

The Future of District Nursing in New Zealand - where do we fit?



Introduction

The launch of the Primary Health Care Strategy (2001) has prompted District Nurses (DNs) to examine where they best fit in the health care system. In December 2006 the National Committee of the District Nurses' Section of the New Zealand Nurses Organisation (NZNO) initiated a survey among DN's to obtain a national viewpoint with results being collated in February 2007.

A discussion paper entitled "District Nurses – Where Do We Fit?" was sent to all members of the DN Section and also to all DN bases in an attempt to contact as many DN's as possible; it was also posted on the NZNO website. Two hundred and forty five responses were received – approximately fifty percent of the DN Section membership – from Northland to Southland.

Seventy four percent of respondents indicated that they were familiar with the Primary Health Care Strategy. Ninety one percent are employed by a District Health Board (DHB) with six percent by Trusts and the remainder split between Non-Government Organisations, Primary Health Organisations and independent or other groups.

This paper outlines the role of the District Nurse (DN), highlights the responses from the survey and provides recommendations for the future of District Nursing in New Zealand.

Background

District Nurses provide episodic care to patients and their families/whanau, with links between primary and acute/specialist services, to meet specific health needs. DN's use specialised nursing knowledge, assessment skills, professional judgement and knowledge of community resources, and collaborate with other health professionals, to work in partnership with people through the lifespan in their home or community setting. DN's work with patients from all cultures and are committed to Te Tiriti O Waitangi.

The practice of District Nursing is extensive and varied and includes but is not limited to palliative care, continence/ostomy, oncology follow up, intravenous therapy, complex wound management, vascular assessment, oxygen services, Hospital in the Home, health education and wellness promotion and rehabilitation. DN's function independently and interdependently in assessing needs, planning, delivering and evaluating care.

Historically DN's were employed by District Health Boards (DHBs), with the exception of Nurse Maude in Canterbury. However in recent years other agencies have obtained contracts to provide district nursing services.

The unique role of district nurses within the continuum of care

District Nurses can balance and strengthen the links between acute/specialist services and primary health care, and can bridge the gap between primary and secondary, between medical and nursing, or between high and low technology care. These activities describe an intermediary care approach that plays a huge role in fostering early discharge from, and preventing avoidable admission to hospital thus promoting health & wellbeing in our

communities. A key success factor in this is the manner in which DNs collaborate with other health care providers via shared information, joint visits and care partnerships.

As the population ages and the points of care continue to be moved to a community focus the demand for district nursing will continue to increase (Flynn, Carryer & Budge, 2005). It is assumed that an increased demand will focus attention on the best use of DN resources and service configurations.

When considering DN service delivery from within a DHB structure the DN National Committee highlight the following points:

Strengths:

- The positive relationship between DNs and acute/specialist services.
- No cost to the patient.
- DNs have access to all General Practitioners (GPs), as they are not seen as 'belonging' to any one practice.
- The PHO enrolled population is often not determined by geographical location so therefore DNs have relationships with many different GP practices.
- Professional development is well supported and enables DNs to develop advanced practice skills to meet community needs.

Weaknesses

- Funding for services is generated from face to face contact not time spent or acuity of the patient or complexity of the care required. This often gives an inaccurate reflection of district nursing activity (Bentley & Tite, 2000). The implications of this anomaly are of real concern to DNs who frequently struggle to meet the demands of their workloads.
- At times there are gaps in the system because providers are not aware of the extensive role DNs provide to the community.

Opportunities

- Develop an acuity tool at a national level to monitor workload capacity and develop nurse sensitive indicators to provide evidence of outcomes obtained.
- Promote DN services to community, hospitals and health providers to maximise opportunities for patients to access the DN service.
- Work alongside PHOs to ensure all are aware of the services offered in each area.
- Continue service development to meet the growing community needs of the local community.

Threats

- The current funding by DHBs to the PHOs in achieving local health goals may cause a duplication of services traditionally provided by DNs.
- There is opportunity for private providers to encroach on service provision and duplicate services.
- PHOs may make a bid to employ DNs. As a smaller provider this would prevent the DN working across PHO boundaries in service delivery.
- PHO enrollees are not geographically located and this impacts on the delivery of services by district nurses who do work in geographic localities.
- Loss of District Nurse identity and the associated loss of clinical governance.

Results of the Survey

Eighty one percent (81%) of DNs felt that they should be employed by DHBs, eight percent (8%) by PHOs and the remainder were divided between Trusts, NGOs, Independent/Other groups. Reasons in favour of remaining under the DHBs included that under the current funding structure better patient care is provided via DHB services. In addition there is better access to products and education and good links with hospital based acute/specialist services.

Other significant comments were that the best employer would be one that *“recognises and utilises most appropriately the multiplicity of skills to improve patient/community outcomes”* and *“whichever system best services the people in the community”*.

Recommendations:

1. That the current model of DNs being employed by the DHBs that are demonstrating the ability to effectively and efficiently achieve service delivery goals in partnership with all health care providers should continue in order to prevent fragmentation of services.
2. That DNs already employed by private providers or PHOs should continue in areas that are meeting the above criteria.
3. That there may be the opportunity for change in some areas if evaluation of service delivery highlights the need for change in order to achieve improvements in effectiveness, efficiency and collaboration.
4. That local solutions should be developed for local needs rather than “one size fits all”.
5. That DNs should be included in discussions and decision making with MOH, DHBs and PHOs over any changes to DN service configuration.

Summary

Collaboration rather than integration that enables DNs to work in partnership whilst retaining autonomy and governance of practice will ensure that DN services continue to develop innovative models of nursing care responsive to community need. To achieve this we believe that District Nurses need a structure of nursing leadership, resources and infrastructure focused on best nursing practice in the community and best outcomes for patients and their family/whanau.

References:

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