to the DHB in going forward.

HR advice Human resource advice related to trialling and implementing a new role was given by a succession of managers during the course of the project. Both the earliest and most recent advice on managing the trial of a new role was consistent with the time-limited nature of a project. However, advice that a ‘management of change process’ would be required had a poor fit with the nature of a trial, and this was a factor in the stalling of the project in Reefton.

ACCOUNTABILITY AND REPORTING

To the Ministry The contract between the DHB and Ministry of Health required accountability and evaluation through two avenues:

- quarterly reporting for the duration of the funding period (July 2003-June 2006), which was managed for the Project Sponsor by the Project Leader/Project Manager (these reports were tabled at Executive Management Team meetings and are available in a Project File)
- participation in an evaluation project run by a Ministry-contracted team, which included the nurses and Project Team members attending three workshops designed to enable data gathering and networking amongst the innovations.

Within WCDHB Reporting and communication happened at several levels of the organization:

- the Project Sponsor was able to report regularly to the Executive Management Team
- a presentation by Project Team members to EMT in October 2004 was requested by the CEO to overview progress to date, identify any blocks, and outline plans to address them
- a report to CPHAC in October 2005 outlined progress as the project was refocussed
- the project and the new role was discussed at regular forums such as the monthly District Nurse meeting
- developments in the project were reported in several issues of the DHB’s internal newsletter ‘The Westerly’.

More widely A belief that funding meant an obligation to share as widely as possible what was learned in creating a new role and service meant that

- the project was presented nationally and locally in professional forums focusing on primary health care nursing in 2003-2004
- the Overview Document (Feb 2003) was uploaded to a Neighbourhood Nurse page on the WCDHB website as the project began, along with six-monthly updates of progress in

Reefton.

Mid-2005 the webpage was edited back to key documents and new materials uploaded to support the opportunity to trial the new role. It is anticipated that this final report and other background material will be available on the WCDHB website once approved.

PROFESSIONAL AND ROLE DEVELOPMENT

Important assumptions for participation in the project were that

- although a position description had been developed, the nurses would effectively create a caseload and role in response to health needs
- the nurses would need to add new knowledge and skills to their considerable competence as they began to practice with a broader and more integrated perspective
- the nurses would benefit from personal and professional support in meeting both their learning needs and the challenge of creating a new role
- the project process would require the nurses' involvement in implementation, monitoring and evaluation activities, and therefore 0.9 FTE was allocated to service and 0.1 FTE to project activities and professional development for each position pro rata.

Three main sources of support were provided: individualised planning for professional development, a monthly workshop programme and clinical supervision. The professional development programme and monthly workshop had some overlap. The monthly workshops and specific learning experiences were evaluated at the time of participation, and an overall review of learning and development was undertaken as the project concluded.

Professional development The Project Consultant had oversight of the nurses' professional development programme (see Appendices E, F, G, H, I), key features of which were

- self-assessment against the competencies identified for the new role
- matching learning needs against strategic priorities in primary health to determine learning experiences for the group
- three nurses continuing in their personal courses of post-graduate study
- all participating in the DHB's mandatory training programme
- attendance at workshops and study days etc offered by the DHB, PHO and other providers as advised by the Project Consultant and/or negotiated between the nurses and their manager
- on-the-job colleague coaching arranged to learn or consolidate skills
- a number of visits to other services made to meet specific learning objectives, most particularly for the nurse in the Whanau Nurse role, where specific needs had been anticipated.

Monthly workshop programme After meeting more frequently in the induction programme of late 2005, the nurses met with Project Team members in monthly workshops through 2006. The workshops enabled the nurses to meet with each other and the Project Team to share experiences, raise issues, participate in project business and receive feedback from the monthly statistical reporting.

An important element was group supervision with the Director of Nursing and Midwifery (DONM) as a confidential, collegial and collaborative exercise. This forum recognised that the experience

of role development and transition would raise issues that could be resolved with expert facilitation by the DHB's nursing leader. Additionally, it ensured the DONM had an early awareness of any issues which professional leadership could address.

Clinical supervision Individual supervision was proposed as a critical element of support for those taking up the new role, and is also an accepted practice within WCDHB for nurses working in similar community roles.

The nurses were briefed by the DONM on a role theory based model of individual supervision, and a highly regarded practitioner (Ruth Cochrane) was contracted to provide external supervision from April 2006. Fortnightly at first, the sessions were then run every three weeks.

The Project Manager met periodically with the Clinical Supervisor to support her involvement in the project and if appropriate, learn of any issues for the Project Team's attention.

BENCHMARKING ACTIVITIES

A series of reports were generated from monthly statistical reporting by the Project Manager to focus on specific aspects of role development and service delivery. Key findings are reported in Chapter 2, and further benchmarking detail is given in Appendix C.

EVALUATION ACTIVITIES

Feedback was sought from a range of stakeholders Evaluation activities were designed to enable feedback from stakeholders in the Neighbourhood Nurse project:

- colleagues, including those who referred clients
- clients
- the nurses themselves as project participants.

Key findings from these evaluation activities are reported in Chapters 2 and 3. The tools used and summaries are found in the relevant Appendices. Project Files for these evaluation activities are available to Project Team members.

Colleague and community feedback Four focus groups were run mid-October in each of the Neighbourhood Nurse localities (i.e. Reefton, Dobson and Hokitika) and additionally, in Greymouth, where a wide group of community and specialist nurses are based.

Representatives of the Neighbourhood Nurses' colleague networks were approached to be involved, including nurses, doctors and those in community-based organisations who had referred clients.

Participants were informed that the focus group process was to gain feedback on the project process and opinion on the new role and its function (see Appendix M). This would inform the DHB's future direction in planning and providing community based nursing services.

The Project Manager facilitated each discussion, assisted by the Professional Practice Coordinator, and the recently appointed Nurse Manager for Community and Primary Health Care Services was an observer.

Project participants' feedback The Project Consultant worked with the nurses to capture two important aspects related to role change at the beginning and end of the project:

- self-assessments against competencies identified for the role, which had enabled the development of individualised and shared learning programmes, and also had identified learning needs met or not met in the course of the project
- their perspectives on what it meant to take on the new role, including expectations of the challenges it would present; and what the new role and project had contributed to personal and professional growth.

The nurses' perspective on the project overall was obtained in a focus group facilitated by their Clinical Supervisor assisted by the Professional Practice Coordinator (see Appendix O). All four nurses were involved in these two exercises to capture participant perspectives.

Client feedback After review of the consumer satisfaction tool most recently used by WCDHB to evaluate community nursing services, along with the results obtained, a new tool was designed. A one page survey of mainly open-ended questions designed to elicit clients' experience of the Neighbourhood Nurse service was piloted with a convenience sample in August 2006, and approved by the Steering Group with slight modifications (see Appendix N).

Returns were analysed and reported on by the Project Manager. A Project File holds the full results.

The new role was trialled in three localities The appointment of four Neighbourhood Nurses moved the project towards its primary goal of trialling a new primary health care nursing role and new ways of working.

As the role was to be trialled in Reefton, Dobson and Hokitika, salient characteristics of the population in each locality were reviewed to orient the new nurses to potential health needs. Ideally a full community profile would have been developed in a partnership process in each locality (as had happened in Reefton), but the project now faced a shortened timeframe.

1 Demographic features of the three localities

Comparisons Compared to the rest of New Zealand, the West Coast population had

- a higher proportion earning less than \$20,000 per annum⁶
- a higher proportion without educational qualifications⁷
- just over half the proportion identifying as Maori - 8.3% vs 14.7%⁸.

While the Hokitika population profile was similar to the rest of the Coast, Dobson and Reefton had

- average lower incomes for all age groups, which meant transport costs would be more likely to inhibit some from accessing health services, especially specialist health and social services based in Greymouth
- a higher proportion of residents with no qualifications in the 15-44 year age groups
- higher proportions of men than women in the 45-64 age group
- the majority of employed men engaged in high risk occupations (agriculture, forestry, fishing and mining).

Appendix B gives graphs and more detail on demographic features.

Implications for nursing services These profiles suggest implications for nursing services in terms of

- encouragement and assistance to access health services
- health promotion and health protection activities
- home-based environmental assessments and assistance with self-care
- ACC referrals.

2 The range of services delivered

Monthly statistical reporting A statistics form developed for the project offered the codes used by all 'types' of community based nursing. However, comparisons with District and Public Health Nursing are not possible as monthly reports identifying patterns in caseload relate specifically to the Neighbourhood Nurses.

A full set of statistics was obtained up until June 2006, at which point new reports were formulated in i-soft, but these were not able to be produced at the time of writing.

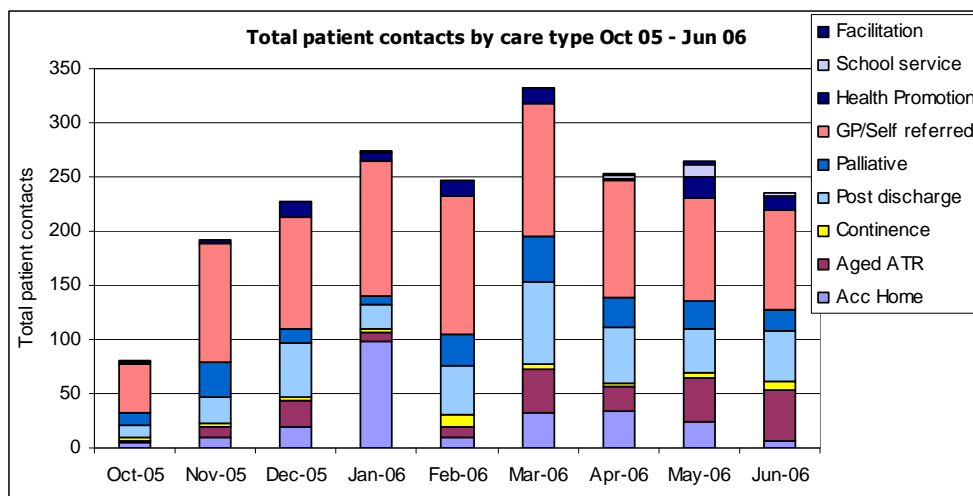
Client contacts and range In the period October to November 2005 the nurses were establishing their caseloads, and in the remaining seven months of data collection, total client contacts steadied to an average of about

⁶ WCDHB Planning & Funding Unit (2005).

⁷ Ibid.

⁸ Statistics NZ (2001).

250 (see below). The March peak is explained by all client contacts for Hokitika being entered in the Neighbourhood Nurse stats as they were covering for other team members on leave in that month.



Source: Neighbourhood Nurse Statistics

Inferences can be drawn from other statistical data and the nurses' reports on their caseloads to contextualise client contacts - particularly as the role had been intended to support individuals and families/whanau in maintaining their own health, wellness and capability, including those with long-term complex conditions or situations:

- the client caseload became more complex, particularly as the nurses started to connect with clients and families/whanau who had multiple needs
- indirect client contact time required to coordinate referrals and services increased with the complexity of client and family/whanau needs
- time spent educating and supporting clients was directed to helping them develop the confidence and skills for self-management.

It had been proposed that the Neighbourhood Nurses work across the range of ages and health needs, and the graph above also shows that services from all in the community nursing contracts were covered (ACC, District Nursing and Public Health Nursing). There was an increasing spread in the breadth of client 'type' as the positions became more established.

Services were delivered to Maori

The 'special health needs of Maori' were to be addressed by the Innovations, and the WCDHB Proposal had included a 0.5FTE Whanau Nurse in Reefton, as well as expecting that other Neighbourhood Nurses would include the health needs of Maori in their focus.

- There was a steady growth in services to clients who identify as Maori in all localities.
- In June 2006, the average rate of clients identifying as Maori accessing the Neighbourhood Nurse services across the localities was 11.5%, indicating a higher proportion in the Neighbourhood Nurse caseload than the 8.7% in the West Coast population.
- Reefton, where the Whanau Nurse was located, had the highest proportion of clients who identify as Maori with an average of 21.5%, compared to 6.5% in Hokitika and 1.6% in Dobson.

Further analysis and graphs from the Neighbourhood Nurse Statistics produced by the Project Manager, including those showing variations across the localities, can be found in the benchmarking reported in Appendix C.

3 Referral patterns and caseload profile

In their September 2006 workshop, the Neighbourhood Nurses outlined the caseload for their locality in terms of geographic area and client characteristics, and patterns in received referrals.

Referrals and caseload profile in Reefton

An initial set of clients comprising Maori families registered with the Reefton Medical Centre were referred by the General Practitioner. The Rural Nurse Specialist, District Nurse and School Counsellor in Reefton also referred clients to the Whanau Nurse.

The caseload was based mainly in the Reefton township, and developed to include three groups:

1. Families with one parent.
2. Young people with a range of needs:
 - problems with self/body image
 - social issues
 - empowerment and support in family/whanau situations
 - sexual health (educating for safe sex, follow up after unprotected sex, referrals and support).
3. 'Other ethnic' groups, reflecting a recent increase of immigrant contractors for local businesses.

A smaller group were those requiring mental health support referred by District Nurses. The Whanau Nurse, along with the Rural Nurse Specialist, was assigned responsibility for school-based services from March 2006.

Referrals and caseload profile in Dobson

The Neighbourhood Nurse in Dobson had the highest proportion of referrals from a GP, probably related to her being based in the Dobson Health Clinic. She also received referrals from District Nursing and Nurse Specialists.

The caseload was contained on the Dobson side of the Grey River (i.e. Dobson, Stillwater, Ngahere and Nelson Creek) and was broadly made up of:

1. Elderly people requiring support in their own homes.
2. Those with chronic health problems.
3. Those requiring palliative care.

There were also some clients with a complex range of physical, mental and social health needs who did not fit neatly into the traditional services, including a number of young families.

Referrals and caseload profile in Hokitika

The two Neighbourhood Nurses based at the Hokitika Health Centre continued to receive District Nursing referrals, which reflected in their higher proportion of post-discharge clients.

After trying various ways to broaden the range of clients in their caseload, by May 2006 the Neighbourhood Nurses had negotiated a geographical assignment with their District Nurse colleagues, under the guidance of their Nurse Manager and the DON. The Neighbourhood Nurses were to cover the outlying areas of Ruatapu, Ross, Arahura, and Kumara. The District Nurses were to cover Hokitika itself, although the Neighbourhood Nurses retained a small number of Hokitika clients with complex chronic conditions directly referred by the Respiratory Nurse Specialist, local GP and Rata Te Awhina. The area east of Hokitika (i.e. Kaniere, Kokatahi, Kowhitirangi) was brought back into the wider team's responsibility when the number of Neighbourhood Nurses reduced from two to one in September 2006.

The caseload was broadly made up of:

1. Those referred on discharge from medical and surgical hospitalisation.
2. Elderly people requiring support in their own homes.
3. Those with chronic health problems.
4. Those requiring palliative care.

There was some extended involvement with clients requiring social assessment, and also households where several members had a range of needs.

Variations in caseload resulted from an interplay of factors The Neighbourhood Nurse project Proposal outlined a new role in which nurses would engage with clients less on the basis of contracted work streams and more as a response to needs ranging from *'...actual health problems, to the education and support people need take responsibility for maintaining their own health, wellness and capability'*. The Neighbourhood Nurse service would be one in which *'They just do what needs to be done'*.

Therefore, the variations in caseload characteristics across the three localities need to be understood as resulting from a dynamic interplay between

- provider and referrer relationships which determined the nature of the caseload
- unmet needs in each community
- the set of competencies particular to each Neighbourhood Nurse.

Provider and referrer relationships

- The nurses in Dobson and Reefton had a 'greenfield' potential to build a broad caseload, and also received referrals from the GPs with whom they were co-located.
- However, the pattern of post-discharge referral in Hokitika was strongly established for the two Neighbourhood Nurses transitioning from District Nurse roles, and it took longer to develop a caseload reflecting a broad range of needs.

Unmet needs in particular communities

- All the Neighbourhood Nurses were able to address needs proactively where clients might not otherwise have accessed health services.
- An apposite example of meeting a gap was the role the Whanau Nurse in Reefton played for young people and their families/whanau, particularly through the school service.

The competency profile particular to the nurse

- Previous experience and specialisation understandably provided a strong platform for each nurse's caseload, e.g. a strong background in child health was key for the Dobson Neighbourhood Nurse in supporting a number of families with young children.
- Competencies developed in the course of the project enabled a broadening or deepening of skills, particularly in the areas of promoting healthy lifestyle practices and supporting clients in self-management.

4 Feedback on the service from referrers and colleagues

Stakeholders gave feedback in a focus group process A significant element in the evaluation was to seek feedback from community and service provider stakeholders in the Neighbourhood Nurse project. Four focus groups involving representatives of referrers and the wider community-based nursing colleague group were asked for their feedback on the project process. They were also asked their opinion of the new role's value and function (see Appendix M).

The Neighbourhood Nurse role was supported by referrers When asked '*What are your thoughts on the value and usefulness of this role compared with existing nursing roles?*', the four focus groups supported the overall concept of the Neighbourhood Nurse role.

Referrers to the service, including the GP practices (in all areas) and schools (in the Reefton area), were most supportive of continuation of the new role. Giving examples of positive impacts in the community and for particular clients, their anecdotal accounts included:

- direct feedback to the GP on the client's progress and well-being at home
- reduction in number of home visits by GP for some clients
- completion of home 'environmental assessment' of 'at risk' families/whanau and clients
- maintenance of a terminally ill client at home
- reduction by 50% of hospital readmissions for a client with a chronic condition
- implementation of a service for high school children where there had been a serious service deficit
- development of services for ethnic minorities
- involvement in health promotion activities such as healthy eating and supporting clients in weight loss programmes.

What differentiated the new role was not clear for other nurses However, Public Health Nurses, Practice Nurses and District Nurses in the focus groups had more difficulty in seeing an immediate need for such a role transition. They were not able to identify key differences between the new role and their own. There were concerns that there might not have been the preparation required for a role that encompassed the range of community-based nursing. It was also thought that if nurses in roles such as their own had more time, they too would have been able to respond to a greater range of presenting needs.

5 Feedback on the service from clients

Clients gave feedback in a postal survey A 'consumer satisfaction survey' was posted to a database of 130 clients who had received services from a Neighbourhood Nurse within the last three months (see Appendix N). The survey comprised one page of mostly open-ended questions. The covering letter from the Nurse Manager Community and Primary Care Services requested return within a week in the stamped addressed envelope provided.

Within three weeks of distribution, 76 returns had been received, giving a response rate of 58%, which compares well with a standard postal return rate of 33%. The returns were sorted by locality, and clients' verbatim responses entered into a spreadsheet for thematic analysis by the Project Consultant and Project Manager, reporting being completed by the Project Manager.

Sources of referral Of the clients who indicated source of referral:

36 (53.5%) had been referred by the hospital

20 (30%) had been referred by the GP
 10 (15%) self referred
 1 (1.5%) was referred by the school.

The greatest proportion of hospital referrals occurred in Hokitika, while GP referrals were higher in Dobson and self-referrals higher in Reefton.

The most important things the nurse assisted clients with Responding to the question '*Please give the three most important things that the nurse assisted you with*', many clients mentioned specific tasks or treatments as important, most likely reflecting the initial reason for referral. However, overall, two thirds of clients mentioned advice and support amongst the most important assistance they received. Key themes and representative comments were:

Specific aspects of nursing care

The healing process on a leg ulcer.
Cleaning up skin round PICC line where I had a skin breakdown.

Health promotion activities and health advice

She provided excellent dietary advice to promote bone healing.
Help in giving up smoking [and] talking over how to help in my breathing problems.

Health assessment

Visits me every month at home to ensure I am well and takes my blood pressure.

Advice and support in self-management

A genuine caring and supportive role in wellness. A willingness to help in prevention - observation and follow up when visible signs and symptoms appear.

Arrangements to connect them with needed services

She has helped me with all the paper work and has followed through by ringing or contacting all the different departments.

Most helpful aspects Key themes and representative responses to the question '*What did you find most helpful about the assistance you received?*' were:

Responsiveness, flexibility and reliability of the service

The availability of appointments either at the clinic or at home.

Approachability and helpfulness of the nurse

The caring nature of the nurse. I know her help gave me a lot of confidence to get well.
It is sometimes difficult to get appointment for the doctor who you don't want to waste time for with lesser problems like blood pressure and weight management.

Receiving care at home or locally

Saved me a difficult trip to the GP.
As it was a major effort to get in the car, the nurse coming [to the house] was a terrific help. Not having to travel was much appreciated.

Differences noticed in this service Clients were to answer this question only if they had received other nursing services: ‘*What made this nursing service different from any other nursing service you have received?*’ One third responded, suggesting that only this proportion had experienced other nursing services. Key differences noted were that the nurse seemed:

More flexible, available and less hurried

Made me feel at ease because wasn't in and out like a flash of lightning. I had time to ask questions.

Her availability to come to my workplace.

More likely to attend to the client's wider needs

This tended to be more ongoing and not just for one specific problem.

It was more than medical. Was able to discuss other issues and this opened up other channels of help.

Able to give a complete response without referring back to others

Accessible, on the spot help. Didn't have to go through other health professionals to access help and information.

Improvements suggested Of the 55% who responded to the question ‘*Have you any suggestions on improving this nursing service?*’ just over half specifically stated they did not have any suggestions for change. The rest commented on the excellence of the service as it was, with specific comments about increasing or retaining the service.

Overall The main objective of the client feedback process was to learn about the clients' experience of the Neighbourhood Nurse service as part of project evaluation. It is important to recognise that these comments cannot be used to compare the Neighbourhood Nurse service with any other nursing service, where it is possible that clients would give similarly appreciative responses.

Overall, the Neighbourhood Nurse clients responding in this survey appeared to

- find the nursing service a reliable source of advice and support in managing the health related challenges in their lives and the social repercussions
- be impressed with the nurses' knowledge of systems and their apparent ability to arrange and access services and equipment impressed clients
- feel that the nurses were approachable and interested in them holistically, which enabled clients to explore more fully their condition and needs in self-management at home.

6 The Neighbourhood Nurses' perspective

The nurses undertook two separate processes to explore the nature of the service the Neighbourhood Nurse role could deliver:

- the development of resource material for the role - a leaflet for colleagues referring clients and an information leaflet for clients and their families/whanau - in late 2005/early 2006, supported by the Project Manager and Project Consultant (see Appendices K and L)
- the exploration of a 'Model of Care' - working with the DONM from August 2006 and making significant progress.

The Model of Care corresponded with earlier expectations

The Model of Care exercise was informed by the nurses' experiences with their caseload. This meant they were more confident in defining the service they had tentatively outlined earlier in the leaflets.

Their goals were to

- have a broad focus on the whole community, and defined populations or groups within it
- create autonomy, capacity and capability in the community and individuals through negotiated partnerships and relationships at all levels, and thus to mobilize strengths and reduce unnecessary dependence
- improve health awareness, and support independence and self-management for optimal outcomes for people in leading healthy lifestyles or dealing with health problems
- provide options in nursing interventions across the life span and health continuum
- improve accessibility and coordination of services.

They found that they had been able to focus on those who were

- requiring 'conventional' activities of care, e.g. in recuperation and healing, chronic disease state management, terminal illness
- vulnerable or 'at risk'
- newly diagnosed, where education of the client and wider support group was needed
- 'slipping through the gaps', i.e. people whose needs are not met by existing services
- seen as people 'who take more time', especially those who may be difficult to engage, treat and manage
- healthy, to encourage them to remain so.

Key markers or transitions noted in their clients' journeys were

- a willingness to accept partnership
- a change in their understanding about their health/illness (development of insight or a capacity to recognise) leading to change in behaviour
- a decision to make a change
- changes in patterns of engagement/relationship with the nurse
- hospitalisation or accessing other services
- death
- acknowledgment and mobilisation of others to work together toward common goals - a shared recognition of community problems, common goals and responsibility.

Vignettes: what was possible in the new role

Catchphrases the nurses used from the beginning to the end of the project were to 'do whatever needs doing', and 'wherever suits the client'.

They saw themselves being available to people in a more-or-less geographically defined area, and worked with them in their homes, schools, workplaces and community, or in a clinic setting, as it suited. They were free to offer their services widely and they approached people they believed needed support, in what one GP described as a key insight from the project: *'...by being proactive in this way, we made a small investment, and saw a good return (despite the short time period) in terms of improved health outcomes for targeted individuals and families'*.

The following vignettes from the Neighbourhood Nurses exemplify the new role.

SUPPORTING SELF-DIRECTION

My first introduction to this family came when the mother phoned into the office, concerned about her new baby's breathing. A visit to assess the baby at home revealed a household under some stress. This initial contact was soon followed by a referral for post-discharge followup of another child after an accident at home. I've now been visiting regularly over a four month period, working closely with Plunket for parenting support. The family have had multiple services involved in the past, which means it's critical that they make their own decisions about what support to seek and when. I visit when they call me, or just to see how things are going. It means being responsive to whatever is happening at the time, but keeping an overall aim of helping this family find their own way through.

WALKING ALONGSIDE ON A DIFFICULT JOURNEY

A young woman was referred for an assessment of her social situation. Though she had been fully investigated, no reasons could be found for her evident problems. She wasn't particularly open to the encounter, and after explaining the reason for the referral, I emphasised that my role as a nurse was to provide whatever support would be helpful. We met once, and then again. Eventually, she began to open up and it became apparent that her anxiety level was impacting on her ability to enjoy and cope with life. I was able to suggest that she could look at talking with a psychologist and her doctor, and she found both these avenues useful. Family members had been at a loss as to what to do, and I was able to support them. She is sleeping well, her overall health is improving slowly and having accepted referral to a specialist service, she has kept those appointments.

COORDINATING SERVICES TO FACILITATE INDEPENDENCE

I introduced myself to all the residents in the local pensioner flats. One man was concerned that a problem with his feet was making it difficult to walk. He couldn't afford podiatry himself and had got nowhere through the avenues he'd tried. On the podiatrist's advice, I approached WINZ, who suggested he would be eligible for various health allowances, which his GP signed off. This is a good example of how difficult it is for some elderly people to access what they're entitled to: the process with WINZ was reasonably complex, he had neither personal nor public transport, and could not call on family for support. Once he had the information, he made the arrangements he needed without any assistance from me.

SUPPORTING THE ABILITY TO COPE

A family member who looked in on an elderly relative had sought support from the Practice Nurse when she'd found him in a distressed state. The Practice Nurse asked me to assess the situation. I knew this man and felt that what had happened was out of character. When I visited the next day, he told me that he'd felt very despondent when he'd been advised to

make some lifestyle changes for better management of his chronic condition. I liaised with his family, GP and social worker to arrange respite care and an independent carer. He continues to live in his own home with this support, and the family has been able to resolve a potential breakdown in the relationship.

SUPPORTING THE NEED FOR INDEPENDENCE

We were getting calls from neighbours concerned about an elderly lady who was losing weight and withdrawing from her usual activities. They knew she'd had cancer. We visited, explaining that people were concerned. She came to accept our visits, even though she was adamant about not seeing the doctor and not going to hospital. As her health deteriorated, she was less able to cope in her home, and our daily visits focused on safety and emotional support. We talked about what palliative care could provide and assured her that if she wanted, she could ask us to connect her to more support. After a particularly unpleasant night, she asked me to take her to hospital, which I arranged through her GP, and she died there a few days later.

KNOWING WHO IS AT RISK

I 'cold-called' on someone I knew through my community network to be vulnerable. My purpose was to introduce myself and what I could offer as a nurse. Things intensified for this person and I got two calls from people who were very concerned. I visited and found a situation requiring urgent intervention. I felt the support and referral I offered at this point was easier to accept because of our connections through the community and my earlier contact. I was able to arrange an urgent appointment with the GP, who began an intervention. My involvement increased as deeper support was needed through a crisis period. Now discharged from a specialist service, this person is stronger: *'The skills I've learnt, I'm able to talk to my friends and pass them on'*.

7 How the service met challenges for primary health care

The Neighbourhood Nurse role was proposed to address a number of challenges put to primary health care providers by the then Minister of Health:

Services will be directed not just at those who seek care when they are ill, but will be there to look after the health needs of the whole population group. So primary care providers will need to know not just who is sick, but who might become sick because they are not getting access to preventative health care and health education.

We need to coordinate our primary health care professional resources far better. For example, we have 11 or more different types of primary health care nurses. We need linkages between all sorts of community care, hospital services and other key areas like social welfare, disability support, housing and local government.

We also need continuity in care, especially for the increasing number of people with complex long term health needs...⁹

The open brief that the nurses had in trialling the new role meant that they were unconstrained by service specifications in meeting these challenges:

Promoting health and prevent illness

- They could 'legitimately' take self-referrals and approach individuals and families/whanau where support might be needed.
- They could also attend to a range of needs within a household or family beyond an initial referral reason or presenting need.

⁹ Minister of Health (30 May 2002).

- They advised and supported clients in maintaining or achieving good health - while a third of clients identified specific treatments as the most important thing the nurse assisted them with, two-thirds identified health advice, assessment, assistance with self care and navigation through health and social services as most important.

Increasing coordination and reducing risk of fragmentation

- 40% of clients indicated that the nurse had undertaken specific activities to connect them with services and/or co-ordinate and streamline their care, whether checking on appointments, replacing a visit to the doctor or advocating for the patient with other services, such as the pharmacist.
- A number commented on the time saved when the nurses organized their visits, and that they had enabled fewer hospital or GP visits (which the elderly and rural find more difficult and costly to manage).

Linking with other services that impact on health

- Client feedback from all localities indicated that the nurses had provided advice and connected them with other support services, but most notable was the linkage in Reefton with the schools, where the school counsellor found improved and timely access to health services for local adolescents who would not otherwise engage.

Providing continuity in care (especially for the increasing number of people with complex long term health needs)

- A key feature of the Neighbourhood Nurse role is its geographic assignment to a particular community. Client feedback showed a case management aspect arising out of the local and home-based nature of the service as it facilitated their accessing health services and reduced difficulties associated with travel.

A secondary goal for the project was to explore factors impacting on success (or otherwise) in introducing a new primary healthcare nursing model. Being open to learning about what went well and what could have been done differently was part of the ethos of the Primary Health Care Innovations. Openness to learning also determines the usefulness of the project to WCDHB and primary health care service provision on the Coast.

1 Choice is critical in role development and transition

Assumptions were made in proposing a new primary health care nursing role for Reefton

The Innovations funding's intention to '*...allow for new models of nursing practice to develop and reduce current fragmentation and duplication of services*'¹⁰ seemed to have a good fit with recent developments and thinking within WCDHB's primary health services for these reasons:

- an integrated role similar to the RNS role was thought to be attractive to primary health care nurses as it removes any constraints perceived to be associated with service contracts
- there were thought to be efficiencies in a geographical assignment of caseload in a smaller rural area that nevertheless encompassed outlying areas
- different approaches to primary health care nursing service delivery had been explored relatively recently in Reefton, and it was thought there was a general readiness to continue that dialogue.

In short, the Proposal suggested that a more generic role was '*an idea whose time had come*'.

A commitment was made to exploring a new role

The four nurses in community-based positions in Reefton were open to exploring the possibilities around a new role, and the nurses and Project Team agreed to work together to define it.

A position description was completed in May 2004, but negotiations begun between the DHB and the nurses' union representatives over transition arrangements had made little progress by the end of that year. The Steering Group formed by the new Project Sponsor in early 2005 believed it critical to ascertain the Reefton nurses' wishes before any management decision was made on the future direction of the project. The nurses' individual replies indicated that while there was support for the goal of the project, the role would not be trialled by the whole team.

Many factors contributed to the nurses' freely made decisions, however the following points are important for the DHB when planning role development:

- a step in consultation was missed at the beginning of the application process for Innovation funding
- being in a smaller community, the nurses felt they were already able to practice more holistically and with greater continuity, and they did not feel constrained by service contracts and felt they were able to respond to need as it arose - therefore the new role did not represent an advance on how they already worked
- they felt they worked flexibly within the team and thus minimised distance factors.

The Proposal for a new role and a new way of working had come to be felt as a comment that their practice was not seen as good.

¹⁰ Feek & Hughes (June 2002).

Applications to trial the new role were sought Refocussing the project, the Steering Group decided in May 2005 to open up the opportunity to nurses across the Coast to trial the new role. This decision was informed by what had been learned in Reefton - that any nurse who stepped forward to try a new way of doing things must be making a free and informed choice to do so.

A concerted effort was made to make inform nurses and others of the new role and the opportunity to trial it, including

- flyers and a roadshow presentation run in Westport, Hokitika and Greymouth
- an information package available on enquiry and on the WCDHB website
- an advertisement for fixed term positions which ran locally and nationally in late June
- applicants having the opportunity to be briefed by the Project Consultant.

Those appointed held expectations congruent with trialling a new role Although the position had been advertised as a 'Primary Health Care Nurse', the nurses appointed were clear that they wished to be called 'Neighbourhood Nurses'. Exploring on their first day what it meant to take on the new role, they saw it as:

- an opportunity to put their beliefs and learning about primary health care into practice
- an opportunity to practice differently and in a way that would meet need
- a personal and professional challenge, and an opportunity to develop new skills
- requiring new ways of interacting with colleagues, service providers and the community.

The new role was experienced as an opportunity for growth, but it must be freely chosen At the project's conclusion, reflecting on the experience of trying a new role, the Neighbourhood Nurses felt they had become more skilful and confident (particularly when working in more complex situations), and that participation in the project itself, overall, had been a positive learning experience. Their advice to others taking on a new and untried role, was to

- *Grasp the opportunity and run with it, learn as much as you can on the way*
- *Keep your enthusiasm and sense of humour*
- *Make sure you have a good [personal and professional] support structure*
- *Work inclusively - you need the help of your colleagues*
- *Find out who's in charge and test your manager's understanding of the role*
- *Make the most of the opportunity to work with others at national level and learn from them - think globally and beyond your own patch.*

However, they were aware that there were many amongst their colleagues who valued their current roles highly, and some did not view the new role (or the project) positively. The Neighbourhood Nurses advice was that it would be important to '*check out if nurses want to work in this way*'.

Recommendations related to 3.1 *That nurses are free to decide to take up the new role or not, and are respected in their choice.*

That there are information resources and opportunities to discuss what transition into the new role and new way of working means.

2 Ongoing communication with stakeholders is key

Focus groups were asked about their knowledge and involvement The focus groups in Hokitika, Greymouth, Dobson and Reefton were asked what they knew of the project and new role, and how they'd received information and been involved (see Appendix M). The Neighbourhood Nurses were asked in their focus group about whether they felt others were sufficiently informed about the project. All groups were asked if communication and involvement could have been improved, and their suggestions were recorded.

Feedback was that some were well informed... Those colleagues who felt best informed were either personally involved or briefed as they:

- worked alongside or with a Neighbourhood Nurse
- had met with one of the Project Team and had the project explained to them
- were on the Steering Group.

Most direct referrers had received an explanation of the role from a Neighbourhood Nurse in late 2005 when the nurses were establishing or extending their caseload, and had discussed which kinds of clients could benefit from the service. The colleague referral leaflet (Appendix K) and client information leaflet (Appendix L) had been developed to support this process. Project Team members had recommended the leaflets be used in the context of a conversation with a colleague or client, rather than being sent far and wide without personal contact.

...but there had been a lack of communication for those not directly involved Although the Project Team and Steering Group had undertaken appropriate communications with key people or provided specific information at key points, such as when the fixed term positions were offered, there had been no overall ongoing communication plan from the beginning, nor as the project refocused mid-2005.

At the conclusion of the project, therefore, it was not surprising that those in the focus groups not directly involved felt they'd had insufficient communication about the role and no involvement in the project. Most said that the colleague referral and client information leaflets attached to the focus group invitation was the first written information they'd seen about the project. Although the leaflets and position description were amongst the information on the Neighbourhood Nurse webpage, only about 60% of focus group participants said they accessed the intranet in general.

There was a lack of knowledge about the nature of a project itself... Few understood that the new role was part of a project, or what a project involved in itself. In some of the focus group meetings the facilitator (Project Manager) judged it useful to give information about

- what a project is and the role of those involved, including the nurses
- criteria attached to the funding received by the project
- the rationale and intent of the project.

...and why the project had refocused to include other localities Focus group participants were aware that the project had begun in Reefton but noted that there was little followup after initial information. While they had heard informally from colleagues regarding '*the Reefton situation*', they felt there been no official explanation of what happened, or the rationale for refocusing the project, nor why and how strategic decisions - such as the choice of localities - were made and by whom.

The Neighbourhood Nurses too commented that the project had appeared '*a bit of a mystery*' and the roadshows promoting the opportunity to trial the new role '*a rushed process*'.

Considerable responsibility for explaining the new role fell to the nurses creating it Once appointed, the Neighbourhood Nurses explored in their initial workshops the kinds of client situations they believed their role could address, and developed resource material (the leaflets) to communicate that. To build or extend their caseload, they spoke to potential referrers. Effectively, the nurses had found themselves in the position of communicating a role they were yet to make.

The Neighbourhood Nurses had understood that they were taking up a personal and professional challenge. However, challenges they hadn't anticipated were

- explaining a role that was new and as yet untried
- explaining what the project was, and what it involved
- dealing with a degree of misunderstanding (and sometimes hostility) from some colleagues which had developed in the absence of planned and ongoing communication.

The Neighbourhood Nurses felt that their own explanations lacked the credibility that a management or leadership voice carried and recommended that *'a clear message should have come from the DHB as to the reasons for the project and the DHB's commitment to it, that it saw it as the way of the future. This would have given the role a mandate'*.

More planned and ongoing communication would have been helpful In retrospect, specific aspects of communication where a more deliberate and sustained engagement across various groupings of primary health care nurses might have helped were:

- explaining the new role and its project context might have better engendered colleagues' support for a new idea, and allayed feelings that their own role was under threat or somehow thought lacking
- a more explicit expectation of Steering Group members as champions of the new role
- the monthly report for project participants instituted by the Project Manager from May 2006 might have gone wider
- where there were staffing or cover pressures, misunderstandings about the new role were heightened if it appeared that workloads were out of balance within a team, and therefore being informed of an expectation that a more complex caseload would represent a smaller number of daily client contacts may have helped in these situations.

Where there was facilitation for a team as issues arose, this worked well (for instance, initially the Nurse Manager met fortnightly with nurses at the Hokitika Health Centre, and involved the DONM in helping that team work out a geographic allocation of clients).

Paradoxically, a low profile may have been helpful as it meant the Neighbourhood Nurses were not swamped with referrals, nor were they in the spotlight as they developed their practice.

Recommendations related to 3.2 *That the proposed PHCN workforce and practice development coordinator work with line managers, the DONM and Communications Manager to formulate and implement a communication plan which includes*

- *formal communication through newsletters and PHC forums*
- *ensuring that team members are well-informed as change is anticipated and implemented*
- *available communication opportunities (e.g. monthly District Nurse meeting) are used for giving and receiving information.*

3 Role development requires upskilling and support

An important undertaking to those trialling the new role was that role development and transition would be supported. This was done through a professional development programme based on identified learning needs (see Appendices E-I), a monthly workshop programme and clinical supervision.

Feedback on professional and role development support

Evaluation of the monthly workshops and specific learning experiences was undertaken at the time, and at the project's conclusion, a review of learning and development was completed (see Appendix O).

Overall, the opportunity to try a new role and involvement in the project were seen by the nurses to have been powerful learning experiences in themselves, and the support provided for professional and role development was thought the right mix.

Professional development programme

- There was a useful interaction between developing a new role and what was being learned in personal courses of post-graduate study: *'Studying for the post-grad diploma in health science gave me a really strong knowledge base ...the project was instrumental in consolidating it, and enabling me to try out new knowledge and skills in practice'*.
- The brief to 'do what needs to be done' meant that the nurses could offer services ranging from health promotion to personal care in post-hospitalization, chronic and palliative care situations. The nurses identified the most useful learning experiences as those related to health assessment and supporting clients in managing their own health - suggesting an expansion of their practice in these areas:
 - effective brief intervention around smoking cessation, diet and exercise
 - adult health assessment
 - self-management in chronic conditions (Flinders model)
 - and additionally for the Whanau Nurse, visits with a youth health service and Maori health services.

Some elements planned for the professional development programme were not able to be delivered (e.g. child health assessment). The delivery of some topics was less well matched to the nurses' learning needs than anticipated: *'Make sure invited presenters have clear guidelines on what expected outcomes will be'*. An overview is given in Appendix H, and full details to assist future planning are given in the relevant Project File.

Monthly workshop programme

The workshops gave the nurses *'time away from caseload to consider the bigger vision'*. Overall ratings for sessions within the workshops were 'very useful' or 'useful'. Key themes in the nurses feedback were about the importance of giving time to

- what was happening in the project - *'It was great to have a full day to devote to project business'*.
- discussing caseload and practice - *'I do miss our 'round-the-table' time. It was such a good opportunity to hear what each nurse is doing in their area and how they address issues'*.

- group supervision - *'Again, the group supervision with [DONM] is hugely beneficial'*.

Clinical supervision

The individual clinical supervision sessions - initially run fortnightly, then three weekly - were felt by the nurses to have been one of the most helpful aspects of project participation, and essential when developing a new role. Over eight months of sessions, their clinical supervisor saw both personal and role development:

Each person was in a different space and had different issues - some were client-related, some systems-related, and some related to work stress. Each time I saw them, I saw development, especially around their role: What it was, and where did it fit in to the bigger picture, and what was its relationship with District Nursing or other services.... Over time, as they understood more of their own place and role, they became less fragmented and more proactive and got on with doing their own work. When people take on a new role like this, other people need to make space for what they do. I saw them become increasingly confident in identifying their stressors and looking after themselves.

Time must be available for role and team development

The 0.9/0.1 FTE split between service and project participation made available approximately a day per fortnight, pro rata, for project activities and professional development. A review in May 2006 by the Project Team of how this was tracking suggested implications for staffing levels where the new role was implemented. However, points to consider in a rollout situation are that:

- nurses would be able to undertake the required learning over a longer period, in contrast to the shortened project period (15 months) which intensified the learning to be achieved and also meant that not all the required learning opportunities were able to be provided within the timeframe (e.g. child health assessment course was not available, not all were able to have a colleague visit with a Maori health service)
- planning for individual development could see better integration between DHB-provided training and self-directed learning (personal courses of study and workshop enrolments)
- although there would be no demand around project activities, local primary health care nursing teams would need time to work through implications of role change around client allocation, caseloads and practice development (see also discussion under 3.4).

The learning that the Neighbourhood Nurses found most useful in expanding their skills was available to all, and it is anticipated that a programme which could be accessed by any primary health care nurse would enhance the capability of the total group.

Recommendations related to 3.3

That a programme of professional development activities/opportunities is provided from which nurses may 'pick and mix' a personal programme according to their learning needs in order to develop a broader set of skills (see Appendix J).

That coordination of this programme be undertaken by a workforce and practice development coordinator for primary health care nursing (which would parallel the Workforce Development Coordinator for mental health and the CNEs for secondary services).

That the above be supported from the balance of the Innovation funding.

4 Primary health care nursing roles need to be flexible

The development and review of a position description Initial work to define the new primary health care nurse role referenced position descriptions for current community-based primary health care nurses - thus ensuring that the range of health needs across the lifespan were covered. District Nurse, Public Health Nurse and RNS position descriptions were accessed.

The provisional position description developed in Reefton provided both a guide for trialling the new role, and a framework that the nurses' experience in implementing the role would test and refine. An annotated version of the position description is in Appendix D, and it is suggested that further refinement frames it as a range of potential competencies and responsibilities.

Some variations had been anticipated The possibility of variation in Neighbourhood Nurse roles was recognised in the provision of a 0.5 FTE position '*with a particular (but not exclusive) focus on the health needs of the Maori community*' to meet the funder's requirement that Innovations address Maori health inequalities. This position was identified as a Whanau Nurse and the appointee established a role that fulfilled this title, according to feedback received from the principal of Reefton Area School in the focus group process:

The whanau (family) tag is important here. [The nurse] has worked with Maori. However it hasn't been exclusive to Maori. Many school families have benefited from [her] confidential input. Her assistance has been in many, many areas and especially for those who are not from mainstream.

Other variations had not been anticipated Services normally covered in well child contracts had been included in the position description, but the provision of services related to child health varied across the localities according to the need in the community, the presence of Public Health Nurses within a given team and the individual Neighbourhood Nurse's experience and set of competencies.

- While the Neighbourhood Nurse in Reefton provided school-based services, those in Hokitika and Dobson did not, either because there was no school in the area or school-based services were already provided by another nurse.
- Arrangements to provide a child health assessment course had failed when the education provider withdrew the course, consequently, Neighbourhood Nurses without a background in child health could not be upskilled to provide services related to children.
- One of the Neighbourhood Nurses had a strong background in child health, and was able to use those competencies with families in her caseload, but as the demographic profile for that locality was largely elderly, there was not a great call on these skills.

The point of upskilling people in competencies not required, or only required infrequently in their community, has to be addressed. A threshold of involvement is required to maintain competence, and if the caseload does not present it, then the ethic of safe practice and service quality directs that the nurse either refer the client/family or access other resource to ensure the need is met appropriately.

These factors related to providing child health services illustrate issues about safe practice in a broader scope, which was a strong theme in District and Public Health Nurse feedback in the focus groups, and had been a concern for the Reefton team. Addressing this question earlier, the Project Team had said that the nurses would not be expected to take responsibility in areas where they were not yet skilled.

A range of roles are needed The course of the project saw a shift in thinking - that in smaller more isolated rural communities, the all encompassing Rural Nurse Specialist role was appropriate, but larger communities could utilise a range of primary health care nursing roles.

In other words, while those appointed into Neighbourhood Nurse roles may develop a comprehensive set of competencies to meet a range of health needs across a range of ages, it is neither possible nor preferable to expect all primary health care nursing services to be provided from this role.




This thinking was focussed in discussion in the November 2006 Steering Group meeting, when the Project Consultant presented a diagram suggesting

- that all primary health care nurses have a set or toolkit of generalist skills
- and also carry set of specialist interests (personal to the individual) which can be called on by other team members.

Additionally, it was recognised that specialist nurses (such as cardiac, DNE, palliative) carry a highly specialised tool kit, and their expertise is a resource available to the wider group.

Further, there are some other specific functions that must be assigned to particular roles, such as Immunisation Coordination or planning for health promotion campaigns, so that the DHB has the capability to drive these 'programmes' through designated positions. Nurses working in generalist roles are expected to be able to assist and support these programmes e.g. finding difficult-to-contact children in immunisation; contact tracing in a epidemic or pandemic; or participating in health promotion activities (as did the Hokitika Neighbourhood Nurses with a promotion at the Wild Foods Festival).

TYPES OF PRIMARY HEALTH CARE NURSE

generalist nurse	specialist/resource nurse	nurse with designated responsibility for a 'programme'
		
EXAMPLE Neighbourhood Nurse	EXAMPLES Diabetes Nurse Educator Palliative Care Specialist	EXAMPLES Immunisation Coordinator Cervical Screening Coordinator
VARIATIONS <i>determined by the needs of a particular community</i> Rural Nurse Specialist (has PRIME and carries on-call) Whanau Nurse (has focus on needs of Maori)		

The need is for flexibility yet comprehensive service delivery

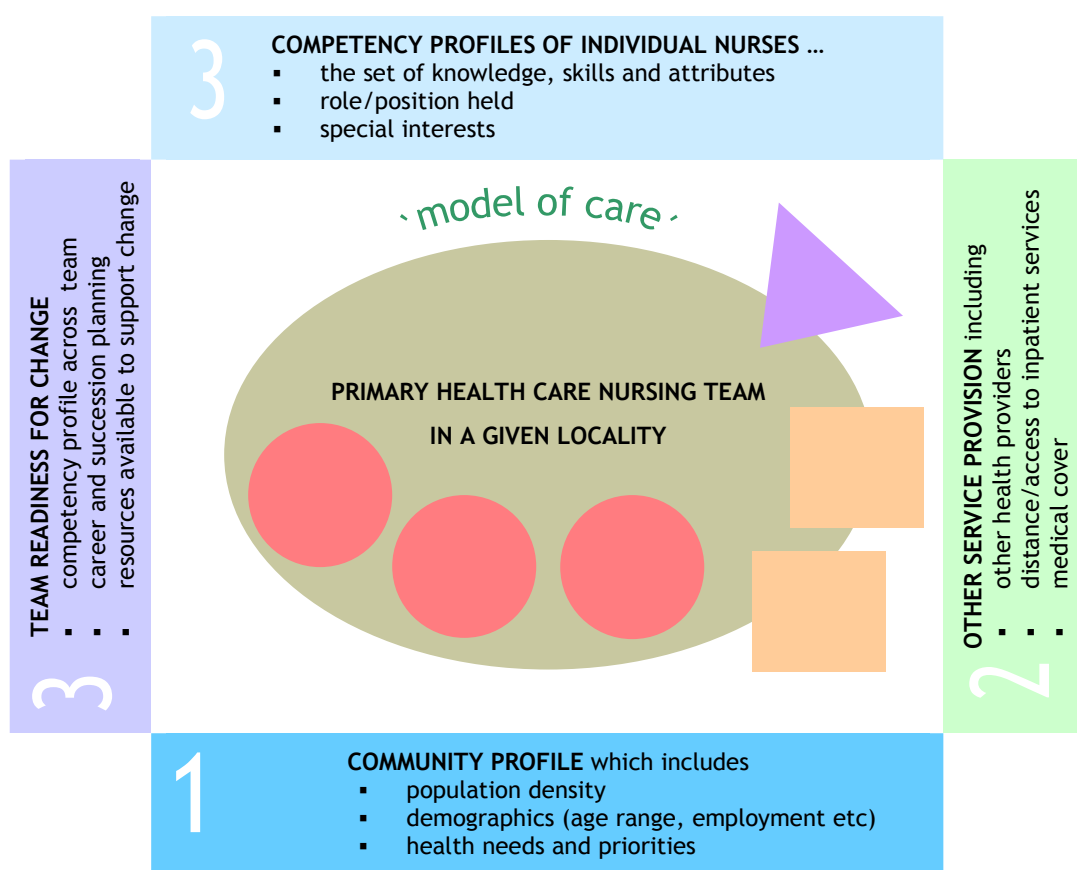
A framework for determining which roles need to be provided within a given team (with the ability to call on specialist resource roles) was reviewed, and refinements suggested in the discussion and subsequently have been integrated into the diagram below.

The implication is that each locality needs to work through a process taking these factors into account, in roughly the following order:

- as a foundation, community profiling to identify needs and resources
- an assessment of other service provision or service gaps
- an exploration of team readiness to explore new ways of working, which will encompass the team's ability to work differently based on the mix of competencies held by individuals.

This approach squares with the strong recommendation from the focus groups that implementation of a new role and/or new way of working be undertaken locality by locality.

A FRAMEWORK FOR USE IN EACH LOCALITY



These framing factors and parameters determine the number and type of primary health care roles in a given team in order to ensure appropriate service provision. The model of care may pertain to the wider primary health care team, or the nursing team.

Recommendations related to 3.4

That the position description developed and refined for the Neighbourhood Nurse role is adopted as a framework for future generalist community-based nursing roles, as it outlines a range of competencies, not all of which may be required in every appointment, but may be developed according to the range of needs presenting in a particular community and the presence or availability of other nursing roles within a given team.

That the framework discussed and refined by Steering Group members is used in a locality by locality review of PHCN services to determine configuration of local teams and implementation of the new role.

5 Change management and leadership are needed close to the action

Project management was provided for A Project Sponsor's responsibility is paramount, yet line managers are frequently not able to give projects the indepth attention they require. The project Proposal provided for a dedicated part-time project management position in addition to the operational coordination and management of the nurses participating in the project.

The position was seen as an opportunity to

- develop an individual by providing learning experiences, coaching and mentoring based on competencies identified for the project management role, and
- enhance organisational capability in that the skills developed by that individual could be applied to other projects and potentially to implementation of the new role ¹¹.

A Greymouth-based appointment was made to a 0.5 FTE Project Leader position as the project began in Reefton, and the appointee attended a project management course and was supported by the Project Consultant as she took up the role. She formed a good working relationship with the Reefton nurses, worked through individual learning plans with them, progressed a community profiling process for the wider Reefton area and oversaw the definition and description of the new role. Her secondment to another position in late 2004 left an important gap at a time when project progress had foundered. A Christchurch-based Project Manager began a part-time contract from late September 2005.

However, a lack of leadership was experienced However, questions about having locally-based project management surfaced several times, especially as external Project Team members were removed from the immediate issues arising for the nurses.

While the involvement of key WCDHB people (CEO, Project Sponsor and DONM) and the Project Consultant was identified in the Neighbourhood Nurses' focus group as amongst the best aspects of the project, responses to questions about what the Project Team and/or DHB could have done better had a common theme:

Management structure.

No clear leader from the DHB for the length of the project.

A DHB clear leader responsible for liaison, day-to-day support and PR, [to be a] strategist, change manager and [provide] advocacy. This role [should] also to clarify role/project to other DHB staff.

Clear leadership role - with a specific focus, not an 'add-on' to an existing mandate.

Prepare the work environment inclusive of other staff in other roles.

Facilitate change through change management.

Although support was provided, problems were experienced Problems experienced by the nurses were:

- That they were not clear about the respective responsibilities of the Steering Group and the Project Team, and were not clear which issue to raise with which Project Team member.
- That although direct reporting to the Nurse Manager was negotiated (as it was felt that reporting through the two CNLs covering the three localities would not facilitate

¹¹ Coast Health Care (June 2003), pages 36-12.

management of the Neighbourhood Nurses *as a group*), and support was received from this role, as it was held by three people from September 2005 to December 2006, there was discontinuity in the reporting relationship.

- Shortening the monthly workshop to a half-day instead (as the other half was allocated to a shared update or other specific learning experience) meant that time to discuss issues related to management of the project or role development was diminished.
- Cumulatively, it seems that these factors meant that the nurses stopped raising some issues with Project Team members - *'Stopped verbalising issues because there was no action/change'*.
- And in terms of practical support in equipping the nurses: *'It took a long time to put [all the] resources in place... still haven't got ophthalmoscopes'*.

Skilled change management is needed

Most importantly, in taking learning from this project forward, the DHB needs to be aware of perceptions about the Neighbourhood Nurse role in particular, and role change in general, and manage them. As reported from the colleague focus groups, while the overall concept of the role was supported, the logistics of transitioning to the new were thought to be too difficult in the current climate. Some of the barriers to implementation - which paradoxically were intended to be addressed by the project - were identified as:

- MOH contracts 'siloing' nursing roles
- nurses' employment contracts
- pressure from existing workloads
- lack of additional nurses perceived to be needed to augment the workforce
- potential for clients to take advantage of the role and develop a dependency on the nurse.

From a more positive perspective, building a team's capability to develop their practice and provide a service closely aligned to community needs requires time and facilitation, especially if they are to come to think of themselves as a 'practice of nurses'. Processes such as the development of a model of care helped the Neighbourhood Nurses *'...in defining what we do and what makes it different from other ways of practicing'*.

The idea of a 'community of practice' is one where a team is *'...fundamentally and simultaneously concerned with producing both practical outcomes for customers and learning for members'* - the challenge being to allow for interaction in *'...which participants share understandings concerning what they are doing and what that means in their lives and for their community'*¹². This kind of learning must be supported and facilitated.

Recommendations *That the proposed PHCN workforce and practice development coordinator works directly with line managers and nursing teams to facilitate change and provide support in a roll out phase.*

¹² Lave J & Wenger E (1991) *Situated Learning* Cambridge, MA: Cambridge University Press, cited by Liedtka J (1999).

6 Benchmarking and client feedback are useful

Benchmarking activities were undertaken Statistics are collected from nursing groups in Community and Primary Health Care Services on parameters related to specific service contracts. The Project Manager modified these existing service delivery data gathering systems to ensure that the range of possible nursing interventions would be captured by the Neighbourhood Nurses, and coached them in their use.

Monthly statistical reporting processes were further refined to enable service delivery monitoring and evaluation, however comparisons with other nursing groups were not possible as monthly reports identifying patterns in caseload related specifically to the Neighbourhood Nurses.

The reports derived from the monthly statistics enabled the Project Team to benchmark the Neighbourhood Nurses' role development in terms of an increasing range of services delivered, and also variances across the three localities.

The most recent consumer survey was reviewed The Project Manager reviewed the tool and results obtained in a 2001 consumer satisfaction for District Nurses and advised the June 2006 Steering Group meeting that the tick box approach used had elicited few useful comments.

The Project Consultant finalised a one-page survey tool and reported back to the August 2006 Steering Group meeting on the results obtained in a pilot. A convenience sample had been formed by asking the Neighbourhood Nurses to approach clients who they believed would turn the tool around in a tight timeframe, and all 15 invited did so.

Descriptions of clients' experience were sought The pilot results showed clients were willing to give narrative responses on what they had experienced as the most important and most helpful aspects of the service, and that this information showed the extent to which the new role had offered the characteristics of care intended. Adjustments to the survey (see Appendix N) included the addition of questions to

- determine if clients noted any differences between this service and other nursing services
- identify ways in which the service could be improved.

There was a high response rate and quality The response rate of 58% compared well with a standard postal return rate of 33%. Although all but two of the seven questions were open-ended, the majority of respondents gave answers to all the required questions, indicating their willingness to provide indepth feedback.

Such surveys could be ongoing Receiving feedback from their clients about the service was rewarding for the Neighbourhood Nurses and their managers. It was also instructive for the Steering Group in providing information on the extent that the service delivered aligned with the project's primary aim.

Seeking feedback about improvements on an ongoing basis enables a service to be responsive. Discussion of the collated client feedback within the Steering Group prompted the suggestion that a similar approach be used across community nursing services.

Recommendations related to 3.6 *That benchmarking data derived from monthly statistical reporting is further developed to enable ongoing assessment of progress and activities related to development of a generalist primary health care nursing role.*

That the client feedback tool developed in the project is reviewed as to its potential for modification and use on an ongoing basis within Community and Primary Health Care Services.

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The Neighbourhood Nurse Project

Appendices

Steering Group terms of reference and membership

Demographic profiles for the three localities

Benchmarking for the Neighbourhood Nurse service : Key features

Annotated position descriptions

Position description with related competencies

Competency self-assessment tool

Comparison of learning needs before and after

Professional development undertaken

Development for Whanau Nurse

Recommended professional development programme

Colleague referral leaflet

Client information leaflet

Feedback from colleagues and referrers: Information for focus group participants

Feedback from clients: Consumer satisfaction survey tool

Feedback from project participants: Outline for focus group and review of learning

List of Project Files held by Director of Nursing and Midwifery

