

# ***Shifting the Balance of Care: Implications for Community Nursing Practice***

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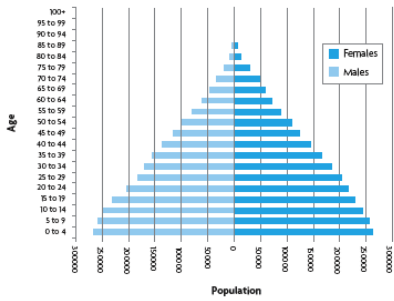
Seonaid Mackay

Acknowledgments: NHS Highland and  
community nurses

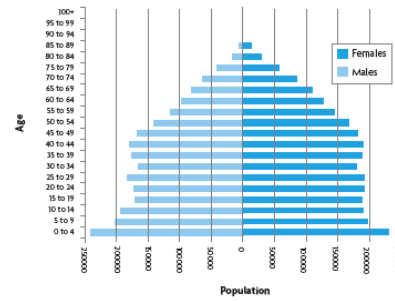
# The context...



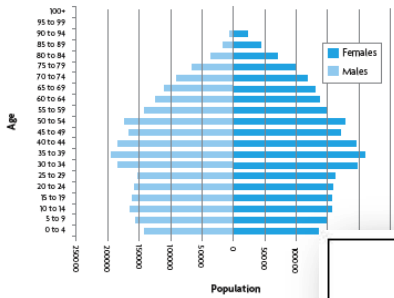
Population of Scotland. 1911



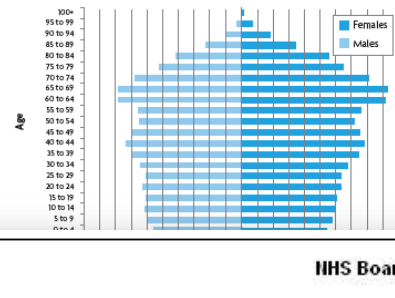
Population of Scotland. 1951



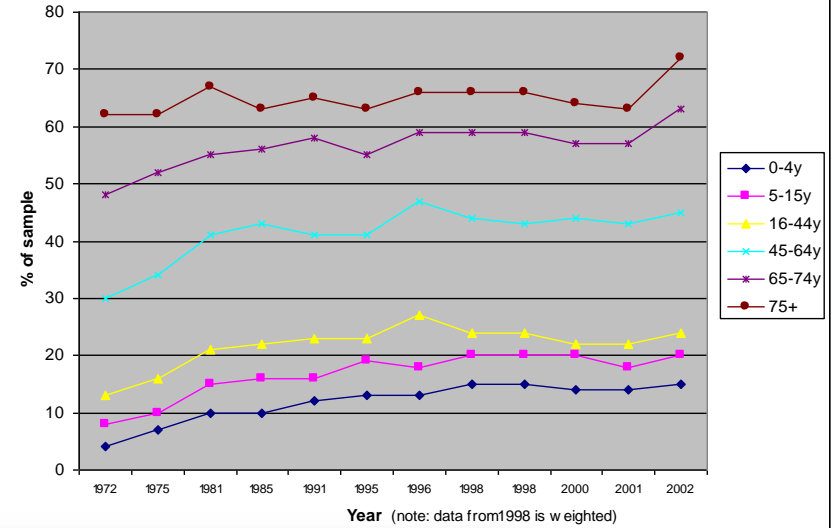
Population of Scotland. 2001



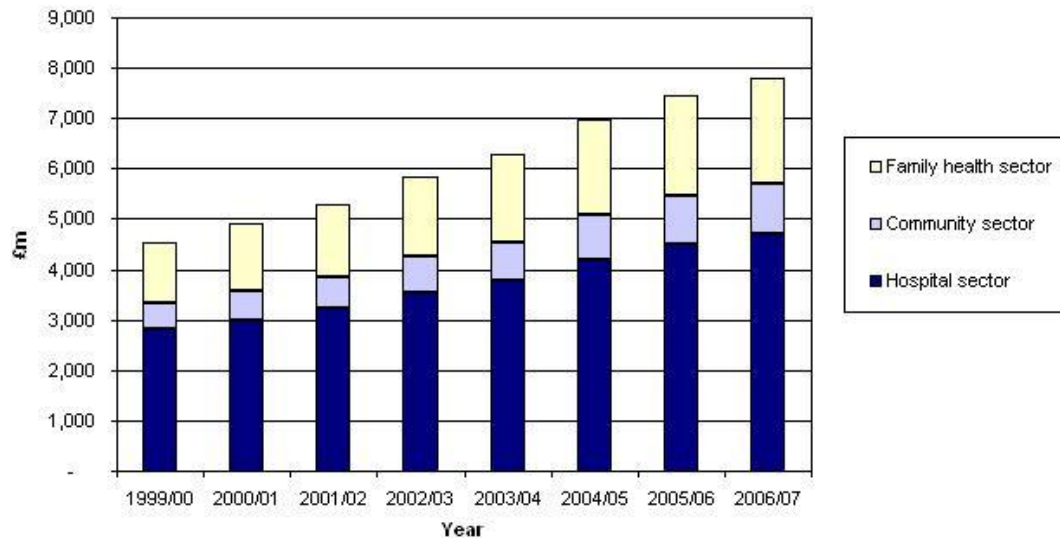
Population of Scotland. 2031



People reporting a chronic condition (by age)

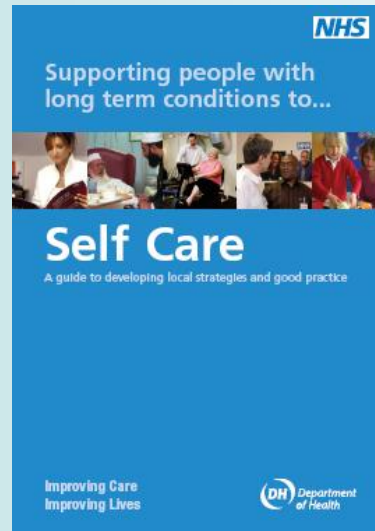


NHS Board costs 1999/00 - 2006/07





# The response...

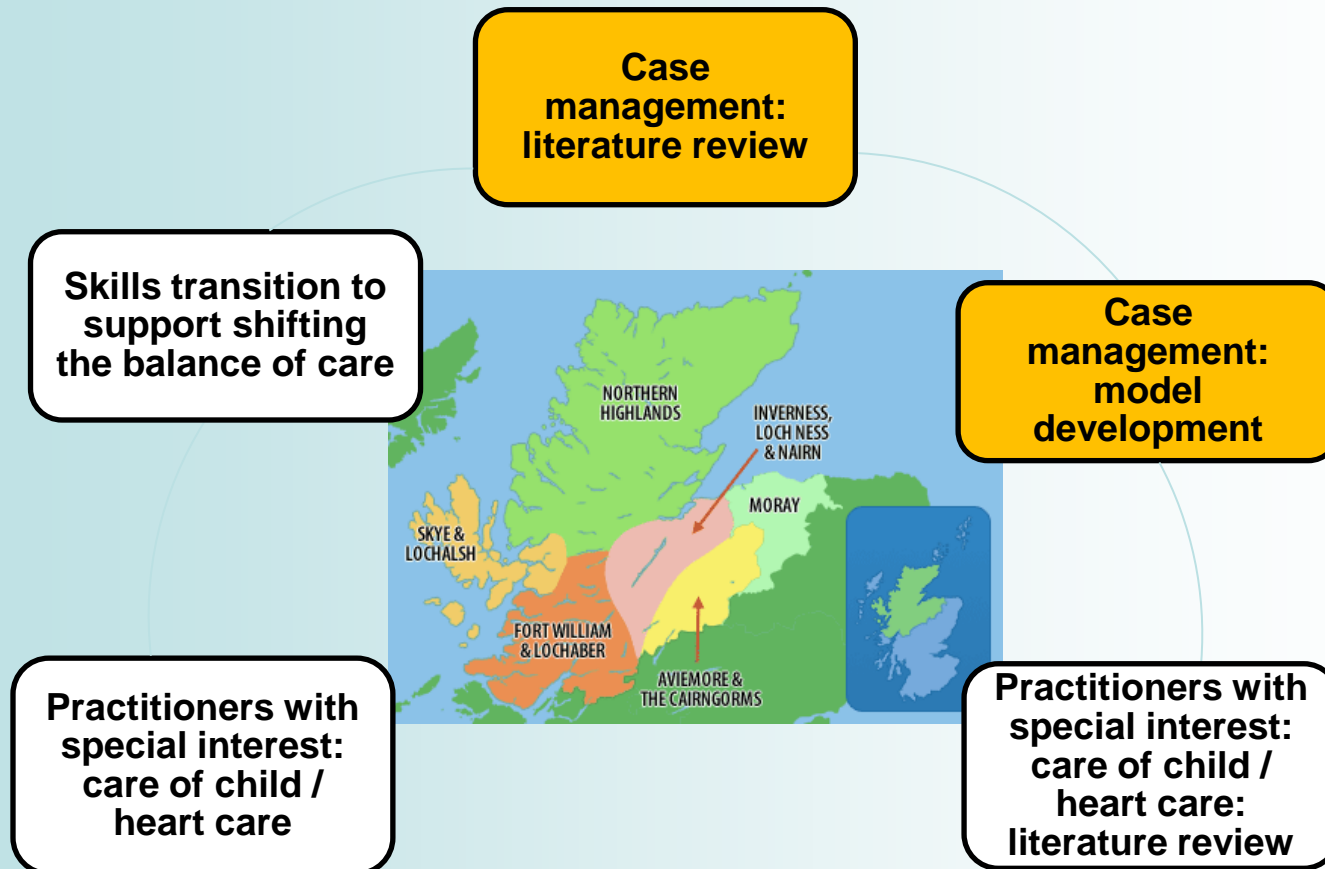


**Scotland's health care challenges require us to shift the balance of care towards community based services which enable continuous, community based care delivered at home or within the community**

*Research-led, Practice-driven, People-focussed*



# 5 interlinked projects



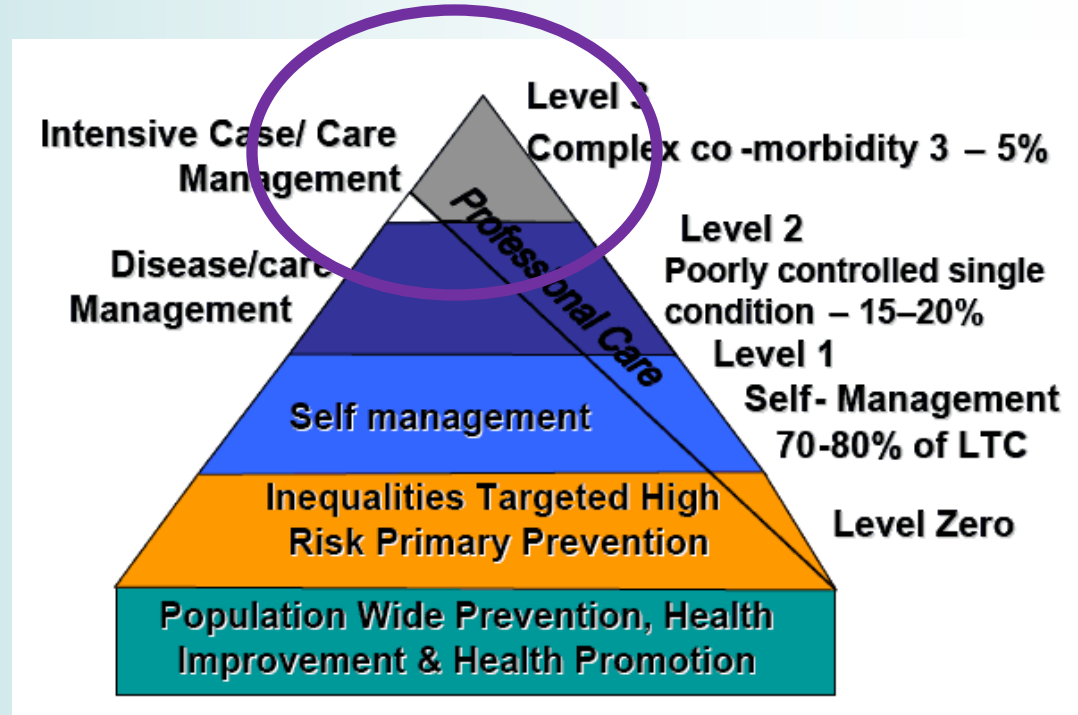
# Case Management

Stage 1

Literature review

Stage 2

Action research



Source: Scottish Government 2009 Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan



# Stage 1: Literature review

## Aims

What are the key features of case management models within community nursing in the UK?

How can characteristics from existing models contribute to the development of the case management models within NHS Highland?

## Method

Narrative synthesis of literature 1996-2010



# Case Management literature review: summary of key findings

- Interchangeable use of terminology to describe case management
- Models not always clearly conceptualised or described
- Case finding methods are mixed
- Case Management has been shown to be effective in improving clinical and behavioural outcomes for long term conditions
- Case management is an effective vehicle for anticipatory care



# Case Management literature review: summary of key findings

- Development of trusting relationships between community nurses, patients and carers key feature of Case Management
- Community nurses make effective case managers
- Inter-agency working is key
- Education & Support:
  - Advanced assessment skills
  - Skills to support self management
    - Patient teaching
    - Disease specific condition (Long Term Conditions)



# Stage 2: Case Management in Community Nursing – Model Development

## Aim

To contribute to the development of a case model approach to support Community Nursing practice.

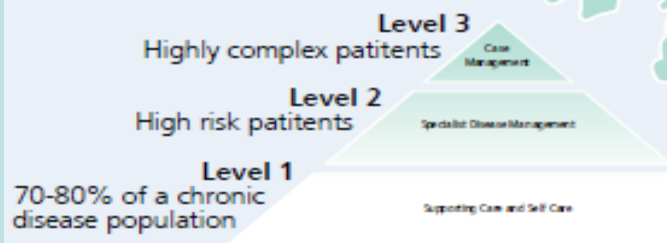
## Research Questions

1. Which aspects of case management models do nurses identify as contributing to the effectiveness of Community Nursing?
2. What is required to promote the integration of case management into the Community Nursing service?



# Sample

**Sample:** 3 groups of community nurses (N=24) from the Scottish Highlands who participated in 6 focus group interviews.



**Method:** Based on **action research** principles community nurses a) reviewed and analysed their current practice and b) identified and evaluated approaches to case management that could be tested in practice



**1. Fact finding:**

established community nurses understanding of case management approaches & implementation in practice

**2. Planning:** established preliminary recommendations by CN of processes & structures that can support case management implementation

**3. Action:** CN reviewed findings that emerged from fact finding stages:

**4. Evaluation:** CN nurses focused on recommendations for practice development that would support implementation of case management



# Case Management research: findings

- **Lack of clarity** about case management approach

*...Try and prevent, having anticipatory care plan that will stall them or stop the cycle of admissions.... (FC1)*

*...When you talk about case management, what are we talking about? Workload or case load or are you talking about case managing, or case finding... (FC1)*

- Variable approaches to **case finding**

*So, top 1%, but having worked with one practice who has used that tool to generate caseload and one that didn't...the practice that didn't it was just the local knowledge of the GP's who they deemed to be the most vulnerable at risk patients...but somebody called about the vulnerable who are not in this system, who aren't flagged up by SPARRA. (FC2)*



# Case Management research: findings

- **Assessment** can be hampered by difficulties with documentation

*...I think everybody uses different types of care plans as well which doesn't help. Social Care use one and homecare and we use a set and GP notes and it's bits and pieces everywhere. ..(FC1)*

- **Case planning** influenced by interface between all stakeholders in care

*...You need to build up a relationship and trust with the staff...and understand how they work and how we work... (FC 2)*

*...the fact that the GP's are more focused on it now and actually makes the job easier...a district nurse doing something different, yes that's very nice because obviously they can see something to be gained... (FC 2)*



# Case Management research: findings

- **Case intervention** influenced by ways of working and availability of resources, ways of working

*...It's a big problem, so to coordinate it properly you would need to have the services in the area and you don't always have that... (FC1)*

*...Yes exactly, if something can't get fitted in by another service, granted it comes to district nurses and we do it, you just have to... (FC1)*

- **Case management** approach is not static and is context related

*...It's all to be fit for purpose and all to be developed at local level to suit the clients and the population in each area and you know that necessarily means there are different needs of staff as well because there is different ways staff are set up in different areas... (FC2)*

# Case Management research: findings



- Workforce planning

- ‘Changing mindsets’

- ...I find it very hard having come into it as I'm still thinking very much traditional district nursing role...I'm certainly still learning even how I introduce myself to patients...so you're suddenly coming into their lives and you can then generate a dependency. As I say, it is a skill that needs to be learnt and I think that's going to be an essential part of the training... (FC1)*

- Who is the case manager?

- Case manager = experienced CH professional with relevant skills

- ...I think a case manager has got to be respected by not just the client and the clients family and carers but by other health professionals, have good relationships with staff... (FC2)*

- BUT...Succession planning / cover

# Case Management research: findings



- Features supporting implementation
  - Case Management focus as part of care delivery
  - Review Of Nursing in Community pilot sites
  - Transition education – ‘CN role development’
  - Effective links with secondary care/ primary care / Long Term Conditions team / social work / voluntary
  - Self management plans/ anticipatory care plans
  - Developing therapeutic nurse-patient-carer relationships

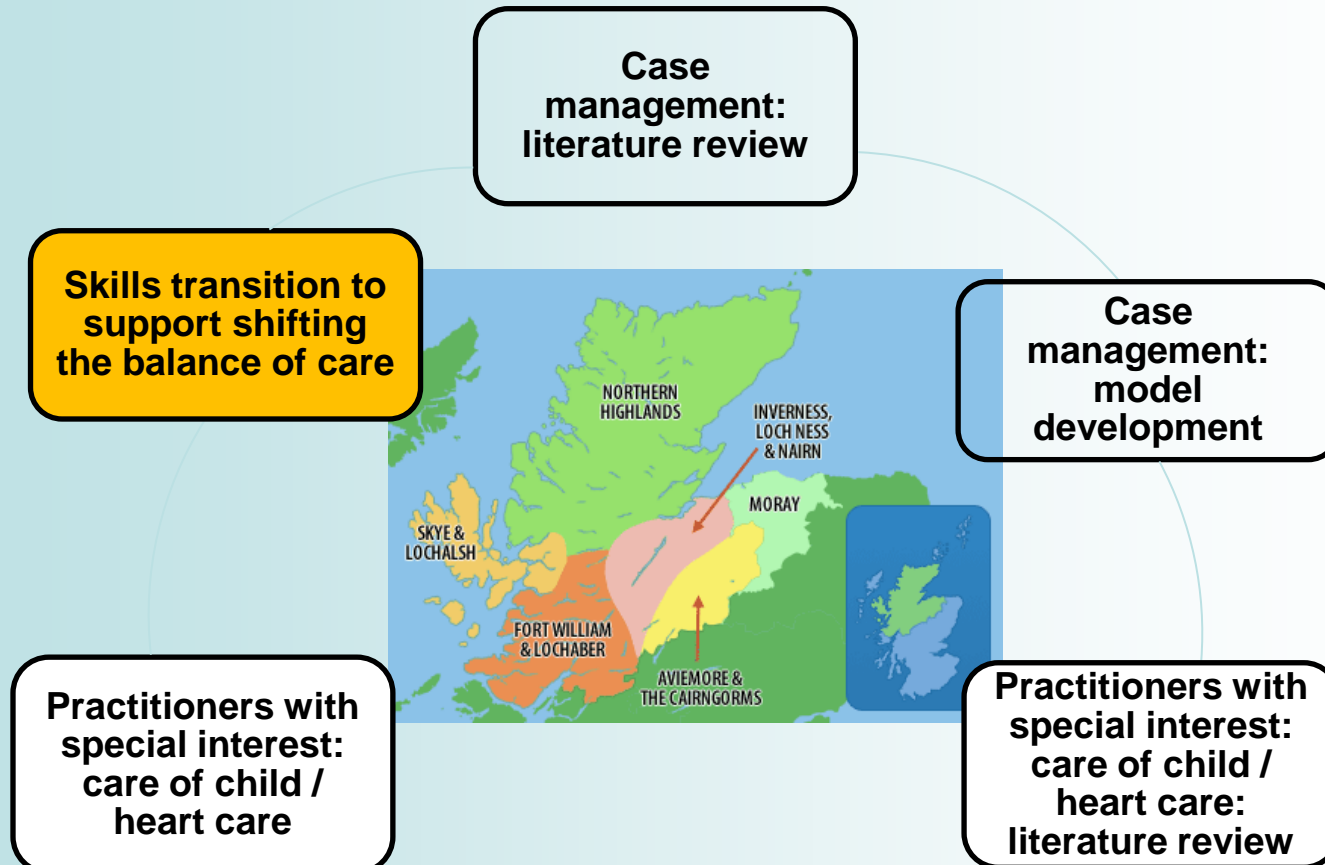
# Case Management research: findings



- Education and training requirements
  - Skills to promote self management
  - Motivational interviewing
  - Skills in advanced patient assessment
  - Non medical prescribing
  - Condition specific education (Long Term Conditions)
  - Brief interventions



# 5 interlinked projects



# Skills transition to support

## SBC

### Aim

To identify model/s to support the transfer of skills from hospital based services to (predominantly) home based services, in particular, those required to support people requiring palliative care and other people requiring interventions such as IV analgesia, antibiotics, hydration, blood transfusions and bisphosphonate administration.

## Research Questions

1. How frequently are primary care practitioners and community practitioners exposed to the above skills?
2. What are the perceived challenges in sustaining these skills and confidence to deliver skills over time?
3. What interventions do primary care practitioners and community practitioners perceive will promote and support the safe and sustainable transfer of knowledge, skills and confidence over time?



# Skills transition to support SBC



## Population and Sample

- Participants were drawn from across three geographical locations in NHS Highland; Baddencoch & Strathspey, Thurso and Tain
- District Nurses, Health Visitors, Community Staff Nurses, School Nurses, Community Hospital Based Staff Nurses
- N= 14

# Skills transition to support SBC



## Method

- One to One Telephone Interviews

## Data Analysis

- Adapted narrative analysis
  - initial impression reading of all data and memo record emergent ideas
  - thematic content analysis
  - detailed analysis with illustrative verbatim quotes.

# Skills transition to support SBC: findings



## 5 Themes Identified

- *Commonly used skills*
- *Skills, frequency and maintenance*
- *Skills development to support Shifting the Balance of Care (SBC)*
- *Top 10 Skills Basket*
- *Interventions to support skill sustainability, transfer and development*

# Skills transition to support SBC: findings



## *Commonly used skills*

*Venepuncture, clinical assessment skills (bp, temp), assessment skills (physical and psychological), palliative care skills, medication administration. I am prescriber so prescribe as well (District Nurse)*

*General observations (TPR,BP) o2 therapy, venepuncture, medication administration (Staff Nurse Community Hospital)*

*The most common skills I use are Venepuncture, wound dressings, IM injections, catheterisation (male and female) supra pubic catheterising and multi layer compression bandaging (Community Staff Nurse)*

# Skills transition to support SBC: findings



## *Skills, frequency and maintenance*

*Catheterisation male and female, suprapubic – I have done training and done one supervised but I, m not confident to do these without supervision. Have done training for cannulation but GPs are a problem as they are not keen for us to do this. Therefore we have not done the competencies. ECGs. CPR but not on regular basis but we get annual updates. IV antibiotics (Staff Nurse Community Hospital)*

*Skin care sometimes it is difficult to know which cream to prescribe. PIC Lines always a thought when not done for a while. Oncology nurse will come down and go over things or we will go out in pairs if not confident (District Nurse)*

# Skills transition to support SBC: findings



## *Skills, frequency and maintenance*

*Colleagues will go over things with me. However the length of time from their going over things and updates has normally expired. I am getting better at ECGS but I am anxious. Cannulation I would need to re-train as that's expired. I think with the suprapubic catheters its really a confidence thing with me . Its the length of time between doing them that's the problem (Staff Nurse Community Hospital)*

*Going to regular updates. If something is not on my caseload then shadowing another member of staff for example if I do not have on my caseload syringe drivers I will go to maintain exposure (Community Staff Nurse)*

# Skills transition to support SBC: findings



## *Skills, frequency and maintenance*

*We have regular contact. We use the Liverpool care pathways. We manage syringe drivers and we liaise with hospice and McMillan (Staff Nurse Community Hospital)*

*Have had terminally ill children and children whose parents are terminally ill. Have worked with other professionals to make it easier for the child involved. Been involved in the transition of the child losing a parent and moving on (School Nurse)*

*Yes if we have a palliative care patient we put sub-cuticular fluids up (Community Staff Nurse)*

# Skills transition to support SBC: findings



## *Skills, frequency and maintenance*

*We have done training (IV Antibiotics). I'm ok with it but it is a thought as we do not do these regularly (Staff Nurse Community Hospital)*

*Don't do this. Been on course (IV Analgesia) but was not getting experience to administer it (Community Staff Nurse)*

# Skills transition to support SBC: findings



## *Skills development to support Shifting the Balance of Care (SBC)*

*Case management skills. Around that we have been told we will manage the top 1% of COPD patients. We have asked for specific training on listening to chests, assessment of disease specific. Administering IV analgesia in complex pain management situations for example palliative care (District Nurse)*

*Expecting to give IV Medication and would expect hydration to prevent hospital admission, Blood Transfusions, chemotherapy could be a possibility. More advanced clinical skills such as chest auscultation for monitoring (District Nurse)*

*Mental Health issues and training for us in relation to children. Wound dressing, palliative and anticipatory care. I would need to develop these skills. Working more closely with police and social services in relation to GIRFEC (School Nurse)*

| Identified core cross-cutting skills presently (Community & Community Hospital) | Skills with limited exposure (Community Specific)          | Skills with limited exposure (Community Hospital Specific) | Perceived new skills cross-cutting (Community & Community Hospital) |
|---|--|--|---|
| Venepuncture  | Care of supra-pubic catheters                              | Care of supra-pubic catheters                              | Chemotherapy administration   |
| Catheterisation (male & female)   | Care of PIC and HIC Lines                                  | IV antibiotic administration                               | IV antibiotic administration  |
| IM injections   | Stoma care   | ECG  | IV hydration administration   |
| Wound care  | Syringe drivers  | Blood transfusions   | Chest auscultation  |
| TPR & BP  | IV antibiotic administration                               | IV drug administration                                     | IV analgesia administration (for palliative care)                   |
| Physical assessments  | Spirometry   |  | Doppler assessment  |
| Palliative care provision   | Doppler assessment   |  | Specific skills linked with chronic diseases                        |
| Medication administration   | Prescribing (specific mentions relating to wound dressing) |  | Prescribing   |
|   |  |  | Child welfare   |
|   |  |  | Mental health awareness and identification skills                   |

# Skills transition to support SBC: findings



## *Interventions to support skill sustainability, transfer and development*

*If we could have rolling programmes of training that we could tap into on a regular basis. A lifelong learning system. Bit like the mandatory's we have to tap into. Also clinical supervision is good for reflection however that's not rolled out at the present (District Nurse)*

*We have to do training in Inverness and this is difficult for us. Be better if the experts from Inverness came to us. There just isn't enough staff to cover us being out for the day on a training course (Staff Nurse Community Hospital )*

*Further investment in our education and training and 'back fill' for us. Its lack of bodies. If we could shadow specialists that would be a great advantage to us in developing and maintaining skills and confidence in our skills (District Nurse)*

# Skills transition to support SBC : summary of key findings



- Variation between skills base of community hospital and community based staff
- Opportunities to develop new skills are available
- Willingness of practitioners to advance their practice
- Frequency & maintenance of exposure to specialised skills is problematic
- Self-efficacy & competency variations

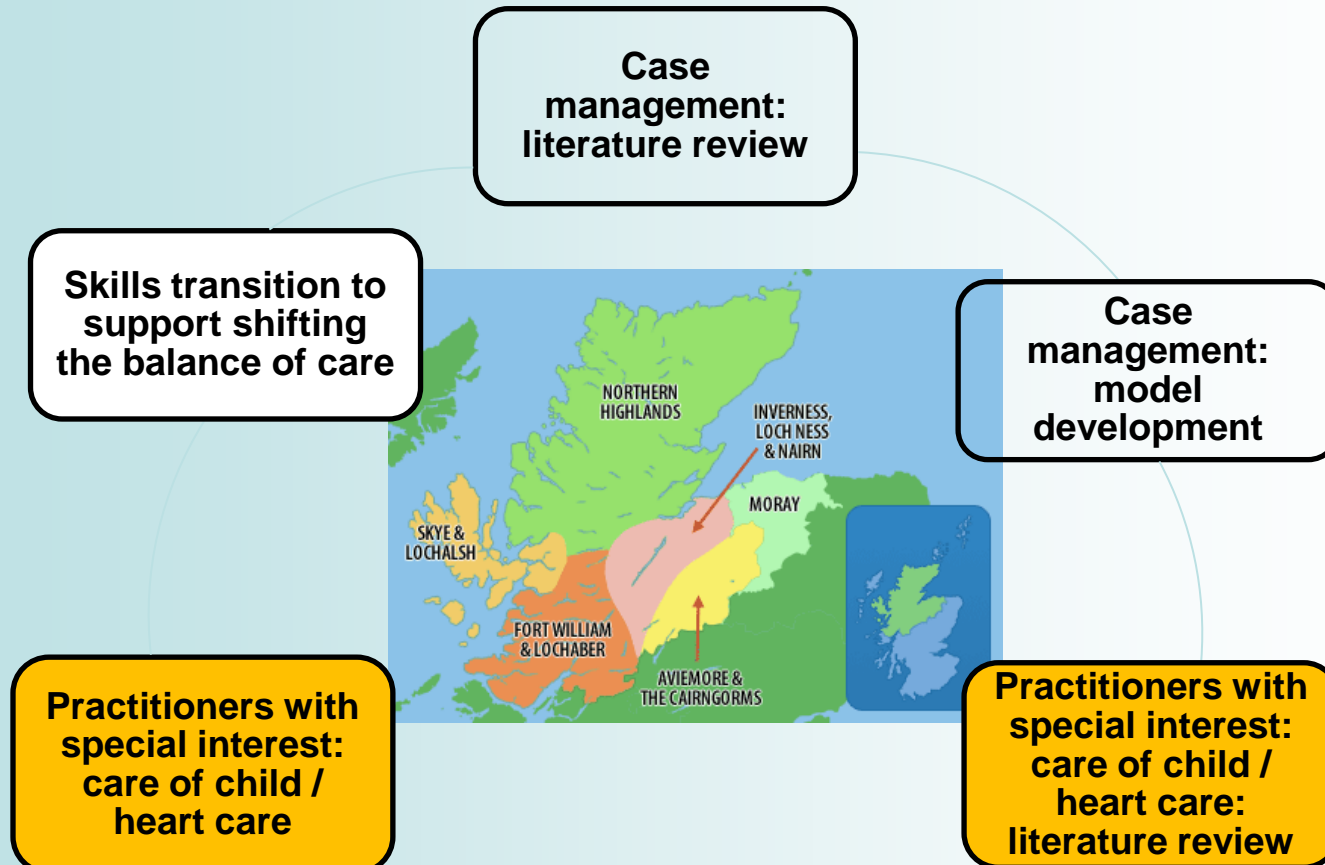
# Skills transition to support SBC : recommendations



- Access to educational materials via Intranet
- ‘Shadowing’ specialists
- Greater access locally to skills based training – ‘drop in’ sessions
- ‘Back-fill’
- Time



# 5 interlinked projects



# Practitioners with special interest literature review: findings



- Focused on heart failure and child welfare
- Around 30 tools (or similar) for community practitioners identified in both areas
- Many evidence-based: e.g. RCT, reliability/validity, quasi-experiment, feasibility/acceptability, case/pilot study, audit/evaluation
- Tools mapped well onto existing generalist, specialist and advanced practitioner distinctions in heart failure; less well in child protection
  - Reflects global responsibility/multi-agency working in child protection?

# Practitioners with Special Interest – child welfare and heart care



## Aim

- To explore the key skills and tools required by community practitioners to a) support child welfare issues and b) take on the role of the cardiac link health practitioner.

## Research Questions

1. Which aspects of practice in relation to child welfare and heart care do nurses identify as falling within the generalist / specialist continuum?
2. What are the key factors that support generalist / specialist roles in these areas of practice?
3. How do tools contribute and interact with other factors?



# Sample

- 2 groups of community nurses (n=8) who participated in 4 focus group interviews
- The nurses in the child welfare group worked in an urban environment and were already specialist practitioners
- The nurses in the heart care group had generalist community roles, but with an interest in heart care, and were considering taking on a cardiac link practitioner role



## Method

Initial semi-structured focus group interviews with community nurses;

- Child welfare group
- Heart care group

Thematic analysis of first interviews used to structure follow-up interviews a month later

## Data Analysis

Focus groups conducted by one researcher, two researchers undertook thematic analysis



# Findings

The experiences of the established specialist practitioners in child health/ welfare were considerably different from those of the generalist community nurses contemplating taking on a more specialist role in heart care, but many of their conclusions were similar



# Findings: Child Health

## 5 Themes identified

- *Role shift and role blurring*
- *Specialist role and skill set*
- *Framework to support role*
- *Preparation for and maintenance of role*
- *Tools*



# Child Health: role shift and role blurring

- GIRFEC has led to a shift towards child welfare for Public Health Nurses, so PHNs more reliant on generalist colleagues in child health work. But were the generalists able to pick up on early signs of child welfare problems?  
*...[the staff nurse had] said that's a really nice baby ... and I said have you not seen how startled she was? So this is a baby, although she was smiling ... well we don't know what that baby's been through ...*
- But on other occasions, the supposed generalist was the practitioner with particular skills, a co-worker consulted on decision making:  
*...whoever is the most appropriate person to consult about the needs of the child...*
- However, judgement might be shared, but responsibility could not be: this seemed to provide the clearest demarcation between the specialist and the generalist.



# Child Health: specialist role and skill set

- Use of tools preceded by advanced communication, relationship-building and observational skills, built on long experience and the knowledge of the norms of child development and child/parent interactions:  
*We are looking for the breadth of care that is going in between the parent and the child, the level of care.*
- But GIRFEC supported professionals in putting the child at the centre. It helped to gather and organise evidence in a rigorous way to inform effective multi-agency decision-making, to identify the threshold;  
*...between OK parenting and not OK parenting*
- And from this arose the need to develop complex skills in building a case and presenting it to other agencies.



# Child Health: framework to support role

- Though many aspects of the professional practice framework were well established, support systems had not “caught up” with the role changes created by GIRFEC:
  - ...and it's a good way of working, but sometimes my observation is that no-one has actually measured the time it takes to do that new role and how that can be supported...*
- Two particular issues were;
  - reliance on generalists (including bank staff) without the resource to prepare them properly, and
  - the extra administration required to support effective multi-agency working and decision making was mainly done by the specialist nurses.

# Child Health: preparation for and maintenance of role



- Whilst GIRFEC was being introduced, training had been provided as part of the project.
- Now it was part of the role of the specialists to train those new to the area – more junior staff taking on more child health/ welfare work.
- Regular clinical supervision, other than “*a rushed 5 minutes at the coffee table*” seemed to be something of a luxury.
- A participant described a situation where a team of health visitors had invested a great deal of time in preparing a particular staff nurse for a wider role, involving six months of shadowing, monitoring, reflective interaction and rehearsal, plus some formal preparation.
- A three-day induction programme had recently been used with new staff, but with far less success: the health visitor that prepared this training felt that staff were still unprepared for the demands of a specialist role after undergoing the training.



# Child Health: tools

- The GIRFEC framework had transformed practice
- Tools within the framework included Wellbeing Indicators, My World Triangle, Resilience Matrix and Child Plan
- Knowledge, skills and experience interacted with the framework – the framework could not be used without them
- So, whilst the framework could be learnt in formal education settings, it needs to be applied in practice to reinforce that learning
- Junior colleagues need the help and guidance of their mentoring colleagues to facilitate reflection on observations, assessments and decisions.



# Findings: Heart Care

## 5 Themes identified

- *Role shift, role strain and role conflict*
- *Specialist role and skills set*
- *Framework to support role*
- *Preparation for and maintenance of role*
- *Tools*

# Heart Care: Role shift, strain and conflict



- A clear message was that the community nurse role has changed, is changing, and will continue to change.
- There has been loss of role:  
*...community nursing has been so diluted ... it's changing ... people could throw anything at us now and I think we have to be careful that we're not just a sitting target for everything ...*
- But the knowledge, skill and technical demands on general community nurses have grown as well:  
*...you can walk into anything and you have to react and do the best you can with the resources you have about you...*
- The new role is both an opportunity and a threat:  
*I think it could be an exciting opportunity, but my enthusiasm is kind of curbed because ... there's bits that I don't know about this role, and if I knew more about what would be expected, or what support mechanisms might be in place, I would feel more enthusiastic about it ...*

# Heart Care: Specialist role and skill set



- As with the Child Health Nurses, advanced communication skills were at a premium
- One set of distinctive skills concerned communication with patients on the “bedrock” of lifestyle management:
  - I think there’s much more that we can bring as nurses ... the ongoing assessment, and rehabilitation of these patients, getting them back to having a full quality of life. The GPs don’t focus on that side, and that’s where I think we’re best placed to make a difference.*
- Another set of skills revolved around communication with colleagues; for networking, being available for advice, education and support, and to disseminate information
- Ensuring best practice became general practice would be part of the role:
  - My hope with this role is that it’s going to enable standardised practice throughout the whole of Highland, because at the moment it’s very different in different areas, it’s dependent on people’s interests and their support.*



# Heart Care: Framework to support role

- From previous experience of change the heart care group were not convinced that the framework to support role change was or would be in place:
  - It all sounds great beforehand, and once you're actually in post, you're left to get on with it, you're very isolated.*
- There were several aspects of framework/structure that participants felt might specifically impinge on the proposed link role:
  - problems with access to patient records,
  - lack of recognition of role,
  - the need for ongoing networking and support,
  - the need for a decent size client base to support the development of specialist experienced practice, and
  - the reallocation of generalist work.

*I feel most times when you are trying to contact a consultant, you are only really speaking to a secretary. It gets fed through a secretary and comes back through a secretary*

# Heart Care: Preparation for and maintenance of role



- These nurse had acquired their education on heart care largely from their own efforts and feared more of the same
- Education in a distance learning format was not favoured:  
*.. you end up doing it at home ... and you miss out on that networking opportunity which is a valuable thing particularly when you work in isolation ... [the] opportunity to meet with others that are in the same boat ...*
- Shadowing and mentoring opportunities in specialist areas and with someone with an established role were thought of as being both educational and networking opportunities



# Heart Care: tools

- Heart Manual (3 versions): this could be a useful tool to structure patient-centred care, but could just be a “tick box” exercise:  
*I think a tool is a tool, and the practitioner needs to be able to use it but they need to have other skills to draw on specific to that patient and that particular environment, their needs.*
- New Heart Care documentation was about to be trialled
- A self-directed learning portfolio for those taking up the link role was about to be introduced

# Practitioners with special interest research: findings



- Roles have already shifted and are still shifting. The move to specialism involves:
  - Advanced communication and relationship-building skills
  - Greater responsibility both for decision-making re patients, for involvement with other staff and for interactions with other professionals/ agencies
- The framework to support new roles can lag behind their introduction:
  - Attention needs to be paid to the process of change, involving practitioners in it, both at an early stage of development, and in its later ramifications
  - An educative process for practitioners to develop the new role should be in place that includes a mentored/ shaped educative practicum
  - Formal recognition of the role would be helpful, that includes analysis of the changes brought about by it, with reallocation of resources to follow
- Tools or toolkits can have a major, even transforming, effect but need to be placed in a much wider practice and learning context, for a service that is already under great pressure

# Recommendations: Shifting the Balance of Care



Core themes have emerged across the 5 projects which link skill enhancement, skill maintenance, and skill sets for toolkits, e.g.

- Self care
- Advanced communication skills
- Opportunity to practice
- Inter-agency networking
- Accessibility
- Reflection

- **Shifting context...**
- Concepts and terms need to be clearly defined:  
i.e. tools/ toolkits/ levels of practice/ case management
- Shared understandings of philosophy of care, underpinning principles, roles and responsibilities.
- Context not static & account needs to be taken of locality, client group, skill mix, case load and resources.



# Some considerations: SBC

- SBC needs to be supported by focused and targeted education and training.
- Communication of aims to support SBC to included all stakeholders including ECCT and secondary care provision.
  - e.g. to support discharge / care closer and return to self care
  - Clarity of how mental health articulates?
- Documentation
  - Purpose / function / accessibility / systems and processes
- Nurses possess knowledge of principles that are fundamental to supporting SBC & many solutions for implementation can be found in practice.
- A scoping exercise to identify related developments across all stakeholder areas would help to identify areas of innovation and good practice.
- An evaluation of the effectiveness of the impact of case management and skills to support SBC would help to further inform practice.

# University of Stirling



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