Developing Community Nursing and Allied Health
Notes from workshop three (22 May 2007)

Background

C&C DHB has commenced the next steps (2007 onwards) in continuing the development and implementation of our Integrate Home and Community Care programme introduced in 2004/2005.

As outlined in the project approach document (available on http://www.ccdhb.org.nz/planning/homecommunity/home_community.htm) a wide sector working party was formed in March to look at the criteria for developing options for the next stages of community nursing and allied health (community therapies) C&C DHB is currently holding workshops with the working party to enable the development of an options paper for consultation.

Working Party

The working party consists of 51 participants. This is made up of two union organizers, 31 participants from the C&C DHB community health services (health care assistants, district nurses, specialist oncology, stoma, continence nurses, physiotherapists, occupational therapists, speech therapists, dieticians, social workers and administration staff) 12 from Primary Health Organisations and six other participants (Care Coordination Centre, Mary Potter Hospice, Package of care providers.

Meetings and Workshops

Workshop One

Initial meeting was held on 19 March 2007 which focused on the introduction and orientation to the development of community nursing and allied health services. Relevant materials in relation to this project was circulated and a presentation to provide context to the Integrated Home and Community Care programme.

Workshop Two

The second workshop held on 24 April 2007 moved to exploration through real case scenarios. Four teams were formed to work through the case scenarios and present their findings. There were common themes and concepts that emerged. Please see summary and detailed notes from workshop on our webpage.

Workshop Three

The third workshop focused on formulating concepts from those emerging themes. Following the real case scenarios of workshop in April a set of questions/ requirements was presented in a matrix format for each of the identified groupings of services. The four groupings of identified services were:

1. Allied Health: relates to physiotherapy, occupational therapy, speech therapy, dieticians and social work within community therapy services

2. Palliative Nursing: relates to palliative aspects as part of district nursing service
3. Specialist Nursing: Continence, Stoma, Oncology, Respiratory, Breast Care
4. District Nursing: relates to all other aspects of nursing and also consider services provided by health care assistants

The working party met on 22 May for a workshop. The group was formed into four teams with representation from the wide community health and primary care sector. The groups identified the most appropriate concept/ theme for their assigned service and worked through the set of questions and requirements as presented in the matrix. Please see matrix below.

Questions/ Requirements	Ref	A	B	C	D	E	F
		Colocation with primary or community	*Develop Care Pathways*	*Lead Agency*	*Early treatment in General Practise*	*Discharge Planning*	*Rapid Response*
Will it support flexibility service delivery? If yes, How? If no, Why?	1						
Will it support responsive service delivery?	2						
Could it support24/7 cover and after hour access?	3						
Would this contribute to achieving the best balance between primary/community and secondary care? What do you believe that could be?	4						
Will it streamline current services?	5						
What are the issues that are local specific (Wellington, Keneperu, Kapiti)? Will it address those issues?	6						
What risks are could there be in terms of staff coverage during leave/ holidays? I.e. annual leave, sick leave, stat holidays	7						
Will this support improved continuity of care and communication?	8						
Will it minimize duplication of elements of services?	9						
Will it strengthen and integrate primary care services to patients with chronic illness?Will it support a case management approach in a primary/community care setting?	10						
Green field thoughts	11						

Summary of Workshop Three group presentations

The following fundamental infrastructure were identified as necessities in formulating option from the emerging themes and concepts

- Competency
- Capacity including 24/7, leave cover, ability to lead and deliver
- Ease of access
- ability to detect issues early
- Multi Disciplinary approach

Other common discussions related to

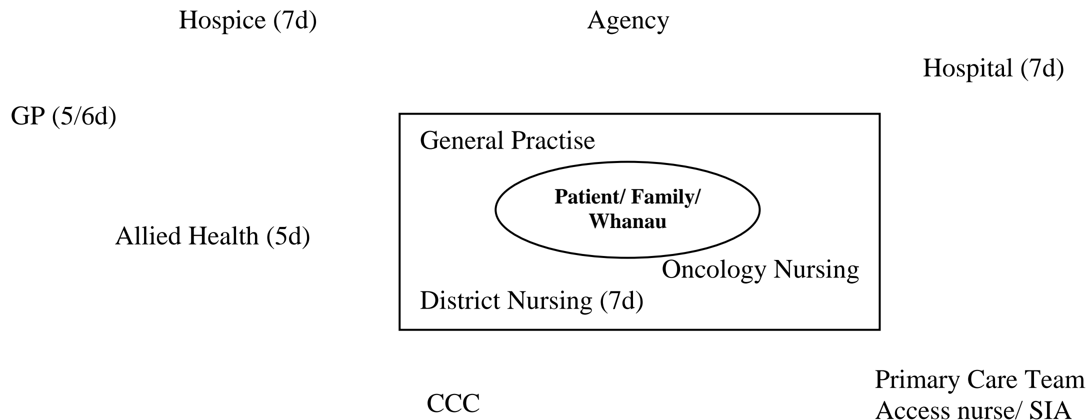
- Involvement of multiple providers depending on the patient journey and therefore multiple answers to take including geography
- Electronic Health Record , ability to share good information
- Improved communication and tools of communication
- Prevention of admission
- Care Pathways
- Combined Education

The next workshop to be held on 28 May 2007 will focus on the workforce issues and planning.

The following are detailed notes from the workshop as presented by the teams.

Team A: Palliative Nursing

The team initially spent some time discussing the case scenario of last workshop and identified the following.



The team focused on the concept of **Lead Agency**

When is a patient identified as 'palliative'?
Generally when the patient is identified as longer receiving active treatment

1) Generalist Palliative Care
Patient can be receiving services for a longer period of time. Could include patients in a residential, rest home facility. Lead person for this could be for example the residential facility or any other organization involved in the care e.g. district nursing

2) Specialist Palliative Care
Usually the lead person/ agency is Hospice, it could also be DN, GP etc

Role of a Lead Agency

This could be a lead agency, lead person or lead coordinator.

The role of a lead agency/person/coordinator is to:

- continuity of care
- carry the thread
- coordinate
- be the key worker
- be the communicator
- 24/7 availability

It was noted that there is a need for clarifying how the existing services such Palliative Care Coordinators (who are now Care Managers of Mary Potter Hospice) Care Managers (CCC) Key workers relate and inter-relate to in this concept.

Who should be the Lead Agency/ Person/ Coordinator?

Depends on the on patient's existing relationships, care in place and assessment of needs

The following is a summary of notes based on discussion against the questions/ requirements of the matrix

Ref	Comments
C1	Yes, lead person will carry the thread
C2	Yes, coordination of responsive services
C3	Lead person need to be available 24/7
C4	Noted the access nurse involvement, increase patient identification of primary care as key person. Current the Hospice and DN service are key in providing the 24/7 service to patient. Specialist Oncology Nurses are available on call as well.
C5	Yes, improved communication, sharing of information. E.g. share assessments
C8	Yes, fundamental functions of lead agent
C9	Yes to some extend
C10	No

It was noted that if the lead person could be different professions/ organisation depending on patient relationships then there needs to be:
- defined processes and care pathways for lead person to follow
- someone responsible to ensure the lead person follows due process
- monitor

Other comments
Need to forward plan on discharge to have capacity and capability to deliver services at home.

Value the services we have in place

Parallels drawn in relation to strengthening families programme (with CCC, assessment, coordination, care planning etc)

Group B: Allied Health

This group considered three concepts Co-location, Discharge Planning and Rapid Response

Co-location

Ref	Comments
C1	with other Allied Health Specialist Nursing CCC Stoma- surgical Pul Rehab – respiratory Oncology – Wellington Cancer Centre Woundcare – Vascular Cardiac Rehab – cardiology Continence- urology Breast – Breast clinic Link with Mary Potter for palliative care Align with HHS for Cover/ collegial supprt/ professional development/ recruitment/ specialist skills/ support Car parking is an issue Need to have links to help provide services C C C Specialist Care AH, Spec Nurse etc Restorative Care incl .primary care Min Care incl. primary care Primary Health AH CCC Nursing Spec Nurse
A2	Yes, with same line management and expectations on cover on all areas by staff
A3	Yes, with - increase cost/ resource to provide on call - staff safety for night - physio already 24/7 and could consult with the community
A4	Doesn’t address issues of communication with primary care All referrals/ admissions communicated to primary care

A5	Yes, with appropriate collocation and IT
A6	- Parking - staff vehicle availability – geographical area and population bases -
A7	See above
A8	See above Electronic referral forms MDT D/C Plans, GP and key others
A9	Related to communication and screening
A10	No, need access/ key worker links with the primary health
A11	Electronic health record be accessible to primary care as well

Discharge Planning – green field

- electronic health record accessible across the sector
- MDT – discharge planning and letter
- Notification of admission, discharge, care plan across sector shared
- Community resources to prevent admission including cover of carer absence
- Weekend availability of support services in the community
- Prevention: Free GP, Rapid Response
- Equipment available

Rapid Response – green field

- Hospital in the Rhome
- Respite provision in "emergency" service develop
- Hospital in the home e.g. IV
- Allied Health team based in ED 0- extended hours
- Rapid equipment made available
- Cost of supplements and delivery times

Group C: District Nursing Services

A summarized set of thoughts from the groups are as follows:

The group felt that the core building block is the client pathway, which will vary at different points in their journey through the health system, but that if the client pathway is well defined and understood then the combination of this and any of the emerging options **should work as long as**:

- There are levels of competency within services
- Good capacity within services
- Easy access to services

So for example, the combination of a good pathway and lead agency will achieve most of the requirements eg:

- Flexible services
- Responsive services etc

As long as this provides competency, capacity and easy access. Same for co-location, or early primary care treatments, discharge and rapid response options. Again, if competency, capacity and access are achieved, then this should encourage more MDT approaches, and earlier detection of problems.

Some 'riders' to this are care needs to be taken around palliative care and smaller services, where for example, a 'lead agency' might have competence, but not capacity – for example if there are too many agencies involved.

Fundamentally, all options should allow increasing convergence between primary, secondary and community rather than the divergence we have at present, this in itself will encourage relationships and communication.

Group D: Specialist Nursing

The team used a process of elimination to identify which of the concept they wanted to explore further. Rapid response and lead agency were concepts that they did not want to explore. The team chose to explore Discharge Planning.

Discharge Planning

Client 'event' often not discharged from specialty nursing regardless of whether client is an inpatient or in the community. It also varies depending on the specialty.
Discharged from specialist service or inpatient setting?

Secondary – Community
Occurs on admission. Assess clients' needs that have to be met on discharge from ward. Nurse to nurse contact and specialist nurse involved in ward, MDT, continuity of 'involvement' throughout the process. Supported by IT application consistent with primary and secondary.

Ref	Comments
E3	24/7: Plan of care developed by specialist nurse to be carried out by district nurses (overnight/ weekends) Specialist nurse on call? Needs to have access to specialist advice (e.g.: palliative vs. oncology) Need to consider the resource levels of specialist nursing across sites as well. Currently specialist nursing covers secondary and tertiary areas Works to have resources that covers across the areas so shift of resources can occur according to need, also continuity of care
E4	Staff cover more effective with single employer If employed by different employers no back up for leave etc
E5	Potential streamline to current services through Education across all sectors needed so access to advice care is consistent Care plan and flowcharts developed for patients by specialty nurse for other providers to carry out. Currently already doing nurse to nurse contact, joint handovers
E6	Currently reliant on district nurses in Kapiti to carry out shared plan (lack of specialist nurses to cover fully all areas) Service needs to be effective in meeting different levels of growth of chronic, ageing population needs. This is different over sites. Also different ethnic related needs in different areas need to be addressed Increase support to specialist nurses to facilitate this (access to cultural support) Language support, interpretation services etc need to be adequate
E7	Staff cover more effective with single employer If employed by different employers no back up for leave etc

Co-location with Primary or Community

- lack of numbers to be spread across primary sites (if to be physically co-located)
- patient been seen in hospital or in community regardless of specialist nurse service location
- specialist nurses need to be located with other staff (DNs?) providing care who need support from specialist nurses
- strong link between community and secondary nurses
- co-funding (part private part DHB) could improve links with primary care nurses
- Specialist nurses need to be kept together to avoid fragmentation
- Improvements to have links between sectors: E.g. Stoma nurses work with patients on ward (post op and followed up in community) Specialist expertise needed regardless of location of patient .. inpatient/ outpatient/ community
- Need for increased level of communication if physical collocation with primary provider
- IT support and application need to be effective
- Who the collocation is what will make a difference. Specialist nurses already view the patients as 'in the community'. The hospital admission are only episodic
- The current gap is the linkages, its the networks not where the service is located
- Other national examples Christchurch and Hawkes Bay