Evolving Models of Primary Health Care Nursing Practice
Foreword

A strong primary health care system relies on a strong workforce. This was implicit in the design and launch of the Primary Health Care Strategy in 2001 and remains just as vital today in mid 2005. Nurses make up a huge part of that workforce, and it can be argued that their changes in roles and responsibilities are a manifestation of the possibilities of the Strategy itself.

I am pleased to see this publication highlighting and showcasing these eight models of primary health care nursing in New Zealand. They illustrate this increasing diversity against the backdrop of incredible passion and commitment for excellence in health care that nurses have.

I hope this booklet will inspire nurses and other health professionals to take advantage of the changes and opportunities to come as the Primary Health Care Strategy progresses and develops, and to share their stories with the public so that we can all see the fantastic changes that are happening.

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Deputy Director-General
Clinical Services Directorate
Authorship and Context of this Document

Nurse intern Erin Beatson was appointed for a 15-day period between November and February 2005 to report on how nurses were adapting and evolving services and models of practice with regard to the Primary Health Care Strategy. These models are intended as a resource rather than examples of best practice at this stage in the implementation of the Strategy.

The objectives of the project and this resulting publication were to report on:

• how health needs are identified and the populations served
• service initiatives and health care
• new practice developments – the new roles and responsibilities of the Nurse Practitioner
• influencing factors in service and practice development
• future directions of the service and practice.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>iii</td>
</tr>
<tr>
<td>Authorship and Context of this Document</td>
<td>iv</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>viii</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Rural Nurse Specialist</td>
<td>3</td>
</tr>
<tr>
<td>Nurse Led Clinic: Youth Health</td>
<td>4</td>
</tr>
<tr>
<td>Primary Care Liaison Nurse: Mental Health</td>
<td>6</td>
</tr>
<tr>
<td>Community Care, Nurse Led Acute Care Team</td>
<td>8</td>
</tr>
<tr>
<td>Aranui Nursing Project, Primary Health Care: Neighbourhood Nurse</td>
<td>10</td>
</tr>
<tr>
<td>Mobile Community Ear Clinic, Regional Public Health</td>
<td>14</td>
</tr>
<tr>
<td>Primary Health Care Nursing</td>
<td>16</td>
</tr>
<tr>
<td>District Nursing Service: Nurse Led Clinic, Leg Ulcer Clinic</td>
<td>18</td>
</tr>
<tr>
<td>Conclusion</td>
<td>20</td>
</tr>
<tr>
<td>References</td>
<td>22</td>
</tr>
</tbody>
</table>
Executive Summary

"The Primary Health Care Strategy (Minister of Health 2001) identifies an increased need for primary health care nurses, with a move towards greater population focus and emphasis on a wider range of services. Evolving models of primary health care nursing practice – with a focus on the development of the Nurse Practitioner role – are emerging as a response. The models described in this report are intended to provide a resource for ongoing practice development.

This report was made possible through a short-term nurse intern position within the Clinical Services Directorate of the Ministry of Health and the contribution of the nurses who shared their practice examples.

Seven practice examples were included in the original report – with an extra example being added prior to printing. Collectively they demonstrate that nurses are aligning their practice to the key primary health care directions, although at this stage they are limited in their development.

Changes to present service delivery models, the establishment of clinical career pathways to support advancing nursing practice and the development of education in primary health care nursing practice were identified as influencing factors in the future development of nursing practice in primary health care.

This report’s findings indicate that while nurses working in primary health care settings have responded to the vision as described in the Primary Health Care Strategy, the additional support structures required to develop the vision are still to be established.

Method

The Ministry’s national primary health care nursing networks directory was used to request examples of primary health care nursing practice.

An email was sent to those in the directory, with a follow-up request two weeks later outlining the specific objectives of the project and the information required. The project was also discussed during a telephone conference with the primary health care nursing expert advisory group as a further source for practice examples.

Eleven written responses were received in the required time and were able to be developed into the practice examples presented here within the short timeframe available and the part-time nature of the nursing internship.

A limited number of practice examples were collected and are therefore not representative of nursing practice in primary health care. Future monitoring of practice development would need to adopt a different method of data collection if representative practice examples are to be collected.
Introduction

Primary health care

The Primary Health Care Strategy (Minister of Health 2001) is one of the five service priority areas in the New Zealand Health Strategy (Minister of Health 2000).

The Primary Health Care Strategy, or PHCS as it is also commonly known, involves a greater emphasis on population health, the role of the community, health promotion and preventive care; a wider range of health professionals and funding based on population needs.

It sets out six key directions:

• working with local communities and populations
• identifying and removing health inequalities
• offering access to comprehensive services to improve, maintain and restore people’s health
• co-ordinating care across service areas
• developing the primary health care workforce
• continuously improving quality by using good information.

Development of primary health care nursing

The PHCS recognises that there will be an increased need for primary health care nurses with the move towards greater population focus and the emphasis on a wider range of services. This creates an opportunity for primary health care nurses to develop advanced skills in speciality practice areas.

In response to, and preparation for, the changing health system, the Ministerial Taskforce on Nursing (1998) recommended strategies to remove barriers that might restrict nurses’ contribution to health care services. The taskforce supported the development of a Nurse Practitioner role and recommended that the Minister of Health direct the nursing council to develop and validate specialist competencies linked to nationally consistent titles.

Furthermore, Investing in Health: A framework for activating primary health care in New Zealand (Ministry of Health 2003) was developed by an expert advisory group. The group identified the need for a substantial cultural change within nursing in order for it to be aligned with the PHCS and emerging Primary Health Organisations (PHOs).

The group developed the following definition of a primary health care nurse:

Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first point of contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people – individuals, whānau, communities and populations – to achieve the shared goal of health for all, is central to primary health care nursing (Ministry of Health 2003:9).

Innovative ways of working together need to be established across nursing disciplines and traditional boundaries. The expert advisory group challenges primary health care nurses to engage fully with their employers in developing new nursing roles and responsibilities and to ensure that their professional partnerships with clients and communities are nurtured and protected. It also challenges employers to support primary health care nurses through appropriate employment and funding arrangements.
The group also recommended that the Ministry fund, monitor and evaluate innovative models of primary health care nursing practice and disseminate examples of best practice to the sector. Eleven primary health care nursing innovations are currently funded by the Ministry and are now a year into their term. In 2005/06, the Ministry will also offer approximately 120 primary nursing scholarships at a cost of about $300,000 to enable registered nurses working in primary health care to undertake postgraduate study.

New nursing roles are already emerging, and boundaries between disciplines are shifting. This is in response to government policy, changing health care demands and demographics, technological advances and the shifting balance between hospital and community-provided health services (Ministry of Health 2003). It is these emerging new roles that are the focus of this report.
Anne Fitzwater is the sole nurse in Fox, near Fox Glacier – part of a designated special area of South Westland – on the West Coast of the South Island. Anne arrived from Central Otago two years ago to take up the position. A Primary Health Organisation (PHO) does not cover the area as yet, but the West Coast District Health Board is progressing towards this. Anne is one of five nurses in South Westland who serve a 350 km corridor with some of New Zealand’s most stunning scenery – and most isolated communities.

A mix of locals and tourist industry workers shapes the health needs of this community – the base population of approximately 350 swells to over 2000 during the tourist season. There are 1300 tourist beds in Fox, which are at full occupancy for five months of the year.

Most of the tourist industry workers are under the age of 45 years, which skews the health needs of the population further.

Identifying need and population served
Residents of Fox all know each other by name. Anne has daily opportunities to meet and move between groups of young mothers, school children, tourist workers and long-time residents. The many and varying needs of the community quickly become evident in such an environment.

Anne says her role includes emergency care, personal care, Well Child, public health, health promotion, immunisation and acting as district nurse and provider of ante- and postnatal care.

Due to the nature of the roads, the numbers of tourists travelling and the many adventure tourist activities, emergency work can be demanding. With only approximately 20 people over the age of 60, the health needs of the population are predominantly sexual health, child health and mental health.

Need identification includes co-ordination with other health providers who travel from Greymouth, such as vision hearing testers, mental health nurses and Māori health providers.

Service initiatives and health care provided
Anne works on a 10-day-on, four-day-off cycle, providing 24-hour on-call service. The nearest nurse colleague is Susan Hawken 30 minutes away at Franz Josef. The five West Coast nurses co-ordinate emergency rosters and each drive cars equipped for emergency callout. Under standing orders, Anne can offer medication to people within established protocols, including contraception and emergency contraception.

Recently the area has secured permanent GP Martin London, who holds separate clinics in Harihari, Whataroa, Franz Josef, Fox and Haast.

Future directions of practice
After two years on the West Coast, Anne believes that the independence and autonomy of the role is one of its strengths. Being in such a close-knit community means that the current health needs of the population are foremost in her mind, but she is also looking to the future.

She is planning initiatives that include health information packs for new employees, ambulance staff training and recruitment and first aid training for play group mothers and the volunteer fire brigade.

Anne is also looking forward to the collegial teamwork and planning that will develop as Dr London settles into his new role.
Nurse Led Clinic: Youth Health

Location: Evolve Wellington Youth Service, South East City Primary Health Organisation (SECPHO), Capital & Coast District Health Board, Wellington

Respondent: Rebecca Zonneveld – clinic nurse

Evolve Wellington Youth Service is a nurse-led youth service in central Wellington that opened in June 2004. Since then, more than 600 clients have been seen. Of the clients seen, 413 were female, 191 male, 289 Pākehā, 79 Pacific, 145 Māori and 37 were refugees.

Currently 30 young people aged 14 to 18 years and from a wide range of ethnicities use the recreation space each day.

Identifying need and the population served

The results of the Youth 2000 survey (Adolescent Health Research Group 2000) highlighted the health needs of the New Zealand youth population. It found that youth wanted a health service that was confidential and cost less. Many respondents had not been attending GP services, even when they acknowledged they needed to, because of costs.

Youth 2000 supported the development of Youth Health: A guide to action (Minister of Health and Minister of Youth Affairs 2002), which recommended the development of youth-friendly services with youth involvement in services and policy initiatives.

In response to these findings and recommendations, a group of Wellington youth became the driving force behind the establishment of Evolve Wellington Youth Service and are now involved at all levels, from the day-to-day running of the service to decision-making on the trust board.

Service initiatives and health care provided

Evolve provides free health and social services to young people aged 10 to 25 years. The service provides consultations with a nurse, general practitioner (GP) and peer support workers. The environment is designed to be a safe place to meet, with an on-site pool table, computer and Internet access.

The service is open four days a week from 11 am to 6 pm. The staff team consists of one nurse working four days a week taking morning and afternoon clinics, a GP taking two afternoon clinics, 10 youth peer support workers and a service manager/administrator.

Clients access the service on a drop-in or appointment basis and choose who they wish to see from the service staff. The centre aims to provide holistic care for young people within the context of their social situation.

The nurse and GP have worked together to create the infrastructure to ensure safe practice by the team, through the development of policies and standing orders.
Practice development – new roles and responsibilities and the development of the Nurse Practitioner role

Nursing practice is evolving in response to the needs of the people who access the service. The assessment tool that the clinic nurse uses is HEADSSS, which stands for: home, education, activities, drugs, sexuality, suicide and safety, which she has found useful in identifying youth issues and risks.

The range of health care that the clinic nurse provides includes:

- wound care and sexual health assessments, including smear taking and oral contraception prescriptions
- pregnancy management and counselling – vaginal swabs, blood tests, scan appointments
- individual health education related to nutrition, exercise, immunisation, alcohol or drug use, and mental health
- youth health promotion – outreach to other health providers, community agencies and education centres such as the YWCA.

Nurse Rebecca Zonneveld has also taken on a new responsibility for all funding claims such as Accident Compensation Corporation (ACC) and General Medical Services (GMS) subsidies, sexual health and maternity benefits and clinical supervision of a group of peer support workers. Her involvement in funding claims resulted from the delegation of this responsibility by an overloaded manager/administrator. However, she feels it has expanded her practice by encouraging her to develop new computer skills and become more aware of funding and sustainability of services, in particular for youth services, in the PHO environment.

Influencing factors in service and practice development

While the DHB nurses who helped set up this service advocated for it to be nurse led, it became nurse led by default rather than actively because funding initially only provided enough money for a part-time GP. A recent increase in funding may allow for an additional clinic each week with a female GP.

This illustrates the cultural shift that needs to occur in developing the role of the nurse in primary health care. In the area of youth health, nurses have been shown to be very good at providing this level of assessment and co-ordinating care and services.

Future direction of services and practice

Evolve sees there is opportunity to expand the services currently offered in social support, sexual health and immunisation to further meet the health needs.

Further practice development is occurring through the clinic nurse promoting the service to other health professionals within PHOs and DHBs, alternative youth community agencies and education centres. Currently, outreach health education sessions have begun at the YWCA.

The nurse sees a key role for the development of the Nurse Practitioner with prescribing status, which would allow for more autonomy. This role would also provide an opportunity to become involved in policy development and research into youth health.

The present clinic nurse plans to complete her Masters by the end of 2006 and apply for Nurse Practitioner status.
The primary care liaison service (PCL) is a nurse-led initiative, based within the Community Mental Health Centres of the Auckland District Health Board. It was formally established in August 2003, building on a collaboration with GPs that began with the Shared Care Project in 1999.

Identifying need and population group served
Service users who have had their mental health needs met via the Community Mental Health Centres have found it difficult returning to the care of their GP, as a number of barriers exist in accessing appropriate mental health care in the primary setting. Any barriers to access also affect the physical health of service users, which has been shown to be significantly worse than that of the general population.

PCL helps create a pathway from secondary care to the primary sector. Many clients have no ongoing relationship with a GP and need facilitation to create one. Clients who meet the criteria see their GP for all prescribing, physical and mental health care, with the added support of the PCL nurse.

The criteria are: that they have been clients of the Community Mental Health Clinics for six months or more; have a known diagnosis and established treatment; are relatively stable at time of referral and are not under the Mental Health (CAT) Act or taking clozapine.

Services initiatives and health care provided
Five primary care liaison positions have been established across the four Community Mental Health Centres to support this transition and provide continuity of care to clients as a flexible outreach service. The PCL offers a range of input; from managed transition to GP-only care and subsequent discharge from the Community Mental Health Centres, to ongoing, shared care arrangements with GPs.

Practice changes – new roles and responsibilities and the development of the Nurse Practitioner role
PCL nurses work autonomously: developing the liaison role, responding to the varied needs of clients, whānau, and their primary and secondary health care providers. Nurse Practitioners in this area could further proactive approaches in what is already an advanced practice role.

For example, the Nurse Practitioner could provide assessment and treatment as the first point of contact for mental health clients within the primary health setting, or refer on to the local Community Mental Health Centre. This role would facilitate rapid and appropriate access for clients to care and support, making better use of GP and specialist skills and time.

Influencing factors in service and practice development
Embracing a primary health care approach and advancing nursing roles in mental health will take time to develop. Forty-two Primary Health Organisations (PHOs) are currently being funded by the Ministry of Health to develop projects that find innovative ways to provide services for people with mild to moderate mental health problems.

Integrating the care of those with serious and enduring mental health issues within the primary setting requires a culture change for secondary services, while care for those with less serious conditions, already under GP care, needs more support.

Changes to service provision and nursing practice are restricted, owing to existing funding and contractual limitations. PHOs and DHBs will be
required to work more closely together to meet these needs.

**Future direction of services and practice**

The transition and support of clients moving to GP care needs to become a more active part of the key-worker role within Community Mental Health Centres.

Early assessment and brief interventions for clients referred by GPs would allow for cases to be co-managed, which would maintain links with primary care providers. Annual mental health reviews for GP clients with serious and enduring conditions would improve long-term care.

Focusing on GP practices that have capacity and special interest in mental health would assist education and support for GPs and practice nurses, via established relationships.

Future possibilities could include joint PHO and DHB positions for PCL nurses. This could create opportunities for Nurse Practitioners to create new roles in this area.
Community Care, Nurse Led Acute Care Team

Location: Christchurch, Pegasus Health, member of Partnership Health Primary Health Organisation, Canterbury District Health Board

Respondent: Christine Tallott, Nursing Team Leader Community Care

Community Care is a collaborative initiative between primary and secondary care teams to develop the management of unwell patients in the primary care setting. The service provides access to comprehensive community based care at times of acute illness; to avoid unnecessary admission to secondary services.

Identifying need and the population served

Increasing numbers of people with mild acute illness were presenting at secondary emergency services in the Canterbury DHB. With increased resources – staff and access to increased range of services – these clients could be safely managed in their homes, rest homes or practice surgeries.

Service changes and health care provided

To offer access to appropriate primary health care and reduce hospital admissions, an acute care team of primary health care nurses and doctors, and seconded secondary care nurses has been formed to provide information and support to Partnership Health practices.

The team consists of 3.5 full time equivalent (FTE) nurses, 3 FTE seconded secondary care nurses, 0.5 FTE medical director, four GPs to cover a weekend roster, and an administration person.

The service is available by phone weekdays from 8 am to 10 pm and weekends 8 am to 11 pm. Referrals come from general practice, emergency departments and after hours surgeries.
The health need must be of an acute nature with care or treatment expected to be between three and five days. At the core of Community Care is a single point of contact to a team of nurses. The team provides information and support to practice teams to manage clients independently, or they can visit clients in their homes, rest homes or general practice.

**Practice developments – new roles and responsibilities and the development of advanced Nursing Practice**

Nurses within the team have advanced their practice in primary health care through in-service training specifically related to the care required by the population they serve. Some of the conditions that the team are able to support are: cellulitis, pneumonia, deep vein thrombosis, acute pyelonephritis, acute chest pain, constipation, exacerbation of chronic obstructive pulmonary disease/asthma, dehydration and end-stage palliative care.

The acute care team nurse’s skills include: nursing assessment and care, intravenous therapy, electrocardiographs, phlebotomy, cannulation, subcutaneous rehydration, palliative care, Graseby syringe driver, administration of clexane, bowel and bladder management, blood sugar monitoring, nebuliser administration, and client and caregiver education about care and treatment.

The nurses enjoy working in an advanced practice role in collaboration with their medical colleagues and in partnership with general practice teams and patients. Continuing development of the role and increasing the range of services provided will further enhance the nursing contribution to patient care in the community.

**Influencing factors to service and practice development**

The Strategy and its six key directions fit well with the development of services and advancement of nursing practice within this service.

The increasing presentation at emergency departments of conditions that could be managed in primary health care and the frustration of the primary health care team in managing acute episodes of illness in the community influenced service development. The commitment between primary and secondary services to develop this workforce has driven practice development.

Developing collaboration between primary health care and secondary care nurses, involving nursing secondment, and discharge planning between primary and secondary services have all impacted positively on the service for the enrolled population.

**Future direction of services and practice**

Much of the future direction is based around:

- developing relationships with other primary and secondary providers and working collaboratively to achieve better health outcomes
- advancing nursing knowledge and skills to extend the range of acute conditions able to be managed in the community.
The Aranui Nursing Project was launched in October 2003 as a clinical nursing service development, based within an existing general practice setting in an area of high health need. The project is a partnership pilot between the Canterbury District Health Board; the University of Otago's School of Medicine and Health Sciences, Department of General Practice; and the medical practices and people of Aranui.

The project aim is to develop innovative models of care delivery, improve access to services for high need populations, advance nursing workforce development and promote the development of the Nurse Practitioner role.

### Identifying need and the population served

The project focuses on a geographically defined population of high health need, identified from the community renewal project analysis and national statistics.

<table>
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<tr>
<th>Description</th>
<th>Aranui</th>
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<td>Motor vehicle access</td>
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Source: Census data 2001

### Service initiative and health care provided

The original plan was to provide three clinics each week parallel with an existing GP offering appointments and drop-in access and incorporating advanced clinical assessment skills. This plan was to reduce waiting times for appointments and reduce time spent in the waiting room.

After the project began, a second doctor unexpectedly started, which relieved demand on services. The project nurse was then able to schedule weekly sessions in a local kindergarten, a
community café, a kōhanga reo and a primary school, as well as at the surgery. During these sessions, the nurse sees people with a diverse range of clinical presentations and provides health education. She also recommends other health and social services. Referrals are taken from case managers at Work and Income New Zealand, budget advisors, GPs, kindergarten teachers, social workers and other primary health care based nurses. Referrals are made to GPs, special education services, other primary health care based nurses, a range of social agencies and various secondary health care services.

On-site health education displays at the surgery have included asthma, sexual health, diabetes, ear care and oral health. Relevant expert speakers may be invited in the future, although a better venue may be the high school or primary school. Given the demographics of the population (Table 1), the project nurse sees the future health of this population as depending on the health needs of the young. To this end, early in the project the nurse visited the local youth drop-in evening sessions attended by 20 local teenagers. The acknowledgement that the nurse now receives on the street from some of these young people has signalled useful acceptance of the project.

Discussions with the principal of the local secondary school about the project as a means to improving access to primary health care led to a vision for an on-site after-school clinic. This added to the services of the existing counsellor, social worker, family planning nurse, public health nurse and school nurse team.

Similarly, the principal at one of the local primary schools was keen to provide a school-based service for people to have greater access to health care. A weekly session addressing parents’ or teachers’ concerns about health issues impacting on students’ ability to learn now involves classroom visits and on-site clinics at the end of the school day. Other family members’ needs are also discussed. The intention is again to supplement the existing services provided by the in-house team of social worker, public health nurse, hearing and vision testing and dental service providers. A specific request to obtain 300 toothbrushes to implement a classroom-based, twice daily teeth brushing initiative provided the catalyst for an emerging relationship between the school and the clinical director of school and community dental services. Their collaboration will provide an opportunity for local research and baseline clinical evidence to develop appropriate services.
It has become clear that there is a significant health need that requires home-based care. Examples of this include the nurse working with the Māori health promoter to reconnect women to cervical screening services where attendance at a surgery would have involved gang-related personal safety risks. Follow-up health care and even acute care management is often obstructed by financial constraints and requires a persistent, sensitive approach to develop relationships based on professional integrity and trust.

**Practice initiative – new roles and responsibilities and the development of the Nurse Practitioner role**

The project launch followed a three-month lead-in time for consultation, networking, service promotion, clinical upskilling and acquisition of project-related supplies. The DHB communications team provided advice on the design and production of service promotional materials. Negotiation between the DHB, the project GP and the nurse determined a list of necessary clinical equipment.

Consideration of the new nursing role scope involved discussing clinical case management with an advanced rural nurse colleague and two project-based GPs and attending a pharmacology workshop to update skills. These activities affirmed an adequate existing knowledge and skill base for safe practice.

Development of relevant clinical practice guidelines for the nursing service – such as standing orders and protocols – began by consulting the Clinical Decision-Making Support Unit at Christchurch School of Medicine and Health Sciences. Early draft documents were discussed and will be further developed, framed by an agreed template. The notion of a practice-based formulary is also being considered. The DHB’s legal advisor was consulted in regard to formal authorisation for the clinical guidance documentation.

**Influencing factors in service and practice development**

The project aspirations of improving access and collaboration are now being met in ways that are different to those initially envisaged. The 0.5 FTE joint appointment model has expanded to a full-time commitment to the project. This reflects the benefits of initial consultation, early implementation activities and the community embracing the concept, as well as ongoing relationship building exercises. The geographical boundaries of the project often needed to be reinforced. Academic commitments in the Department of General Practice have accommodated this clinical demand at present, and the intention is to review the extent to which the demands of the project can be contained within a 0.5 FTE timeframe. Physical examination ability has been shown to be of less significance than advanced clinical decision-making skills, in the very complex, social contexts encountered to date.

Workload pressures, existing responsibilities of group members and technical delays hampered initial progress and the collection of baseline data for the evaluation of the pilot.

A local primary care based nursing network that shares information, provides mutual support and meets three times a year has developed a directory of nursing contacts and clinical expertise.

The subsequent value of the time initially invested with primary and secondary care health professionals, other health and social care agencies and the local community cannot be overstated. Progress to date would not have been possible without the connections and buy-in of these stakeholders. This process is ongoing and vital in demonstrating the sincerity of the responsive, developmental approach being taken. Ethnic and institutional cultures have, at times, created conflicting priorities and significant time management challenges. In spite of this, trust, respect and opportunities for different ways of working are now emerging.

**Future direction**

The partnership model of an advanced nurse working alongside a medical practitioner in a general practice setting, as initially envisaged, has not yet emerged. Instead, a composite-nursing role as a first point of contact with greater emphasis on case management than the expected
initial clinical assessment has evolved. This requires high-level analytical skills, incorporating complex decision-making, risk management and working across boundaries. There is evidence of significant collaboration with many health and social agencies.

Early observations highlight significant practice and service development issues for this and any subsequent similar projects. These include the need for:

- relationship building to improve awareness of the interface between health professionals and social worker skill sets and their availability to the local community
- closer working relationships with the community mental health nursing team
- further development of services to address both hidden, unmet health needs and the effect of the inverse care law
- a more health promoting focus within the community as opportunities arise and a patient advocacy role at a personal and organisational level to increase awareness of health needs for both individuals and specific populations
- ongoing professional development and formal supervision for the project nurse.

The time allocation for the various elements of the project varies from week to week, and finding the time for documentation, reflection and planning is difficult. There is an expectation that the project will provide the foundation for an application to the Nursing Council for endorsement as a Nurse Practitioner. Therefore, time to collect and collate the necessary supporting evidence and write the application is needed.

The emerging role represents that of a neighbourhood nurse accessible from a range of community locations and working to link, signpost and streamline the health care experience of local residents. The role incorporates but differs in the way it integrates, elements of the professional work of GPs, social workers and a range of community-based nurses. The vital skills of these professionals, the available time and the constraints of their contracts are fully acknowledged, with this additional service seeking only to locally support, reinforce and co-ordinate their contribution. The unfamiliar structure of a complementary and reciprocal model of practice, which combines personal health and public health perspectives, may explain the suspicious reaction encountered at times from other health professionals. The multidimensional response to the complex nature of the lives and health needs of people in Aranui has determined the clinical and organisational realities of the project to date. In turn, particular professional skills and personal characteristics have proved to be necessary to simultaneously address such multiple issues at a variety of levels. Targeted interventions for individuals and whānau need a co-ordinated response from many service agencies spanning education, social work, justice, housing and transport.
The mobile community ear clinic started in May 2004 within the school health service, in regional public health. The DHB decided public health would have the contract because of its community links and to ensure close working with the vision hearing technicians and public health nurses.

The new ear van service, as it became known, was to be entirely community based and nurse led. A nurse was employed and trained to run the clinic and the necessary equipment obtained.

In the first six months of the service, there were 791 initial visits and 284 follow-up visits – a total of 1075 visits to the ear van by children in the first six months of operation. Forty-nine children attended the ear van more than twice.

One hundred and twenty initial children (15.2%) were over 10 years of age; 289 (36.5%) were between 5 and 10 years of age and 382 (48.3%) were between 0 and 4 years of age. Four hundred and sixty (58.2%) were male, and 31 (41.8%) were female.

Of the children who had an initial visit, 254 were Māori (32.1%), 98 Pacific (12.4%), 374 New Zealand European (47.3%), 29 Asian (3.7%) and 36 identified as another ethnicity (4.5%). Twenty-one percent of the children were found to have otitis media with effusion (OME or glue ear). Of the children who visited the ear clinic, half had no abnormalities detected at all.

Sixty-five percent of children had a referral done. Out of those children, 37 had two or more referrals in the same visit.

Identifying need and the population served

The wider strategy of the Hutt Valley District Health Board is to reduce inequality in health status, improve access to services and reduce waiting list numbers. Ear health is an identified health need within the population group of children aged under 18 years in the area.

To set up the service, the ear nurse specialist assessed the vision hearing test results for the Hutt Valley, graphing on a map the schools and early childhood centres that had the highest failure rates from the three-year-old tympanometry testing and the five-year-old audio and tympanometry testing. Tympanometry tests the movement of the eardrum by puffing air in and out of the ear canal.

Having identified areas of high failure rate from tests, the nurse drove around the targeted areas looking for spaces that would be appropriate and safe to park the mobile clinic. Plunket clinics and community centres were chosen because they
attracted mainly pre-schoolers (the target group) and were highly visible in the community.

**Service initiatives and the health care provided**

The mobile ear van provides ear clinics to targeted community locations three days a week from 10 am to 12 pm and 2 pm to 4 pm.

Clients can either access the service while the van is in their area or be referred to it. The service provides free health care and includes diagnosis, management and treatment of presenting ear conditions, wax management, ear health education and promotion. Referrals are made to ear nose and throat (ENT) consultants, audiologists and speech language therapists.

There have been many service changes for the staff within the school health team as a result of the new service. The vision hearing technicians rely on the ear nurse for support, advice and training. The scope of their practice has increased as they are now able to refer to the nurse as well as the GP. They are finding that parents are coming to the ear clinic for treatment before seeing their GP.

The public health nurses have also had many changes to their practice. Now when they get a list of children who have failed a hearing test, there is a facility to have a consultation with the child. They see the ear clinic as filling a major gap in the public health nursing service.

**Practice initiatives – new roles and responsibilities and the development of the Nurse Practitioner role**

Additional experience and education is required to become an ear nurse specialist. A nurse must have two years’ postgraduate experience and then spend a minimum of six weeks in placements with local ear nurses, vision hearing technicians, ENT specialists and public health nurses. They become ear nurse trainees when they have attended the three-week ear nurse specialist training in Auckland. One year later, they can apply for ear nurse status, and after three years full time, they can apply for ear nurse specialist status with the national ear nurse specialist group. Ear nurse specialists are able to medicate children when acting under standing orders.

The practice of the ear nurse specialist is evolving as the service develops. The ear nurse specialist is an independent practitioner, making decisions about the ear status of children and acting accordingly. The nurse receives referrals from GPs, consultants, audiologists, public health nurses and other health professionals. She works independently and autonomously, and is responsible for all decision-making. She is able to refer children to the waiting list for ventilation tubes (grommets). The work is research based, and the nurse works closely with the ENT consultant. Although able to work under standing orders, she cannot prescribe the appropriate antibiotic when necessary. Often the nurse has to refer parents on to their GP, at a greater cost to the parents. As more people refer to the nurse and get to know the service better, the role of being able to treat children quickly and appropriately is increasing.

**Influencing factors in service and practice development**

The influencing factors on the development of the ear nurse specialist role have been the support from nursing management and ENT consultants. An influencing factor on the mobile ear clinic role is that it is a new service and there has been a lot of fine tuning to develop it to an effective standard. The nurse has been given the autonomy to change, modify and develop the service.

**Future direction of services and practice**

Apart from the greater work needed on health promotion at a population level to prevent ear disease, the mobile clinic hopes to increase the number of clinics it currently conducts.

More standing orders need to be developed to increase the scope of treatment options that are available. Another future option would be to directly place children on the surgical waiting list from the mobile ear clinic rather than going through ENT outpatients.
**Primary Health Care Nursing**

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<tr>
<th>Location:</th>
<th>Newtown Union Health Service (NUHS), South East City Primary Health Organisation (SECPHO), Capital &amp; Coast District Health Board, Wellington</th>
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<td>Respondent:</td>
<td>Gill Regan, Nurse Team Leader</td>
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The Newtown Union Health Service (NUHS) as part of South East City PHO has been developing their service since 1987, when it commenced as a pilot project for the Ministry. Today it is a capitated primary health care service, managed by a policy board, providing primary health care to a registered population in a designated locality. It includes responsibility for 24/7 acute care cover. The aim of the service has always been to provide holistic care with an emphasis on health promotion and preventative services.

**Identifying need and population**

The service targets low income, marginalised populations that have historically received poor health care. The PHO currently has an enrolled population of almost 10,000 people on low incomes or benefits living in South Wellington.

**Service initiatives and health care provided**

The service staff includes two operations and administration managers, three receptionists, one Māori community health worker, one social worker, seven full time equivalent (FTE) nurses, six FTE doctors and three midwives.

Nurses have a generalist scope of practice, with areas of special interest, and work with all consumers referring appropriately, plus the triage of acute consumers. The service can have up to 60 people a day calling in without a booked appointment. Staff have booked clinics and flexible time for paper work, co-ordination of care and community involvement. Nurses concentrate on health management, prevention education co-ordination and supporting community development and are therefore not involved in the after hours and weekend acute care.

Staff have special areas of work where they are responsible for co-ordination, management and collaboration with other health workers and relevant community services. This includes awareness of the potential population needs and community development. Areas of specialty are generally managed in smaller teams within the NUHS team. The smaller teams consist of appropriate personal health workers such as a community health worker, a social worker, a midwife and/or a doctor, as well as the nurse.

Specialty teams and service provided include:

**Diabetes Team:**
- two nurses co-ordinating the care of people with diabetes
- individual clinics liaising with the doctor and specialist services
- education, management and yearly reviews
- follow-up in homes, support group development and working with whānau
- responsible for keeping the service up to date with changes in management/guidelines and equipment.

**Asthma:**
- one nurse co-ordinating the care of people with asthma.

**Mental Health Team (approximately 350 mental health consumers):**
- consumer member of the NUHS policy board
- one nurse who closely follows up the mental health consumers with secondary diagnosis
- individual clinics
- visits to supported accommodation and Mental Health consumer groups
- works closely with key workers (if one)
- co-ordinates physical care of the consumers.

**Child Health Team plus Obstetric Team:**
- co-ordinates first antenatal appointment, reconnects women with the service via midwives for postnatal check and takes part in the ongoing meetings during a woman’s pregnancy
- follows up at-risk families with a social worker
- follows up any special need families’ issues as a member of the Child Health team
- overviews the immunisation programme.
Refugee Team
• NUHS policy board consumer members
• two nurses – one concentrated on outreach programmes and the other on the internal programme
• works with all new arrivals from Mangere plus family reunification
• follows up physical, emotional and socio-economic needs
• co-ordinates care and settling into New Zealand health services
• works with other providers in the community and interpreters
• community development approach for needs analysis plus support development for self-help groups work and group education.

Strathmore Suitcase Clinic:
• NUHS policy board consumer members
• two sessions weekly in community hall in an isolated area
• local community have a health committee who overview service and support
• works both with and without a doctor present
• follows up home visits to address issues
• works closely with local community and Wellington City Council community worker.

Newtown Park Flats Suitcase Clinic (which includes pensioner flats):
• NUHS policy board consumer members
• weekly morning session by nurse – plus doctor once per month
• follow-up in flats as required – many isolated people
• works closely with Wellington City Council and local community
• links into main service as able.

New roles and responsibilities
Nursing has always held a high profile in the service, and the service has endeavoured to create a model of nursing that supports nurses developing their potential role. All the nursing roles have been developed within the principles of community development and community participation, with a multidisciplinary team. This is the key to the nursing role at NUHS, and advancing practice will be based on this approach. All nursing roles could potentially be Nurse Practitioner positions.

Influencing factors
Most new money such as Services to Improve Access (SIA) funding, comes via the PHO, which is passed on to the consumer in the form of travel support, script reimbursements and interpreting services. As the service has already worked within this model, it has been able to be innovative with its use of any extra money and respond to need.

Future direction
The service will continue to be responsive to the community’s need and to work collaboratively in a multidisciplinary team. While the NUHS nurses have special areas of interest, they do not advocate a specialist approach as such as it is required that all nurses be aware of and respond to all issues of the community and family members.
District Nursing Service: Nurse Led Clinic, Leg Ulcer Clinic

The Nurse Maude Association (NMA) is a community nursing service in the Canterbury District Health Board area, providing district nursing, palliative care and aged care including dementia services.

Identifying need and population served

NMA, working closely with the DHB to meet strategic goals, identified a need to improve the management of chronic wounds – especially venous leg ulcers of patients, many of whom are over 60 years. Leg ulceration can lead to a high burden of chronic morbidity associated with:

- persistent ulceration in individuals over many years requiring regular dressings by GPs and district nurses
- high associated morbidity through lack of mobility, social isolation, depression and poor quality of life
- hospital admissions for management of infection/cellulitis or skin grafting, which is largely ineffective
- referrals to the vascular outpatient department for management of ulcers or varicose vein surgery
- enormous community expense
- relatively high hospital costs.

Service initiatives and health care provided

In response, NMA established the leg ulcer clinic in partnership with Christchurch Hospital vascular services. NMA provided funding for the wound-care nurse co-ordinator position and the purchase of three Doppler ultrasound machines. To reduce the risk of back injury, two hydraulic, purpose-built chairs were purchased with the aid of grants from the NMA District Nursing Conference Fund and a private trust.

The project encompasses a multidisciplinary team across hospital and district nursing. The care pathway includes clearly defined requirements around appropriate assessment and treatment and the supervision of appropriately trained staff. The service provides:

- assessment of complex ulcers and liaison with vascular services as appropriate
- evidence-based compression therapy for venous leg ulcers resulting in a high rate of healing
- multidisciplinary management for chronic wounds
- co-ordinated services spanning the primary and secondary health sectors
- effective strategies for prevention of ulcer recurrence.

Practice developments – new roles and the development of the Nurse Practitioner role

The care pathway implements current best practice in the guideline *Care of People with Chronic Leg Ulcers* (New Zealand Guidelines Group 1999). The NMA wound-care team was formed and standard assessment tools developed.

Training and credentialing was set up for district nurses in compression therapy, and three senior nurses were selected to receive additional training to work in the clinic.

Support was received from secondary services in the development of the clinic, and a medical consultant attends every six weeks to consult on complex patients.

Currently the position of Nurse Practitioner is not filled, however a gerontology nurse specialist commenced in a joint position with Christchurch Polytechnic in February 2005, and she is working towards Nurse Practitioner status.
Influencing factors in service and practice development
Six factors can be identified as influencing the development of the new service and development of practice:

- government strategic direction
- identification of gaps in community care and programmes implemented to address these
- DHB review and strategic intent
- PHO development
- collaborative relationships with tertiary education providers

These factors have facilitated changes in contracting with the DHB to enable work to happen across contract areas and increase the skill-mix of the workforce.

Future direction of services and practice
The leg ulcer clinic has demonstrated its clinical efficacy against international research and published benchmarks on healing rates. It provides world-class treatment and enables patients to enjoy an improved quality of life.

In addition, the leg ulcer clinic prevents clinical complications and the downstream implications of significantly more expensive inpatient episodes of care, additional pharmaceuticals and demand on hospital capacity. The findings of a paper-based review of patient outcomes by Canterbury District Health Board revealed that many patients had required multiple outpatient appointments and admissions prior to being successfully healed at the leg ulcer clinic.

The clinical effectiveness of compression therapy is well documented. Without this service, patients would receive the traditional dressing regime, usually involving daily visits in contrast to the weekly visits with compression bandaging. Additionally, the clinic provides the preventative care for non-ulcerated limbs or healed limbs using compression hosiery.

The partnership between NMA and Christchurch Polytechnic has resulted in the development of nursing education resources. NMA clinical nurse specialists and nurse educators have developed accredited courses in wound and leg ulcer management in conjunction with polytechnic staff. NMA clinical staff deliver the courses, which are available to nurses in both the primary and secondary sectors.

As a result of this service and practice development, the future direction is:

- to continue to develop specialist roles in community nursing that support the generalist district nursing workforce and community needs
- to continuously improve the use of evidence in practice and increase the skill base of the community nursing workforce
- to build workforce capacity through professional development and graduate programmes
- to work in a collaborative way with other primary health care nurses to reduce duplication and fragmentation.
# Conclusion

The practice examples are, with the exception of the Newtown Union Health Service, new services developed in response to identified need. They provide individual disease management, case management and wellness care, with a developing population/health promotion direction. Most nurses involved have extended their clinical assessment and intervention skills, through short course training and advanced practice experience, to practise under standing orders.

While none were endorsed Nurse Practitioners, all nurses acknowledged the potential for the development of this role within their service.

The form these new services are taking can be seen as an emerging model of practice in primary health care nursing. These are speciality or generalist focused nurse led services, community based services, and services working within a collaborative multidisciplinary network of primary and secondary providers.

While the findings present a limited number of practice examples, a number of patterns can be seen that may provide lessons in the ongoing development of primary health care nursing practice.

The emerging models reflect approaches to primary health care nursing practice identified in *The Primary Health Care Strategy* (Minister of Health 2001), *Investing in Health* (Ministry of Health 2003) and models of practice in rural settings as identified by Litchfield (2001).

However, these examples are also reflective of past and present models of community nursing practice. For example, Plunket nurses have provided a specialist service within a community network since 1906, and Public Health nurses in the past provided generalist and specialist care.

With the exception of the Newtown Union Health Service nurses, none of the nurses in the practice examples referred to themselves as primary health care nurses – a title nurses have been challenged to adopt (Carryer et al 1999). While a definition is described in *Investing in Health* (Ministry of Health 2003), the document also identifies that further work is required to define the key elements of primary health care nursing practice that will form a common core of knowledge.

While these issues may be related to the lack of identity and development of innovative practice, the practice examples highlighted other limitations for advancing nursing practice to achieve Nurse Practitioner status.

Firstly, within current employment contracts, many models limit the scope of nursing practice to addressing presenting individual risk factors, rather than proactively tackling inequalities at a population level. What was evident in the practice examples was that there was no structure in place to provide linkages to intersectoral initiatives and public health services to provide the foundation to further develop the scope of primary health care nursing practice.

In addition, the practice examples did not present any evidence of clinical career pathways that would provide the support required to attain Nurse Practitioner status. This would require time to develop competence in direct client contact, research, policy development and leadership activities. The current limited support in present employment contracts to advancing nursing practice was expressed by the Aranui Nursing Project nurse, who found it created an overwhelming workload.

While Directors of Nursing in primary health care have been appointed, the examples highlighted that these positions have not come with the funding to develop advanced nursing practice or to establish Nurse Practitioner positions.

The final area identified as limiting the development of nursing practice was the present post-graduate nursing education programme. The nurses providing services within a generalist focus raised concerns...
regarding the development of the Nurse Practitioner role within a specialist focus. They felt this did not provide the preparation needed for the multiple levels of practice central to primary health care, which includes work across service boundaries, risk management, complex decision-making, high-level analytical skills, political advocacy and community development.

Primary health care papers have recently been introduced into Masters programmes. The future development of this scope of practice within the programme will hopefully address this issue in advancing primary health care nursing practice.
References


