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NURSING AND MIDWIFERY

## **FINAL REPORT**

### **DEVELOPING COMMUNITY NURSING PRACTICE: PROMOTING CASE MANAGEMENT AND SKILL ENHANCEMENT TO SUPPORT SHIFTING THE BALANCE OF CARE**

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Our involvement in this research has been an informative and enjoyable experience. We recognise that we met with community nurses who are truly committed to providing an excellent service to their local population in the Highlands

## **Executive Summary**

### **DEVELOPING COMMUNITY NURSING PRACTICE: PROMOTING CASE MANAGEMENT AND SKILL ENHANCEMENT TO SUPPORT SHIFTING THE BALANCE OF CARE**

Five inter-related projects were commissioned by NHS Highland to further knowledge and understanding of key issues that can be used to inform particular aspects of care delivery that supports the community nurse review. The five projects reflect some of the core elements that have been identified to maximise nurses' contributions in community settings (Scottish Executive 2006a). The projects were designed to provide qualitative evidence of the views of community nurses regarding case management and to support the delivery of skills in community nursing practice. Additionally community nurses identified the knowledge and skills required to develop practice tools that would support areas of generalist and specialist practice, specifically around child welfare and long term conditions (heart care). The five projects were:

- i. Literature review on case management models in Community Nursing.
- ii. Action research project to support implementation of Case Management Models in community nursing.
- iii. Literature review on practitioners with special interest.
- iv. Research to inform development of practitioner tools for child protection and long term conditions (heart care).
- v. Research to explore skills transition to support Shifting the Balance of Care.

## **Findings**

Over the time period that this research was being conducted, related policy and workforce developments were ongoing both within NHS Highland and Scottish Government Health and Community Care. These factors in themselves illustrate the dynamic nature of primary care and the central role community nurses have both in delivering and progressing the community service. This project focused on 3 key initiatives that are influencing community nursing and it was apparent that they all shared common goals and challenges of implementation. For this reason, it was clear that any development in service provision would impact on, and articulate with, other health, social and profession based changes and could not be implemented in isolation from other related developments that underpin shifting the balance of care. Unsurprisingly, given the diverse geography of the Highlands, it was apparent that there were variations between local areas and further recognition that areas are not

static. For example there are differences in patient demographics, degree of rurality, access to services and skill mix. However, one common theme which emerged from the study was the importance nurses' placed on the supportive and trusting relationships between the patient, carer and family. One of the key features noted was the willingness of most staff to participate in contributing to NHS Highlands requirements to Shift the Balance of Care. However, nurses in all the studies articulated insightful challenges for shifting the balance, and related role developments, but these were, in the majority, followed by offering practical solutions.

## **Recommendations**

1. There is a need to achieve a consensus that articulates the principles of care, aims of care, the type and level of intervention, and expected outcomes with the approaches to practice investigated in this study, i.e. case management/ generalist and specialist practice. This includes the need to promote consistent understanding of roles and responsibilities of individual practitioners and others within nursing and/or Extended Care Teams.
2. The approach to care needs to be communicated between all areas involved in care delivery, including primary and secondary health, social care and voluntary agencies.
3. Patient and carer engagement should be sought as soon as possible when designing new community strategies. Patients and their carers need to be informed about new perspectives to care including heightening the awareness partnership roles in care.
4. Strategies for implementing new ways of working should include evaluation of service provision that is inclusive of professional, user and carer perspectives as well as evaluation of service impact and health benefits.
5. There is a need to review strategies to ensure that reliable and regular exchange of information about patients between key stakeholders is embedded into working practices. Strategies should include a review of practice based documentation to ensure fitness for purpose.



6. The success of shifting the balance will be influenced by the support structures, resources, processes, integrated working practices and education provision that are put in place to underpin its integration into community nursing practice. Education strategies need to be developed to optimise acquisition of knowledge and skills but also to include strategies for maintenance of these skills to ensure ongoing confidence and competence to practice safely.
7. A balance between formal education and practice education is suggested. For example, consideration should be given to developing and providing knowledge packages for clinical skills and that these are accessible to practitioners via NHS Highland Intranet site for easy access. Consideration should be given to the feasibility of regular 'drop in' skills session being provided locally whereby practitioners can have the opportunity to practice skills. Thought should be given to reciprocating the 'shadowing' experience which includes experience with 'specialist' colleagues in the Secondary Care Sector. Networking, peer support and clinical supervision should be recognised as essential components of professional development.
8. A scoping exercise carried out across NHS Highland would identify current initiatives related to shifting the balance of care and would contribute to informed practice development.
9. Variations in team working across the Highlands and the desire for nurses to work in closer, more integrated teams can be supported by implementation of the Extended Primary Care Team ( EPCT)
10. It was apparent that there were variations between local areas and a further recognition that areas are not static. Differences in patient demographic indicators will impact on case management and the way the model is delivered. Patient needs will change over time and policy drivers will continue to influence health priorities. Furthermore staffing profiles will not remain static. Therefore, flexibility with case management implementation should reflect these variations and developments.

# **1. Background to Study**

## **1.1 Commissioning**

Across Scotland work is currently ongoing to implement some of the recommendations of the Review of Nursing in the Community (Scottish Government 2006a). NHS Highland is one of the development sites and as part of that development, the Department of Nursing and Midwifery at the University of Stirling was commissioned to undertake five inter-related research projects to evaluate and inform related activity around the Review of Nursing in the Community (RONC) (now Community Nurse Review). The projects were commissioned to further knowledge and understanding of key issues that can be used to inform particular aspects of care delivery that supports this review. The projects were designed to provide qualitative evidence of the views of community nurses regarding case management and to support the delivery of skills in community nursing practice. Additionally community nurses identified the knowledge and skills required to develop practice tools that would support areas of generalist and specialist practice, specifically around child welfare and long term conditions (heart care).

Each study is preceded by a literature review, either as discrete projects (project one and project three) or as an integral component of a project (project five). Although each of the five projects had distinct aims, they were inter-related, as the overall purpose was to inform the development of approaches to community nursing within NHS Highland.

The five projects were

1. Literature review on case management models in community nursing.
2. Action research project to support implementation of case management models in community nursing
3. Literature review on practitioners with special interest.
4. Research to inform development of practitioner tools for child protection and long term conditions (heart care).
5. Research to explore skills transition to support Shifting the Balance of Care.

## **1.2 Rationale for Study**

Detail on each of the individual projects is contained within each section of this report. However in combination, the projects broadly focused on the review and development of community based case management models and identification of the structures required to support a range of direct-care interventions. The direction of travel for health care provision in Scotland is now firmly targeted towards shifting the balance of care where care is increasingly delivered in local settings (Scottish Government 2005a). This approach to care delivery aims to extend the current provision of community based health care and consequently provides increased scope for developing innovative approaches to nursing practice. The five projects reflect some of the core elements that have been identified to maximise nurses' contributions in community settings (Scottish Executive 2006a). They are therefore interlinked and can contribute to the overall, ongoing development of community nursing in NHS Highland. They may also be informative to a wider community health audience.

The outcomes of these projects will also help to inform models of nursing in remote and rural communities and the role of Extended Community Care Teams (ECCT). Importantly, outcomes will contribute to wider debates and opportunities around shifting the balance of care and the practice, education and training priorities set out in Delivering Care, Enabling Health (Scottish Executive 2006b), for example, by supporting sustainable role development within community care. The methods used in the projects and the dissemination strategy will help to ensure that good practice and ways of working in community nursing are shared.

## **1.3 Presentation of Report**

Each of the five projects have been presented in discreet sections, which include references and appendices relating to each of the projects. These sections contain project specific recommendations and are therefore more detailed than the combined recommendations contained within the executive summary.

## 1.4 Context

This study took place in Highland Health Board which covers the largest geographical area in the United Kingdom. The Board area covers 32,518 km<sup>2</sup>, (12,407 square miles) (Scottish Government 2008) around 41% of Scotland, which includes many small sparsely populated communities and 30 inhabited islands (NHS Highland 2008). Community nurses play a key role in Community Health Partnerships (CHP) providing care and support for patients and their families within this area. In common with other health care providers, community nursing services are increasingly required to respond to the current challenges of health care delivery and consequently to review and develop ways of working. The goals of community nursing are outlined in the seven core elements of nursing roles in community settings which broadly reflect the need to improve health and social care outcomes (Scottish Government 2007b).

Nurses in the community have been identified as key players in delivering the new policy agenda (Scottish Government 2006b). Developments in community care have been key to the implementation of the action plan set out in Better Health, Better Care (Scottish Government 2007a). In particular, there is a requirement to address the projected increase of older people in the population and the rising incidence of long-term conditions. Community Nurses and the Practice Nurse are identified as crucial to the monitoring of long-term conditions (Scottish Government 2008). This includes placing emphasis on prevention of disease crises, with systems that anticipate problems, as opposed to reacting to those crises, when they arise. Where the patient cannot regain total independence, either through a long-term condition or because they are at the end of life, it is recognised that dependency levels will rise and the Community Nurse's role becomes crucial in the support of patients and their families (Scottish Government 2008).

NHS Highland (2008) have emphasised their goals for improving services and reducing unnecessary travel by delivering care closer to home. These goals are central to the outcomes reflected in the shifting the balance of care framework, the provision of services that promote independence and quicker, more personal care delivered closer to home (Scottish Government 2008). One of the aims of the ECCT is to reduce multiple visits to secondary care wherever possible and to return the patient to care within the community, as soon as is practicable, dependant upon the disease condition

and the resources available locally (Scottish Government 2008). Community Nurses have been identified as integral to the hospital team ensuring facilitation or early discharge and return to self-care (Scottish Government 2008). Additionally community nurses play a key role in preventing hospital admissions and looking after patients post discharge at an earlier stage to avoid unnecessary hospital stays and delayed discharges (NHS Highland 2008).

Some of the strategies to support the community nursing roles described in this section are reviewed in the studies contained in this report. The strategies all require a level of competency to support knowledge level and skills sets to maintain the patient through the continuum of care. Additionally, structures and processes which impact on nurses' ability to progress workforce initiatives are also reviewed.

## **1.5 Ethics Approval**

Advice and guidance were sought from National Research Ethics Service (NRES). NRES judged this project as service evaluation and therefore advised there was no requirement for NRES approval. The project team decided to apply for ethical approval through the University Of Stirling's Department of Nursing and Midwifery Research Ethics committee and this approval was gained.

All participants were provided with written information about the study and were offered the opportunity to discuss the study with a member of the research team before deciding to participate. Written consent was obtained from each participant. It was also emphasised that participants were free to withdraw at any point from the study without detriment.

## **2. Case Management in Community Nursing: Literature Review**

### **2.1 Introduction**

Case Management originated in the social work disciplines and was firstly used in the provision of care to community mental health clients in North America in the 1950's (Lee et al. 1998). In the United Kingdom, case management has had a more recent impetus, which according to Bergen (2003) was partly due to the North American heritage but also was a response to the White Paper, *Caring for People* (Department of Health 1989). In this document the Government pledged to 'make proper assessment and good case management the cornerstone of high quality care' (Bergen and While 2000).

In the Cochrane Collaboration protocol considering case management, Zwarenstein et al. (2009) describe case management as a fluid term and accordingly authors and professional groups use the term to describe different initiatives, which may also have divergent goals. Although there is no universal definition of case management among health professionals, Onyett (1992) as cited by Bergen (2003) described case management as 'a way of tailoring help to meet individual need through placing responsibility for assessment and service coordination with one individual worker or team'.

An awareness of the changing demographics in the UK, a rapidly increasing elderly population with long-term and enduring conditions grew through the decades of the 1980's, 1990's and 2000's. The ensuing increase use of health care resources has resulted in the recognition that services need to be realigned in order to have greater impact upon the needs of clients and their families in the community. The Scottish Executive as part of the modernisation of the National Health Service in Scotland presented an agenda that challenged traditional ways of caring for older people in the community. The primary focus being, a reduction of acute care through emergency admissions and improvement of health and well-being through preventive care, and support for self care, targeting those at risk through pro-active approaches in the form of anticipatory care (Scottish Executive 2005a, 2005b). Case management has been identified as one means of meeting some of the national health targets (Scottish Government 2007). Case management has been widely practiced in a variety of forms as a means of service delivery to effectively, efficiently and economically provide

quality care to populations with complex service needs (Yau et al. 2005, Lee-MacKenzie et al. 1998, Chan et al. 2008).

## **2.2 Aims of the Review**

This literature review aimed to identify case management models used in community nursing, and their relevance to case model development in NHS Highland. The evidence within the literature has been critically reviewed in order to answer the following research questions:

1. What are the key features of case management models within community nursing in the UK?
2. How can characteristics from existing models contribute to the development of the case management models within NHS Highland?

## **2.3 Methodology**

This review is based on a narrative synthesis of the literature to address the different aspects of case management and to gain an understanding of this approach to patient care. A narrative synthesis of the literature will address different aspects of case management approaches in order to provide a bigger picture of that phenomenon (Dixon-woods et al. 2004). A narrative synthesis of the literature will therefore provide a valuable summary helping to identify and explain different perspectives of case management. Importantly, a narrative literature review helps to advance best practice, to present new perspectives on important and emerging issues (Rumrill and Fitzgerald 2001), usefully informing practice development.

The following systematic approach was utilised for the search strategy:

- Aims for the review were identified
- Criteria for considering studies in this review were identified
- Literature was determined according to a clear search strategy
- Studies were selected according to precise inclusion and exclusion criteria.

## 2.4 Search Strategy

The first step for the search strategy was to identify the relevant electronic databases and retrieve the main sources of literature for the review. The following databases were searched:

MEDLINE (1996 to 2010)

EMBASE (1996 to 2010)

British Nursing Index (1996 to 2010)

Cumulative Index to Nursing and Allied Health Literature (CINAHL) (1996 to 2010)

The keywords used in the search strategy were community health nursing, family nursing, school nursing and case management

Using the principles of the Boolean logic using the AND/OR commands the following record of hits was accessed:

*Databases: MEDLINE 1996-present. Search term: community health nursing: Total number of hits: 7551*

*Databases: MEDLINE 1996-present. Search term: Community Health Nursing OR family nursing OR school nursing AND case management: Total number of hits: 231*

*Databases: EMBASE 1996-present. Search term: Community Health Nursing OR family nursing OR school nursing AND Case Management: Total number of hits: 260*

*Databases: British Nursing Index 1994-present. Search term: Community Health Nursing: Total number of hits: 18021*

*Databases: British Nursing Index 1994-present. Search term: Community Health Nursing OR family nursing OR school nursing AND Case Management: Total number of hits: 0*

*Databases: CINAHL 1996-present. Search term: Community Health Nursing OR family Nursing Or school nursing AND Case Management: Total number of hits: 245*



*Databases: Social Policy and Practice: 1999-present. Search term: Community Health Nursing OR family nursing OR school nursing AND Case Management: Total number of hits: 111*

The inclusion criteria specific to the review consisted of:

Primary research directly related to community health nursing and case management

English language only 1994 -2010

As the search progressed it became apparent that there was a paucity of good quality research studies that evaluated case management models of community nursing. The search yielded a plethora of descriptive studies which described outcomes of case management however many studies failed to indicate which case management model had been utilised. For the purpose of the review there was a limitation as the features of the models used were not always clearly articulated. In total 15 UK studies, met the inclusion criteria. The search was subsequently expanded to include studies from the USA, Hong Kong, Canada, Spain and the Netherlands. Cumulatively, 40 international studies were deemed suitable for inclusion.

In response to the literature obtained and the limitations experienced of using electronic searching alone, the approach of snowball sampling as described by Greenhalgh and Peacock (2005) was further applied. The British Journal of Community Nursing and Nursing Case Management was scrutinised for other relevant studies. This method was a most effective approach and yielded a further 253 publications, 10 of which were suitable for inclusion. Several articles were also obtained by scrutinising the reference lists of key articles relating to case management.

The selected studies for review have been summarised and appended at the end of this chapter (Appendix 1). Despite the stated limitations, including the relevance of some of the studies considered for this review, several key themes have consistently emerged from the literature and formed the basis of this review.

## **2.5 Findings**

### **2.5.1 Case management models are not always clearly conceptualised nor described**

Despite the pledge of the government, through the White Paper Caring for People (DOH 1989), 'to make proper assessment and good case management the cornerstone of high quality care', the implementation of case management remains variable (Lee et al. 1998). Bergen (1994) suggests that the absence of a widespread agreement relating to the definition of case management has been an obstacle in moving forward the practice and research of case management. Singh and Ham (2006) in their comprehensive review of UK and international frameworks concerning improving care for people with long-term conditions, stipulate that there is limited high

quality evidence about the impact of any model. They suggest that this is largely because the models are not well conceptualised or described. The variability of case management is further acknowledged by Long and Marshall (1999) in their suggestion that organisations planning to introduce case management must be sensitive to the varying dynamics of the different case management models and implement a model that is consistent with the desired outcome.

Long and Marshall (1999) suggest that case management models can be categorised into one of two types. The first is a model, referred to as the gatekeeper model, which emphasises the importance of cost-effectiveness by restricting the use of care. Ebert (2001) argues that as case management continues to evolve it has become cost-centred rather than patient-centred. Being critical of this assumption, Ebert (2001) proposes that the time has come to return to the original mission and philosophy of case management which is to 'make proper assessment and good case management the cornerstone of high quality care'.

The second model is based on the co-ordination of a wide range of services with a view to improving quality of care (Long and Marshall 1999). This model is more concerned with quality of life experiences. Hyduk (2002) presents a vision of case management which combines aspirations of quality and cost, describing it as an intervention that involves assessment, service planning, service co-ordination, monitoring and re-assessment of high-risk individuals to provide the best care while containing costs.

The Chronic Care Model is a key feature of case management and according to Singh and Ham (2006: 5) is the best known framework concerned with caring for people with long-term conditions. Most chronic care policies in developed countries now draw on this model to a certain extent. The Chronic Care Model (CCM) is an approach to quality improvement and service redesign that was developed by Wagner and colleagues in the USA during the 1990's (McEvoy and Barnes 2007: 234), and described by Piatt et al. (2006: 811) as a multi-faceted framework for enhancing health delivery. The Kerr Report, (Scottish Executive 2005a), described how case management should be developed in close collaboration with social care providers to prevent hospitalisation. Although the report does not recommend one particular model it highlights the "Evercare" model which was piloted in England using Community Matrons as case managers.

### **2.5.2 Case finding methods are mixed**

The requirement to build capacity in primary care to deliver proactive, preventive care and provide early interventions to prevent escalation of health care need is integral to Scottish health care policy (Scottish Executive 2005a, 2005b). Case finding has been described as an essential component of case management for accurately identifying high risk patients (Billings et al. 2006). Broadly the literature describes two approaches to case finding. The first is where an individual is identified as being at risk of exposure to a crisis situation and are at risk of an unplanned hospital admission (referred to as very high intensity users). These individuals are likely to become more dependent and therefore place greater demands on health and social care systems (DOH 2008). The second is a method of identifying people who have never had an admission, but who are predicted to be future high users of secondary care services (DOH 2008). A variety of approaches to case finding are described in the literature which aims to identify individuals who fall into one of the approaches described above.

Peretz and Bright (2007) describe a case study approach to implementing a model of anticipatory case management focussing on individuals using the Patients At Risk of Re-admission to hospital algorithm (PARR). The PARR tool picks up patients who have had an emergency admission and then allocates a risk score showing the likelihood of re-admission to hospital within 12 months. Those with a risk score of above 70 have a 73-90% risk of being re-admitted. This project identified 31,174 patients in Oxfordshire who were likely to be re-admitted within 12 months (Peretz and Bright 2007). From the total risk numbers, 2,099 had a predicted risk of re-hospitalisation of >50%. While the projections from this study demonstrate significant projected savings, further investigation would be required to demonstrate the effective outcomes of this approach to case finding.

In Better Health, Better Care, (Scottish Government 2007) emphasis is placed on the need to develop the Scottish Patients At Risk of Readmission and Admission tool (SPARRA). SPARRA is a risk predictor indicator which facilitates identification of the most vulnerable patients. This is done by utilising a risk prediction algorithm to identify patients aged 65 years and over, at greatest risk of emergency inpatient admission (NHS Scotland 2006) There is commitment to extending the SPARRA tool to include patients of all ages (Scottish Government 2007).

Mistiaen et al. (1999) demonstrated the use of the Baylock Risk Assessment Screening Score (BRASS) index as an effective case finding tool. In a study undertaken in Amsterdam 503 patients were screened on admission with the BRASS index which contains 10 items: age, living situation/emotional support, functional status, cognition, behaviour pattern, mobility, sensory deficits, previous hospital admissions, active medical problems and medication regimes. Outcomes after discharge were measured by postal questionnaire at day 7 and day 30. According to Mistiaen et al. (1999) the BRASS index was found to have good predictive validity as high-risk patients were identified as having the potential to experience problems after discharge. Algorithms like BRASS, PARRA and SPARRA have been widely supported by health agencies and professionals. However, Billings et al. (2006) suggest a note of caution proposing that complete understanding of the most effective design of interventions for high risk patients identified by algorithms can be difficult to achieve.

One example of reported outcomes from case finding is described in an evaluation of the Nairn Case Finder (Gallagher and Ireland 2008). The Nairn case finder is one example of an approach to case finding that used an algorithm using chronic care disease data to target proactive anticipatory care to the most 'at risk' patients. In an evaluation of the model, Gallagher and Ireland (2008) report beneficial outcomes from patients and health professionals. For example, patients' emphasised positive benefits and valued the emotional and practical support they received from highly motivated and highly trained professional staff involved in this multidisciplinary collaborative case management (Gallagher and Ireland 2008). The view of professionals was also positive, where they reported delivering a high quality, supportive service (Gallagher and Ireland 2008).

Drennan et al. (2005) described a mixed methods study which incorporated case finding into its aim. A specialist health and social care team was commissioned by an inner city London Borough for 18 months, the main aim being to reduce isolation amongst older people, to enable healthcare services to be targeted more effectively towards older people and encourage self-help to improve quality of life (Drennan et al. 2005). The team proactively contacted people over the age of 75 deemed "at risk" by GPs and offered a joint health and social care assessment, followed by information giving, support and short term case management strategies. The assessment process covered all domains of physical, emotional, social and mental well-being. The core component was the Camberwell Assessment of Need in the Elderly (CANE) tool. 327 people consented to inclusion in the evaluation process which found that 71% of

people had no unmet needs recorded on the CANE assessment tool. Those that did were referred by the team to 27 services across the spectrum of health, social service, housing, leisure, voluntary sector services and transport services.

Anticipatory care can be provided in many forms. One example was an initiative pioneered by the Met Office, using weekly weather forecasts to enable the Chronic Obstructive Pulmonary Disease (COPD) outreach team in Plymouth to target patients at risk of developing exacerbations (Barnett 2006). During the winter of 2004/2005, 8 health authorities used the COPD weather forecast. Each COPD team member had a caseload of 50-80 patients, and following the forecast emailed by the Met Office <sup>1</sup>, they were responsible for contacting vulnerable patients by telephone or home visits and initiating intervention to avoid exacerbations. Although this was a small study, hospital admissions related to COPD were reduced, potentially resulting in cost savings and improvement of quality of life in these patients.

### **2.5.3 Anticipatory care and assessment**

Delivering For Health (2005b) identified the need to shift the focus of care towards health improvement, self-care and preventative medicine. The emphasis is on targeting resources for those most in need and for the proactive delivery of anticipatory care through case finding and assessment. Good assessment skills have been identified as key to case management (Kersbergen 2000) and involve getting to know the patient, the family and the community (Kennedy et al. 2008). Evans et al. (2005) refer to a cyclical approach to case management, the key elements being; assessment, planning, implementation, monitoring and evaluation to provide systematic proactive care to people with complex health and social care needs. There is increasing evidence to support the effectiveness of the multifaceted role of Community Nurse case management in supporting anticipatory care including, counselling and supporting, linking clients to community resources, health assessments, risk assessments and preventive health education (Banning 2009, Barnett 2006, Behice 2005, Brady et al. 2007, Hallberg and Kristensson 2004, Kennedy et al. 2008, Kersbergen 2000, Kesby 2002, Morans 2006, Peretz and Bright 2007, Weissert et al. 2003).

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<sup>1</sup> **The UK's National Weather Service<sup>11</sup>**

According to Minkler, (2007) no single assessment tool or technique is sufficient in itself to capture health sensitively and accurately. A significant outcome regarding assessment was reported by Cowley and Houston (2003). They investigated the changing educational needs of Community Nurses with regard to needs assessment, and determined whether the use of Health Needs Assessment Tools (HNAT's) were beneficial in identifying the individual needs of patients. Results from their study indicated that Community Nurses had difficulty in implementing the HNAT due to its' incorrect use and notably that the checklist approach was criticised since nurses tended to ask specific questions and make judgements without listening to individual answers (Cowley and Houston 2003).

The Government's key policy document *Designed to Care* (1997) acknowledged the potential for better patient care offered by technological advances. The implementation of the electronic patient record was identified as a tool to support the patient and improve their experience of care throughout the healthcare journey. The benefits of electronic assessment have been demonstrated by a study by Kraft and Scott (2007). They described how inconsistencies in home and community care data collection across Canada was the driving force for changing the process of assessment of case-managed clients from a paper-based assessment tool to computerised assessments. The outcome for this intervention was positive, as the health authority in British Columbia became a leader in using technology for data collection to enhance the quality of care delivered .(Kraft and Scott 2007: 28). An interesting feature of their study was the view held by some of the nurses that taking a computer into a client's home was creating a physical barrier to rapport building.

#### **2.5.4 Case management has been shown to be effective in improving clinical and behavioural outcomes for long term conditions**

A number of studies have reported on the outcome of case management implementation and findings are generally supportive of the model. One of the limitations of the literature reviewed was the paucity in reporting concise application of the models used in practice. However, studies have evaluated the outcomes for people with long terms conditions, including diabetes, heart failure and mental health conditions. There is evidence to suggest that implementing the Chronic Care Model in the community is effective in improving clinical and behavioural outcomes in patients with long-term conditions (Barr et al. 2003, Behice 2005, Bergen 2003, Bernal et al.

2004, Blaha et al. 2000, Boulton et al. 2008, Corser 2009, D'Addario 2002, Ekers and Wilson 2008, Gangon et al. 1999, Gravelle et al. 2007, Hyduk 2002, Lee et al. 1998, Marshall et al. 1999, McEvoy and Barnes 2007, Moran et al. 2008, Piatt et al. 2006, Rosenberg 2009, Simpson et al. 2003, Suter et al. 2008, Thomas 2009).

One example of a study that reviewed long-term condition outcomes was reported by (Thomas 2009). The Swansea Chronic Conditions Management service was introduced during 2006 to address the escalating problem in Wales of clients with long-term conditions and complicated needs receiving uncoordinated, fragmented care and unnecessary hospital admissions (Thomas 2009). Five experienced nurses were recruited, educated and trained in case management. The aim of the pilot project was to prevent unplanned hospital admissions or re-admissions by focussing on patients with the highest burden of disease through assessments, medication reviews and working in partnership with acute, social and voluntary sector services.

There is evidence to suggest that following these interventions, data on the number of emergency medical admissions demonstrated a significant decline. Thomas (2009) acknowledges that the success of this project served as a catalyst to recent developments within the Chronic Conditions Management service such as a telephone based case management intervention, anticipatory care, assessment, monitoring and computer-based information to provide additional preventative care and support to clients and families.

According to McEvoy and Barnes (2007) between 20% and 50% of older adults with long-term conditions, such as diabetes, osteoporosis and hypertension, have clinical symptoms of depression. There is strong evidence to indicate that when the Chronic Care Model is adapted to support the management of depression in older adults, significant improvements in outcomes can be achieved. Three influential approaches – the Improving Mood Promoting Access to Collaborative Treatment (IMPACT) programme, the Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT) programme and the programme to Encourage Active, and Rewarding Lives for Seniors (PEARLS) have all incorporated the key features of the Chronic Care Model (Levine et al. 2005, Arian et al. 2001, Bruce et al. 2004, Ciechanowski et al. 2004). The 3 approaches share many features, advocating collaborative, pro-active care as well as the need to engage patients as active partners in the management of their conditions, promote anticipatory care, good assessment and effective systematic follow-up. Results from a randomised controlled trial of PEARLS indicated significant



reductions in depressive symptoms, as well as improvements in functional and emotional outcomes (Ciechanowski et al. 2004).

Piatt et al. (2006) reported on the implementation of the Chronic Care Model (CCM) in a randomised controlled trial for multifaceted diabetes care intervention. The aim of their research study was to determine whether using the CCM in an underserved community led to improved clinical and behavioural outcomes for people with diabetes. The premise of the model was that quality diabetes care was not delivered in isolation and could be enhanced by community resources, self-management support, delivery system redesign, education and a collaborative, pro-active approach to case management. The findings of this study demonstrate how clients in the intervention group experienced a marked improvement in their glycaemic, blood pressure and lipid control, and an improvement in their knowledge of diabetes, enhancing both their feelings of empowerment and quality of life (Piatt et al. 2006).

Kuei-Yun et al. (2006) further add to the research evidence that Community Nurses are effective case managers by highlighting the benefits of case management of 766 elderly patients in Taiwan diagnosed with hypertension, diabetes mellitus and hypercholesterolemia. The results portrayed a decrease in blood pressure and blood sugars in the clients being managed by the Community Nurses. According to the authors, this study highlights the importance of good assessment and nursing intervention and the opportunities for community nurses to educate their clients.

There are a number of studies which report improved outcomes with patients who had diagnosed cardiac conditions. According to Rich et al. (1995) congestive heart failure is one of the most common indications for hospitalisation among adults over the age of 65. This is compounded by behavioural factors such as poor compliance with treatment. The aim of this randomised trial was to determine whether a nurse-directed, multidisciplinary intervention would prevent the re-admission of elderly patients with congestive heart failure. In total 282 patients were randomised to the control group (n=140) or the intervention group (n=142), and rates of readmission within 90 days of hospital discharge, quality of life and costs of care were considered. The intervention consisted of comprehensive education of patients and families, a prescribed diet, a review of medications and collaborative intensive follow-up.

Results showed that survival for 90 days without re-admission, the primary outcome measure, was achieved in 91 of the patients in the treatment group compared with 75 in the control group. There were 94 re-admissions in the control group and 53 in the treatment group. Outcomes suggest that the nurse directed, multi-disciplinary intervention also improved the quality of life of these elderly patients with congestive heart failure and reduced medical costs (Rich et al. 1995).

Similar results were identified by Riegel et al. (2002) following a randomised controlled clinical trial to assess the effect of nurse telephonic case management intervention in decreasing resource use in patients with chronic heart failure. Patients were identified to receive 6 months of intervention (n=130) or usual care (n=228) following discharge. The telephonic case management was standardised using a computer software program. Patients were telephoned within 5 days of hospital discharge and thereafter at a frequency guided by the software and the nurse case managers judgement based on symptoms, knowledge and needs. The patients in the intervention group required fewer resources over the 6 months of study than the patients receiving routine care. Significant cost savings were also demonstrated and patient satisfaction was higher in the intervention group (Riegel et al. 2002).

Allen et al. (2002) describe a randomised clinical trial that aimed to test the effectiveness of a nurse case management programme to lower blood lipids in patients with coronary heart disease following coronary revascularisation. This US study, randomised 228 patients to receive lipid management, including individualised lifestyle modification and pharmacological intervention from a nurse practitioner for one year after discharge from hospital in addition to their usual care (NURS), or to usual care enhanced with feedback on lipids to their cardiologist (EUC). Results showed that significantly more patients in the NURS group than the EUC group achieved low-density lipoprotein cholesterol levels and experienced improvements in dietary and exercise patterns. Allen et al. (2002) conclude that case management by nurses provides an ideal opportunity to improve adherence and achieve full effectiveness of new treatments.

Similar results were demonstrated by Zhao and Wong (2009) following a randomised controlled trial of the effects of a post-discharge transitional care program for patients with CHD in China. The participants in the study group who received assessment, structured home visits and telephone follow-up, showed significantly better

understanding in diet, medications and health-related lifestyle behaviour at day 2, and in weeks 4 and 12, a better understanding of the importance of exercise and an overall satisfaction with the care delivered by the Community Nurses.

Case management has also been evaluated to assess its impact on patients with mental health conditions and outcomes described in studies are similar to those studies that have assessed impact on diabetes and CHD. Nurse case management was evaluated in a community psychiatric nursing service in a study by Chan et al. (2008) whereby patients diagnosed with chronic schizophrenia living in Hong Kong were randomised to receive either routine care by Community Psychiatric Nurses (CPN's) or care by CPN's using a case management model concentrating on assessment, liaison, case discussion and life skills training. Results highlighted that clients in the experimental group had more improvement in their mental status and their level of functioning, compared with the control group.

Depression case management by practice nurses was recently audited by Ekers and Wilson (2008). Practice Nurses in the North East of England collected data from clinical records on 161 newly diagnosed depressed patients and patient satisfaction was assessed using a questionnaire. Results showed a high level of satisfaction and according to the authors supported the belief that depression case management can be effectively delivered by nurses.

Further clarification of the positive impact of case management of people diagnosed with mental illness or mental health problem is highlighted in a qualitative exploratory study of the provision of additional support for veterans diagnosed with mental illness (Malone et al. 1999). 275 clients enrolled in the case management system and attended weekly groups to promote self-discovery, self-realisation and self-direction, over a three-year period. The case management group achieved positive results with clients becoming more compliant with medication, which in turn reduced the use of inpatient services and increased the quality of life of these veterans.

Evidence from the studies reviewed suggests that a range of beneficial outcomes have emerged following case management intervention. These outcomes include more positive health related behaviours, for example improved concordance from patients with lifestyle change and medication, improved patient satisfaction and increased feelings of empowerment and control.

Reference is also made to the benefits of lower financial costs as a result of reduced hospital re-admission rates. However, in a recent analysis of 73 “success stories” with regard to nurse case management in primary care in Wales, Elwyn et al. (2008) suggest that the evidence for the effectiveness of case management in preventing hospital admissions to acute care in elderly patients was weak and often contradictory. Following a qualitative study exploring how 5 advanced nurse practitioners described their work and how they perceived benefits for patients, Elwyn et al. (2008) conclude that from the overall caseload of 121 patients, 73 success stories were collected during the year. They suggested this indicated that nurses felt that they had made a significant positive difference for over half of the patients cared for. Following these first-hand accounts Elwyn et al. (2008) indicate that avoiding hospital admission is not necessarily the most sensitive indicator of success or of best care. Expediting an admission could well be best for patients. This qualitative study raises the possibility that admission rates is the wrong measurement for case management research and that more emphasis should be given to the ability of case management to deliver co-ordinated packages of care that result in improved quality of life for patients (Elwyn et al. 2008).

#### **2.5.5 Case management is an effective means for promoting self-management**

The Long Term Conditions Collaborative (Scottish Government 2009) focus on the need to empower people to have more control and choice to enable them to self manage their condition. Suter et al. (2008) suggest that the process of collaborative self-management support is the key principle to disease management. They further identify patients as their own caregivers, who should take charge of their own disease management. However, Suter et al. (2008) also caution that this could lead to patients feeling overwhelmed. According to Metcalfe (2005), community nurse case managers can help patients with long-term conditions attain a better quality of life through purposeful interventions that aim to minimise symptoms, reduce the intensity and frequency of acute exacerbations of the disease, and enhance psychological well-being.

An exploratory study in the Netherlands by Jaarsma et al. (1999) tested the effect of education and support by a nurse on self-care and resource utilisation in patients with heart failure. 179 patients hospitalised with heart failure were evaluated prospectively and randomised to the study intervention or usual care groups. Education and support

took place within a week of hospital discharge in the form of home visiting. Data were collected on self-care abilities, self-care behaviour, re-admissions, visits to emergency departments and use of other resources. Findings concluded that education and support from a Community Nurse significantly increased self-care behaviour within a month of discharge and led to gains in autonomy (Jaarsma et al. 1999).

Husbands et al. (2007) undertook a study concerned with people living with HIV/AIDS who were randomised to an experimental group and received self-directed use of a service program and case management, rather than usual care, had a 31% improvement in their mental health compared to 1% deterioration in the control group. They also had a 45% improvement in social functioning compared with 27% deterioration in the usual care group. The authors contend that empowering people can be an effective way to help them gain confidence to access available services and improve the quality of life of the very depressed.

In a small study undertaken in primary care settings in an underserved urban suburb of Pittsburgh, Pennsylvania, Piatt et al. (2006) describe the effectiveness of education to promote self-management, empowerment and autonomy in diabetic patients. The chronic care model was utilised in the case management strategy. Patients in the experimental group received diabetes self-care management training sessions focussing on self-care education and empowerment. Survey instruments included the Modified Diabetes Care Profile, Diabetes Empowerment Scale, Diabetes Knowledge Test and the World Health Organisation quality of well-being index. Cholesterol and blood pressure levels were recorded. Improved cholesterol levels and rates of self-monitoring of blood glucose were noted in the intervention group. The patients also presented with improved behavioural actions and diabetes knowledge outcomes (Piatt et al. 2006).

Similar positive study results, were reported by Krumholz et al. (2002) in a prospective randomised trial of an education and support intervention to prevent re-admission of patients with heart failure. 88 patients were randomised into 2 groups. The study intervention was based on a broad range of self care interventions. These included, home visits, telephone contacts with educational sessions about patient knowledge of the illness, relationships between medications, health behaviours and the illness, knowledge of early signs and symptoms and when and where to obtain assistance. Outcomes demonstrated that fewer patients in the treatment group experienced re-admission or death (Krumholz et al. 2002)

### **2.5.6 Development of trusting relationships between community nurses, patients and carers underpins case management**

One of the key features identified in the literature central to developing continuity of care and good community case management is the nurse-patient-carer relationship (Hunt 2009). Guttman (1999) proposes that the nurse-patient relationship can be described as a connected relationship whereby the nurse views the patient first as a person and second as a patient. Following a qualitative study by Kellett and Mannion (1999) where patients and carers were interviewed to elucidate the meaning of caring, results show that the family carer has a need and desire to be involved in providing care for their relative and community

In a qualitative exploratory study Guttman (1999) described how caring was conveyed by frequent, self initiated contact with the patient and carer. Following a phenomenological study to better understand the meaning of district nurses' experiences of encounters with patients with serious chronic illness and their close relatives, results of interviews with ten district nurses identified several themes connected to being in a close relationship (Ohman and Soderberg 2004). These included the availability and commitment of District Nurses with regard to having time for the patient and being readily accessible. Touch and active listening were vital to developing intimacy and understanding. According to Luzinski et al. (2008) community nurse case managers establish rapport and trust with clients by using empathy and humour and maintaining a consistent and reliable presence.

The development of a close trusting relationship between Community Nurses and their chronically ill patients and families is a key feature disseminated through many of the papers focussed on in this review (Blaha et al. 2000, Blue et al. 2001, Bushy 2003, Chan et al. 2008, Cowley et al. 2000, Ekers and Wilson 2008, Gallacher and Ireland 2008, Guttman 1999, Kennedy et al. 2008, Malone et al. 1999, MacKenzie et al. 1998, Moran et al. 2008, Morgans 2006, Ohman and Soderberg 2004, Olbort et al. 2009, Suter et al. 2008, Thomas 2009, Wilson 2002).

### **2.5.7 Collaborative working underpins case management**

The need to develop and sustain effective collaborations with all the stakeholders in care is central to health care policy and is a major facet identified with successful case management. The literature supports the assumption that successful community health practice and case management takes a team effort to care for a client well. Significantly, the team leader is often the Community Nurse (Allender and Spradley 2005 Keller et al. 1998 Schraeder et al. 2008). Kesby (2002) supports the notion that the time is right for nurses in the UK to become the case managers in all health care settings, promoting partnership working and collaborative practice

Jo Vetter et al. (2004) typified the ethos of collaboration in a randomised clinical trial to determine whether multi-faceted, culturally sensitive, primary care based behaviour interventions implemented by a nurse case manager and community health worker could improve diabetic control. The study sample consisted of 186 African American adults in East Baltimore with type 2 diabetes. Care provided in the treatment group consisted of interventions focussing on diet, physical activity, foot care, vision care, blood glucose self-monitoring, blood pressure control, adherence to medication and appointments, referrals and smoking cessation. Results demonstrate that the collaborative approach to care produced improvements in diabetic control and reduced the excess burden of diabetes related complications.

### **2.5.8 Information technology**

Advanced technology has contributed in many ways to shaping the practice of community nursing and has been identified as an important key feature of successful case management (Allender and Spradley 2005). Technology impacts on case management in many forms. For example, earlier studies in this review have reported on initiatives with telehealth and telephone which have had positive outcomes. Telephone communication has been shown to be an effective adjunct in the care of patients with chronic conditions including congestive heart failure, diabetes, respiratory conditions and depression (Barnett 2006, Blaha et al. 2000, Blue et al. 2001, Gangon et al. 1999, Guttman 1999, Krumholz et al. 2002, Morales-Ascencio et al. 2008, Rich et al. 1995, Reigel et al. 2002).

Duke (2005) investigated the effects of community based case management on frail elderly patients in North Carolina. Case managers provided hands-on care as well as distance-based health care through a telehealth unit which allowed regular physical assessments in the home setting by providing two-way audio and visual interface. It was proposed that this part of the case management model would allow earlier identification of health-related problems, an overall decrease in fragmentation of health care delivery, and a reduction of health care costs for the population (Duke (2005)). The study reported positive outcomes including a decrease in hospital admissions, emergency room visits, length of hospital stay and total healthcare costs.

Non face-to-face communication to enhance preventive strategies was studied by Hughes (2003) to encourage adherence to prescribed therapies and promotion of education and self-management. Hughes (2003) concluded that telephone or internet based communication appears effective, possibly more so when the health professional and the client has had a face-to-face relationship, in

#### **2.5.9 Community nurses make effective case managers**

Community nurses have a pivotal role to play as case managers. According to (Kennedy et al. 2008) the community nurses' role encompasses both human qualities and specific clinical skills. Referring to the human qualities, Allender and Spradley (2005) describe how nurses' interactive approach is highly valued by clients and their carers as nurses exercise their ability to understand, communicate, motivate, delegate and work collaboratively with other health professionals. These are qualities required to support implementation of case management and have been widely reported throughout the literature.

There is evidence to demonstrate that Community Nurses are effective case managers in relation to dealing with patients with chronic illnesses such as cardiovascular disease, diabetes, depression, and chronic respiratory conditions (Allen et al. 2002, Barnett 2006, Blue et al. 2001, Bonaiuto 2007, Chan et al. 2008, Chow et al. 2008, Ekers and Wilson 2008, Jansen et al. 2005, MacKenzie et al. 1998, Morales-Ascencio et al. 2008, Rich et al. 1995, Riegel et al. 2002, Sochalski et al. 2009, Sloand 2005, Stanton et al. 2005, Sutherland and Hayter 2009, Yau et al. 2005). By improving care, these patients may be facilitated to stay in their homes and communities longer, a key outcome of case management. The meaning of "home" has implications for community nursing practice. As Bowden and Bliss (2007) aptly point out, it is widely agreed that it



is the desire of most chronically ill and dying patients to be cared for at home. While (2000) suggests that the role of the community nurse has in fact become synonymous with expert nursing care tailored to the home environment (While 2000).

Sutherland and Hayter (2009) state that Community Nurses are the main health professionals involved in caring for patients with long-term conditions in their homes and that the key feature paramount to effective nurse case management defined by the Department of Health (2006) is that of the highly experienced nurse. The concept of the experienced community nurse has been acknowledged as central to the success of delivering case management strategies through the new role of the Advanced Practice Nurse (APN) in the Evercare and Keiser Permente models for case management using community matrons (Hudson and Moore 2006). According to Sargent et al. (2008), the role of the APN describes as a nurse who provides advanced clinical nursing in addition to case management. Much of the research that reports on the nurses' contribution to case management does focus on an 'advanced role' and describes how this role positively impacts on outcomes. Additionally, the literature is informative about the skills nurses require to support advanced practice for case management.

The concept of the Community Matron evolved in 2004, and was part of the NHS Improvement Plan (Banning 2009). In a study which conducted in-depth interviews with a purposive sample of 72 patients with long term conditions and 52 carers, Sargent et al. (2007) highlight that there was an overall satisfaction with the components of the community matron service. Salient themes and concepts related to the care provided by the community matrons were identified, including, clinical care, care co-ordination, education, advocacy and psychological support. In a small qualitative study Banning (2009) explored the views of 5 community matrons in training, who described the role as developing, multifaceted and proactive, promoting health education and patient assessment.

The literature also explores the role of the community nurse working in a specialist capacity. For example, in a recent literature review Sutherland and Hayter (2009) appraised the evidence for the effectiveness of nurse case management in improving health outcomes for patients living with diabetes, chronic obstructive pulmonary disease or coronary heart disease. 18 papers were subjected to thematic analysis based on the health outcomes evaluated in the studies. Significantly, positive results were reported for nurse case management on five health outcomes including, objective clinical measurements, quality of life and functionality, patient satisfaction, adherence

to treatment and self care and service use. Sutherland and Hayter (2009) conclude that the results of the studies reviewed provide excellent evidence for the effectiveness of nurses working in a specialised, co-ordinating role and their contribution to improvements in the care of patients with long-term conditions.

In a randomised controlled trial undertaken by Blue et al. (2001) to determine whether specialist nurse intervention improved outcome in patients with chronic heart failure, 81 patients were assigned to a control group and 84 patients to a nurse intervention group. The intervention started before discharge from hospital and continued with home visits up to one year. The specialist nurse intervention group initiated home visits supplemented by telephone contact when necessary to educate patients about heart failure and its treatment. The nurses liaised with other health professionals, taught self- monitoring and self- management, monitored electrolyte concentrations and provided psychological support. The results of this study found that intervention by a specialist nurse can substantially reduce the risk of readmission to hospital for heart failure (Blue et al. 2001).

As well as being clinically effective, the literature also suggests that the advanced practice community nurse is instrumental in improving the fiscal benefits of a care through case management. The role of the Advanced Practice Nurse (APN) as described by Chow et al. (2008) was examined in the case management of patients making the transition from hospital to home. Patients were diagnosed with cardiovascular diseases, chronic respiratory diseases and other general medical conditions. Although this was a small study using secondary analysis of the hospital records documented by community nurses, the outcomes suggest that the APN's role was fundamental to effective improvement in patient outcomes and provided high quality health-care services while controlling health care costs.

The evidence suggests that the attitude of other health care professionals to nurses acting as case managers have been largely supportive. However Baid et al. (2009) reported that the response of GP's in South Downes Health NHS Trust to nurses undertaking physical assessment had been mixed with some welcoming the initiative, while others had been less supportive. Such concerns have not been reflected in study outcomes and authors highlight the multi-faceted role of the community nurse as being pivotal in effective delivery of care to patients and families who are leading initiatives in the management of long term conditions (Hudson and Moore 2006). There is evidence to suggest that the efficacy of the role of the advanced practice nurse in community

case management has significantly positive results pertaining to the care of patients with diabetes, COPD, CHD, and mental health disorders. Nevertheless, Sutherland and Hayter (2009) suggest that further research is required to focus on other long-term conditions to provide additional data to strengthen or weaken the evidence base for nurse case management. The studies in this review describe case managers as nurses who have advanced or specialist skills to enable them to support patients and implement the goals of case management. Referring to advanced practice roles, it is also noteworthy that Lee et al. (1998) suggested that there are differences in nurses' interpretation of their advanced roles.

### **2.5.10 Skills to support case management**

The literature details a range of professional, clinical and interpersonal skills that are synonymous with advanced practice and case management. Hudson and Moore (2006) clarify that in order for advanced practitioners to reflect on their role transition they must establish new ways of working in the community. This includes moving from a task-oriented approach to a more holistic, patient centred approach.

Robertson and Baldwin (2007) US study of 10 nurses highlight more specific role characteristics, including advocacy and policy setting at organisational, community and state levels, a leadership style centred on empowerment, a broad sphere of influence, and high-level skills in large scale program planning, project management and building partnerships. Similarly Allender and Spradley (2005) illustrate the role of the community nurse case manager as one that engages in planning, organising, leading, controlling and evaluating. Banning (2009) reported that community matrons agreed that it was vital to have good working relationships with other health care professionals, a unique understanding of case management of patients with chronic illness and experience of masters level education and training, to confidently lead the development of new services. The patient success stories described in a study by Elwyn et al. (2008) are attributed to the practice of autonomous, generalist nurse-clinicians, who reviewed medication, made suggestions for changes, arrived at diagnosis, instigated investigations, judged priorities and made recommendations. Similarly, Bernabei et al. (1998) suggest that the reasons for successful case management pertain to the skills of the highly trained community nurse case manager able to use effective assessment techniques.

### **2.5.11 Education and training support requirements for case management**

In order for nurses to acquire the skills to develop the case manager role, the literature identifies a range of knowledge and skills based education that is needed to underpin safe and effective practice. McClaren et al. (1999) suggest that the need for health professionals to learn about and participate in multi-disciplinary care and case management may initially demand an attitudinal change.

In a descriptive research study undertaken in Alberta by Anderson et al. (2001), case managers (n=150) and nurse administrators (n= 39) responded to a questionnaire to identify the perceived learning needs of nurse case managers. Results reported that the case managers valued the need for physical assessment but stated that their current skills were inadequate to meet the needs of their clients. Participants in the study wanted to be more confident about diseases of thorax and lungs, cardiovascular/peripheral vascular systems and abdomen.

An initiative described by Baid et al. (2009) described similar education requirements. Some of the nurses in the study had completed an accredited module about physical assessment in adults' which helped to inform their overall assessment of a person's nursing needs, especially for patients with long-term conditions. It is significant to note that Baid et al. (2009) conclude that despite having completed the module successfully, many community nurses considered themselves to be novices, viewed physical assessment as a new skill and were concerned about making mistakes. This finding suggests that education by itself is not enough and knowledge and skills about patient assessment needs to be embedded into the nurses' practice.

As a case manager, the nurse is involved in the education of the patient and carer to optimise understanding of their condition. Suter et al. (2008) assert that the provision of quality patient education is an essential nursing role and the use of quality research based interventions is pivotal to help patients understand and cope with their chronic disease conditions. Effective patient education will therefore be supported by the nurses' own knowledge base and particularly by their appreciation of current evidence. Referring to the evidence, Ball (2000) concludes that nursing world was never really prepared for the dramatic changes in accessibility, variety, breadth and depth, and the overwhelming potential of the information age. Consequently, Ball (2000) advocates education in advanced technology to empower nurse case managers to competently educate their clients about their particular health issues.

## 2.6 Conclusions

The search for literature about case management highlighted some differences in models selected for implementation. The rationale for model choice were not clearly explored in the studies reviewed; however models did appear to be selected on the basis that they reflected local health priorities and ways of working. Case finding methods which use tools based on algorithms and GP case finding, detect patients who are at most risk of readmission or who have been discharged from hospital. There was less evidence of case finding being used to identify patients who experienced gradual decline as a result of chronic diseases (with the exception of the Nairn Case Finder).

Key components of case management have been identified from the literature that successfully support anticipatory care approaches. Patient assessment is at the centre of anticipatory care and forms the basis for appropriate patient interventions and support strategies. These support strategies include those which facilitate self-management. The evidence from the studies reviewed presents convincing evidence that a range of beneficial outcomes have emerged following implementation of case-management support systems. These systems are wide ranging and include patient education and more frequent contact with patients and carers to provide ongoing support. Outcomes include more positive health related behaviours, for example, improved concordance from patients with lifestyle change and medication, improved patient satisfaction and greater feelings of empowerment and control. Studies also reported a lessening in exacerbation of symptoms as a result of improved disease management. Furthermore, these outcomes have been linked to reductions in hospital admissions with a corresponding reduction in health costs.

Case management is supported by collaborative working practices with all the stakeholders involved in care. Although evidence suggests that collaboration does result in successful outcomes for the patients, implementation and performance of collaborative working practices were under reported in the case studies reviewed. There is growing evidence to suggest that technology and notably the role of telehealth has an increasingly important role to play in supporting case management.

Evidence robustly supports the premise that nurses are effective as case managers. There is evidence to demonstrate how Community Nurses have a pivotal role to play in the effective case management of patients with long-term conditions such as cardiovascular disease, diabetes, depression and chronic respiratory conditions (Allen et al. 2002, Barnett 2006, Blue et al. 2001, Rich et al. 1995, Sutherland and Hayter 2009). Community Nurse case managers can help patients with long-term conditions attain a better quality of life through purposeful interventions that aim to minimise symptoms. Evidence also suggests that patient outcomes include enhanced empowerment and autonomy following effective nurse-led interventions of self-management and education (Sutar et al. 2008, Jaarsma et al. 1999, Minkler 2007, Husbands et al. 2007, Piatt et al. 2006). Importantly it has also been demonstrated that the nurse-patient-carer relationship based on trust is the foundation of co-ordinated care (Hunt 2009).

Additionally, effective case manager roles were underpinned by knowledge and skills that reflected specialist and advanced levels of practice (Hudson and Moore 2006). The concept of the highly experienced nurse is a key feature paramount to effective case management through the new role of advanced practice nurse. To be effective case managers nurses need to develop a range of advanced professional, clinical, interpersonal and managerial skills. These are used to implement and support case management and include skills for patient assessment, care planning, education and coordination of care. Significantly, skills need to be underpinned by relevant knowledge and access to evidence based sources.

## **2.7 Recommendations**

1. Further research that explores the experience for patients and carers who experience nurse case management in the community will inform ways of working.
2. Further research examining the experience of the case manager will help to identify facilitators and barriers to practice.
3. The level of practice for the case manager in the community should be clearly articulated including defining areas of responsibility and accountability.
4. Case managers need to have appropriate education support.
5. To effectively manage patients with long term long term conditions in the community, nurses should be given the opportunity to develop mutual trusting relationships between the patient, carer and family.
6. Patient and carer input should be sought when designing new case management strategies.
7. There is some evidence to suggest that telehealth, which can provide information and disease or symptom monitoring, is a useful adjunct to the nursing management of chronic illness but further research will inform best practice.

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## 2.9Appendix 1 Case Management Literature Review

	3 Reference	3.8 Summary
1	<p>Allen JK., Blumenthal RS., Margolis S., Young DR., Miller ER. &amp; Kelly K. (2002) Nurse case management of hypercholesterolemia in Patients with coronary heart disease: Results of a randomised clinical trial. <i>American Heart Journal</i> 144 (4) 678-686</p>	<p><b>Type of study:</b> Randomised clinical trial  <b>Method:</b> A total of 228 consecutive, eligible adults with hypercholesterolemia and CHD were recruited during hospitalisation after coronary revascularisation. Patients randomised to receive lipid management, including lifestyle modification and pharmacological intervention, from a nurse practitioner for 1 year after discharge in addition to their usual care (NURS), or to usual care enhanced with feedback on lipids to their primary provider (EUC).  <b>Findings:</b> Significantly more patients in the (NURS) group than the (EUC) group achieved low-density lipoprotein cholesterol levels. (NURS) group also showed significant changes in dietary and exercise patterns.  <b>Limitations:</b> USA study. The possibility of a type II error introduced by the conservative methods of the intention-to-treat analysis. The multi-factorial nature of the intervention which limits the ability to draw strong conclusions about which components were most effective.  <b>Key Messages:</b> Nurse case management offers key opportunities to enhance appropriate application of new treatment paradigms.  <b>Themes:</b> patient education, collaboration, interventions, preventive approach</p>
2	<p>Banning M. (2009). Evaluating practice-based learning specific to the community matron role. <i>British Journal of Community Nursing</i> 14 (2) 76-80</p>	<p><b>Type of Study:</b> Qualitative exploratory  <b>Aim:</b> To elucidate the views of nurses training to become community matrons on the current provision of practice-based education and its future development.  <b>Method:</b> Using a focus group approach, 5 community matrons from a London PCT were interviewed to discuss their perception of the community matron's role. The interview lasted for 80 minutes and was digitally recorded and transcribed verbatim. The data was analysed using thematic analysis.  <b>Findings:</b> Community matrons CM's felt that their role was not only developing but becoming multi-faceted as it involved liaising with practitioners from cancer, social, accident and emergency services.  CM's agreed that the role required previous experience, leadership skills, and a knowledge of case management and thorough patient assessment skills.  <b>Limitations:</b> Very small study of only 5 CM's.  <b>Key Messages:</b> Practice-based learning, as a model, has been used to educate and train nurse practitioners in primary care. As a CM nurses are expected to have experience of case management and inter-professional communication.  <b>Themes:</b> nurse education, leadership, collaboration, patient assessment, case management, autonomy.</p>
3	<p>Barnett M. (2006)  Providing anticipatory care for patients with chronic obstructive pulmonary disease. <i>Nursing Standard</i> 21 (9) 41-47</p>	<p><b>Type of Study:</b> Descriptive survey  <b>Method:</b> An initiative pioneered by the Met Office which uses weekly weather forecasts to enable the chronic obstructive pulmonary disease (COPD) outreach team in Plymouth to target patients most at risk of developing exacerbations. During the winter of 2004/2005 eight health authorities used the COPD forecasts. Each COPD member had a caseload of 50-80 patients</p>

		and following the weather forecast emailed twice weekly by the Met Office were responsible for contacting vulnerable patients by telephone or home visits and initiating anticipatory intervention to avoid exacerbations. <b>Findings:</b> Hospital admissions related to COPD were less, potentially resulting in cost savings. Quality of life of patients was improved. <b>Limitations:</b> Small scale study. <b>Key Messages:</b> Implementing anticipatory care in routine clinical practice has been well received by patients known to the service. <b>Themes:</b> anticipatory care, self-management, patient education.
4	Behice E. (2005). Global Case Management: Impact of Case Management on Client Outcomes. Case Management 10 (1) 32-38	<b>Type of Study:</b> Descriptive study <b>Aim:</b> To determine the usefulness of nursing diagnoses, on the basis of the Omaha System Framework, in explaining utilisation of primary health care services. <b>Method:</b> The research included 139 people in 38 families who lived in Erzurum, Turkey. 19 senior nurses undertook case management for a 4 month period and had weekly or bi-weekly encounters with clients. Assessments using the Omaha Classification System were undertaken and frequencies were obtained for all problems identified and interventions determined. <b>Findings:</b> The most common problems identified were in the physiological domain, health-related behaviours domain, psychosocial domain and environmental domain. The Omaha System provides a guiding framework for systematically identifying and addressing a broad range of problems. <b>Limitations:</b> A Small descriptive study undertaken in an underserved, poverty-stricken minority population in Turkey. The participants were poorly educated with limited knowledge on self-care. <b>Key Messages:</b> The study demonstrates that case management using the Omaha System can have a significant impact on outcomes to specific problems. This model provides a more complete tool for measuring patient outcomes. <b>Themes:</b> health education, guidance, counselling, treatments and procedures, case management, surveillance.
5	Bergen A. (1997). The Role of Community Nurses as Care Managers. British Journal of Community Health Nursing. 2 (10) 466-471	<b>Type of Study:</b> Qualitative Exploratory. <b>Aim:</b> To identify the current and potential relevance and value of care management to community nursing and its clientele. <b>Method:</b> Data were collected by telephone surveys, detailed questionnaire and 13 in-depth case studies following provisional findings. <b>Findings:</b> Community nurses have the potential to develop the care management role. Effective team working is a feature of good practice, especially in multidisciplinary care management. All respondents anticipated a future that is likely to be very different from the present. <b>Limitations:</b> Small sample size highlighting a diversity of views among community nurses. Historical research study. <b>Key Messages:</b> Nurses have made valuable contributions to the evolution of care management in the UK but need to be prepared educationally and experientially for the future. <b>Themes:</b> assessment, care planning, care delivery, collaboration, budgetary issues, role specific preparation, ethical issues.
6	Bergen A. (2003) Case management revisited: a follow-up study. British Journal of Community Nursing 8 (1) 16-23	<b>Type of Study:</b> Longitudinal research. <b>Aim:</b> To determine the viability of care management as a practice model for community nursing. <b>Method:</b> 54 responses received to the follow-up questionnaire from managers responsible for community mental health nursing, district nursing and community learning disability nursing. Response rate was 73% of the original sample. Analysis of data comprised a simple summation of the responses in each category to the different questions. <b>Findings:</b> About ¾ of community nurses were still acting as care managers. There was a rise in number of community health

		<p>care managers. Where posts had been discontinued, reasons given were primarily due to policy changes. Half of the responses indicated possible future expansion of the community care manager role. There was still (5 years later) much variation in the interpretation of the terms "case management" and "care management"</p> <p><b>Limitations:</b> The time lag between the collection of data in the original research study and the presentation of findings leads to the question of the reliability of this study. The potential for change in the nurse/client relationship may alter, or even militate, against the practice of care management as conceived in this study.</p> <p><b>Key Messages:</b> Care management has had a somewhat chequered history over the last 10 years, however, the purpose to ascertain the viability of care management as a practice model for community nurses, within the confines of this study, has been met.</p> <p><b>Themes:</b> nurse-patient relationship, nurse-led care management, change management, collaboration, autonomy.</p>
7	<p>Bemabei R., Landi F., Gambassi G., Sgadari A., Zuccala G., Mor V., Rubenstein L.Z. &amp; Carbonin P. (1998) Randomised trial of impact of model integrated care and case management for older people living in community. BMJ 316 (7141) 1348-1351</p>	<p><b>Type of Study:</b> Randomised study with 1 year follow-up.</p> <p><b>Aim:</b> To evaluate the impact of a programme of integrated social and medical care among frail elderly people living in the community.</p> <p><b>Method:</b> In Rovereto, Northern Italy, all people over the age of 65 who were recipients of home health care were identified. 200 subjects were randomly stratified by age and sex according to a computer generated list. 100 subjects (control group) received primary and community care with the conventional organisation of services. 100 subjects (intervention group) received case management and care planning. Assessments were performed and patients were evaluated with a modified version of the British Columbia long term care application programme, measuring physical function, activities of daily living, cognitive function, depression, diagnoses and drug treatments. The multi-disciplinary team discussed problems emerging from home visits on a weekly basis.</p> <p><b>Findings:</b> In the control group all functional indices deteriorated. In the intervention group less consistent changes were observed. The adjusted mean number of medications was reduced in the intervention group.</p> <p><b>Limitations:</b> Italian study. Because of the nature of the intervention all professionals were aware of the assignment of patients to either group. General practitioners who followed both control and intervention groups may have introduced a contamination bias.</p> <p><b>Key Messages:</b> The study shows that an integrated community care programme implemented by an interdisciplinary team including a general practitioner and case manager reduced the risk of hospital admission and length of stay in hospital or nursing home.</p> <p><b>Themes:</b> assessment, collaboration, education.</p>
8	<p>Blaha C., Robinson JM., Pugh LC., Bryan Y. &amp; Havens DS. (2000) Longitudinal Nursing Case Management for Elderly Heart Failure Patients: Notes from the Field. Nursing Case Management 5 (1) 32-36</p>	<p><b>Type of Study:</b> Randomised Clinical Trial</p> <p><b>Aim:</b> To test the effectiveness of the Partners – in – Care (PIC) Model using the approach of longitudinal case management for elderly heart failure patients.</p> <p><b>Method:</b> 58 patients were randomly assigned to a treatment or usual care group. The PIC control group received standard care whereas the PIC treatment group (n=27) received enhanced discharge planning and longitudinal nursing case management for a period of 6 months. Patients and family members were interviewed, collaboration with other healthcare providers was initiated. Teaching programmes were individualised to meet patients needs. There was a minimum of 5 visits and 8 phone calls.</p> <p><b>Findings:</b> Recurring patient issues that emerged were fear, knowledge deficit related to living with heart failure and insecurity about reporting symptoms that could lead to hospitalisation.</p>

		<p><b>Limitations:</b> Small study conducted in USA. Limited information with regard to methodology and data analysis.</p> <p><b>Key Messages:</b> While longitudinal case management is becoming increasingly common in healthcare settings, very little has been written about issues encountered during the actual implementation of this follow-up care. These issues can be overcome through education and by mobilising support systems and resources available to patients.</p> <p><b>Themes:</b> patient education, collaboration, self-care, self-management, nurse/patient relationship.</p> <p><b>Type of Study:</b> Randomised Controlled Trial.</p> <p><b>Aim:</b> To determine whether specialist nurse intervention improves outcomes in patients with chronic heart failure.</p> <p><b>Method:</b> Patients admitted as an emergency to the Western Infirmary, Glasgow, with heart failure due to left ventricular systolic dysfunction were eligible for the study. Those who gave consent were randomised to usual care (n=81) or nurse intervention (n=84). Nurse intervention included home visits, telephone contact, education re heart failure and treatment, teaching of self monitoring and management, liaising with other health professionals.</p> <p><b>Findings:</b> By discharge, more patients in the intervention group than the usual care group had started an angiotensin converting enzyme inhibitor and stopped a calcium channel blocker. Length of hospital stay was shorter in the intervention group. Fewer patients had events in the nurse intervention group and death or re-admission was also reduced.</p> <p><b>Limitations:</b> Small Study undertaken in Scotland before there was good evidence to support the general use of beta-blockers for heart failure.</p> <p><b>Key Messages:</b> Home visiting and education of heart failure patients seems to be pivotal to reducing hospital admissions.</p> <p><b>Themes:</b> nurse/patient relationship, education, nurse intervention.</p>
9	Blue L., Lang E., McMurray JJV., Davie AP., McDonagh TA., Murdoch DR., Petrie MC., Connolly E., Norrie J., Round CE., Ford I. & Morrison CE. (2001). Randomised controlled trial of specialist nurse intervention in heart failure. BMJ 323 715-718	<p><b>Type of Study:</b> Descriptive study.</p> <p><b>Aim:</b> To show the impact of school nurse led case management on 5 target areas - attendance, behaviour, academic performance, quality of life and health compliance the large south-eastern urban district of Scarborough.</p> <p><b>Method:</b> Data were collected through a retrospective review of health records of all students who received school nurse case management according to a newly developed policy.</p> <p><b>Findings:</b> In the 4 year review of data 84% of the students case managed in the district showed improvement in at least one of the five target areas.</p> <p><b>Limitations:</b> No control group. Research methodology unclear. A standard quality of life tool, would have provided more reliable data.</p> <p><b>Key Messages:</b> This project highlighted the need for school nurse case management and outlines the steps for case finding, needs assessment, interventions, referral and collaboration.</p> <p><b>Themes:</b> Education, collaboration,</p>
10	Bonaiuto MM. (2007) School Nurse Case Management: Achieving Health and Educational Outcomes. The Journal of School Nursing 23 (4) 202-210	<p><b>Type of Study:</b> Case-control group design.</p> <p><b>Aim:</b> To compare the outcomes of case management service with that of the conventional Community Psychiatric Nurse Service (CPNS) for chronic schizophrenic clients living in Hong Kong.</p> <p><b>Method:</b> Clients who were new to the CPNS were chosen and randomly assigned to case (n=31) and control (n=31) groups. All case managers and the control group CPNS were required to record their care activities weekly. Assessment of both groups took place at time of selection and 5 months later by using the following instruments – The Brief Psychiatric Rating Scale, The Specific level of Functioning Scale, client's satisfaction and readmission rate.</p> <p><b>Findings:</b> results showed that clients in the experimental group had more improvement in their mental status and their level of functioning when compared with the control group.</p>
11	Chan S., MacKenzie A., Tin-Fu Ng D. & Ka-yi Leung J. (2008) An evaluation of the implementation of case management in the community psychiatric nursing service. Journal of Advanced Nursing 31 (1) 144-156	

		<p><b>Limitations:</b> Hong Kong study. It could be argued that the improvement in the experimental group may be due to the increased frequency of visits by the case managers. Relatively short intervention period. More female participants so one may argue that male subjects could have a different response to case management.</p> <p><b>Key Messages:</b> The use of the case management model appears to have a positive impact on this vulnerable group. The case manager's role included assessment, planning, co-ordinating, monitoring and evaluating.</p> <p><b>Themes:</b> patient/nurse relationship, trust and support, collaboration, assessment.</p> <p><b>Type of Study:</b> Secondary analysis of the hospital records documented by community nurses for the study-group patients. Original study design was a randomised controlled trial.</p> <p><b>Aim:</b> To examine community nursing services for patients with cardiovascular diseases, chronic respiratory diseases and other general medical conditions, making the transition from hospital to home.</p> <p><b>Method:</b> 46 subjects were obtained from the intervention group with 15 – 16 records randomly selected from each disease group. Home assessments were undertaken and hospital records analysed using the Omaha System.</p> <p><b>Findings:</b> Community nursing services did not vary across the 3 patient groups in the 4 home visits. The respiratory and cardiovascular group patients reported general improvements in self-reported health.</p> <p><b>Limitations:</b> Hong Kong study.</p> <p><b>Key Messages:</b> Advanced Practice Nurses (APN's) effected an improvement in patient outcomes, provided high-quality health-care services while controlling health- care costs. The results of this study show the benefits of health teaching, counselling and case management with discharge planning in enhancing the effectiveness of community nurse interventions.</p> <p><b>Themes:</b> assessment, Omaha system, APN's, self-reported health, collaboration and communication.</p>
12	Chow S., Wong F., Chan T., Chung L., Chang K. & Lee R. (2008) Community nursing services for post-discharge chronically ill patients. Journal of Clinical Nursing 17 (7b) 260-271	<p><b>Type of Study:</b> Multiple case study design.</p> <p><b>Aim:</b> To investigate the changing educational needs of community nurses with regard to needs assessment.</p> <p><b>Method:</b> 4 cases were identified, incorporating the geographical variation in England. Recently qualified practitioners were observed during a regular shift (n=134 visits), concentrating on their practice of assessing needs, and on liaison and collaboration within teams. Participants were interviewed after the observation period.</p> <p><b>Findings:</b> The variable and multi-faceted nature of needs assessment was reflected in data across all four cases.</p> <p><b>Limitations:</b> UK study. Small study. Good information about data analysis. The practitioners generally recognised the complexity of assessing the needs they encountered, acknowledging that their own perceptions and levels of ability were some of the variables which helped to add to the confusing diversity.</p> <p><b>Key Messages:</b> This study has highlighted the changing educational needs of community nurses with regard to needs assessment. The challenge for education, is to prepare practitioners to be able to identify the purpose and type of assessment required.</p> <p><b>Themes:</b> assessment, communication, patient/client and family relationship, trust, collaboration,</p>
13	Cowley S., Bergen A., Young K. & Kavanagh A. (2000) A taxonomy of needs assessment, elicited from a multiple case study of community nursing education and practice. Journal of Advanced Nursing 31 (1) 126-134	<p><b>Type of study:</b> Audit</p> <p><b>Aim:</b> To improve depression outcomes in primary care, using collaborative care models.</p> <p><b>Method:</b> Practice nurses, in the North East of England running depression case management services, collected data on 161 newly diagnosed depressed patients. Routine data were collected from clinical records and patient satisfaction was assessed using a questionnaire. Results were benchmarked against appropriate randomised trial data.</p> <p><b>Findings:</b> 64% of patients were very satisfied with service, 95% of Gp's used the service and supported its continuation. 55% of people had a 50% reduction in symptoms.</p>
14	Ekers D. & Wilson R. (2008) Depression case management by practice nurses in primary care: an audit. Mental Health in Family Medicine 5 111-119	

		<p><b>Limitations:</b> Audit. Non-randomised sample that accepted the intervention when offered. No control group. Incomplete data collection.</p> <p><b>Key Messages:</b> Depression case management can be effectively delivered by nurses, following brief training, with results similar to those seen in randomised controlled trials.</p> <p><b>Themes:</b> Care collaboration, needs assessment, patient/nurse relationship, education,</p> <p><b>Type of Study:</b> Qualitative exploratory.</p> <p><b>Aim:</b> To answer the research questions: 1. To what extent do practice nurses use the 5 cyclical element of a case management approach when caring for people over the age of 65? 2. What determines or deters the use of the 5 elements of a case management approach?</p> <p><b>Method:</b> A random sample of 500 practice nurses was selected from the Royal College of Nursing Practice Nurse Association member database. A 26-item structured postal questionnaire was used to explore both practice nurses' use of a case management approach when working with older people, and what factors influenced the care provided.</p> <p><b>Findings:</b> 45% response rate. Practice nurses appeared to assess, plan and implement care, but reviewing medication opportunistically and evaluating care was uncommon. The extent to which practice nurses used elements of a case management approach was highly variable.</p> <p><b>Limitations:</b> Small UK study undertaken in Camden and Islington NHS Trust.</p> <p><b>Key Messages:</b> The need to develop systematic approaches to providing proactive care to older people in primary care is evident. Nurses' professional expertise in assessing and planning care, and their frequent and on-going contact with older people places them in a position to develop their practice to act as case managers. This leadership role would require acknowledgement, education and support.</p> <p><b>Themes:</b> assessment, education, autonomy, care collaboration, leadership.</p>
15	Evans C., Drennan V. & Roberts J. (2005). Practice nurses and older people: a case management approach to care. Journal of Advanced Nursing 51 (4) 343-352	<p><b>Type of Study:</b> Qualitative evaluation study.</p> <p><b>Aim:</b> To assess the patient experience of the care provided and to examine the efficiency of this management method of people with complex needs through evaluation of the Nairn Anticipatory Care Project (NACP).</p> <p><b>Method:</b> Semi-structured face-to-face interviews with patients who had been involved with the NACP to ascertain views, experiences and expectations. Interviews were also undertaken with members of the Nairn ACT and health and social care professionals. Interviews recorded and transcribed verbatim. Analysis was conducted using appropriate qualitative analysis techniques and software.</p> <p><b>Findings:</b> From the patients' perspective all interviewed stated that they benefited practically, emotionally or practically and emotionally from the NACP. Positive outcomes in all areas studied. Good evaluation.</p> <p><b>Limitations:</b> Wider evaluation of proactive and reactive anticipatory care in Scotland is required to make strong evidence-based conclusions on how to develop these community based services for a range of different populations.</p> <p><b>Key Messages:</b> The Nairn Anticipatory Care Project shows one possible model for how community based anticipatory care and support services could be developed.</p> <p><b>Themes:</b> Anticipatory care, collaborative care, patient/ nurse relationship, trust, assessment, support,</p> <p><b>Type of Study:</b> Randomised controlled trial</p> <p><b>Aim:</b> To compare the effects of nurse case management with usual care provided to community-dwelling frail older people in regard to quality of life, satisfaction with care, functional status, admission to hospital, length of hospital stay and readmission</p>
16	Gallacher M. & Ireland E. (2008) Evaluation of the Nairn Anticipatory Care Project. Cancer Care Research Project. University of Stirling. <a href="http://www.cancercare.stir.ac.uk">www.cancercare.stir.ac.uk</a>	
17	Gangon A., Schein CN., McVery LN. & Bergman H. (1999) Randomised controlled trial of nurse	

	case management of frail older people. Journal of American Geriatrics Society. 47 (9) 1118-1124	<p>to emergency department.</p> <p><b>Method:</b> 427 frail older people at risk for hospital re-admissions were randomised into the nurse case management group (NCM) n=212 and the usual care group n=215. 4 nurses with a minimum of 2 years geriatric experience were hired as full-time case managers. Outcomes were assessed 10 months post-randomisation by telephone or home interview and by medical record review and questionnaire.</p> <p><b>Findings:</b> No significant differences were found in quality of life, satisfaction with care, functional status, admission to hospital, or length of hospital stay.</p> <p><b>Limitations:</b> American study. Inclusion/exclusion criteria were not sensitive enough to identify the optimal population for NCM. The intervention was not strong enough. 10 months was too short. Nurse case managers were given only 24 hours training.</p> <p><b>Key Messages:</b> Effects of specific nursing activities need to be examined in addition to broadly defined nursing interventions.</p> <p><b>Themes:</b> assessment, collaboration, nurse education, patient/nurse relationship, leadership, autonomy, self-care</p>
18	Gravalle H., Dusheiko M., Sheaff R., Sargent P., Boaden R., Pickard S., Parker S. & Roland M. (2007) Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data. <i>BMJ</i> 31 (6) 334-341	<p><b>Type of Study:</b> Practice level before and after analysis of hospital admissions data with control group.</p> <p><b>Aim:</b> To determine the impact of outcomes in patients of the Evercare approach to case management.</p> <p><b>Method:</b> Evercare Intervention pilots started in 9 primary care trusts in England in 2003 and ran to 2005. The control group was all other practices in England which varied between 6960 and 7695. Regression and matching analysis was undertaken.</p> <p><b>Findings:</b> The intervention had no significant effect on rates of emergency admission, emergency bed days, and mortality.</p> <p><b>Limitations:</b> A randomised controlled trial was not performed. Poor selection methodology of control group. A negative study showing weakness in every area.</p> <p><b>Key Messages:</b> Ineffective research</p>
19	Guttman R. (1999) Case Management of the Frail Elderly in the Community. Clinical Nurse Specialist 13 (4) 174-178	<p><b>Type of Study:</b> Qualitative exploratory study.</p> <p><b>Aim:</b> To describe the most salient aspects of nursing care as practiced by the case manager within the framework of case management.</p> <p><b>Method:</b> A random sample of frail elderly patients, discharged from the emergency dept. within the previous 6 months, were recruited for the study. 4 nurses were hired as nurse case managers. Each case manager followed 45 to 50 elderly clients for a period of 6-8 months. Themes that emerged in caring for elderly clients were illustrated.</p> <p><b>Findings:</b> From the case studies it was found that Nurse/patient relationship developed over the duration of the study enhanced by home visits and telephone contact. Continuity of care was achieved. Nursing interventions served as the impetus to engage the client. The contribution of the case manager to the patients' healthcare team was invaluable to promoting professional and service collaboration. Preventive approach by advanced nurse practitioners proved effective.</p> <p><b>Limitations:</b> Canadian study. The nurse case managers were "on call" for the clients. This may not be financially feasible in non-research situations.</p> <p><b>Key Messages:</b> The advantages of Nursing case management, are knowledge of client health and social status before crisis, relationship built between nurse and client in stable situation affording a trusting relationship in event of crisis, lack of institutional barriers, nursing coordinated across healthcare continuum and access to patient information.</p> <p><b>Themes:</b> Preventive approach, collaborative care, team facilitator, nurse/patient relationship, trust, education, client advocacy.</p>
20	Husbands W., Browne G., Caswell J., Buck D., Braybrook D., Roberts J., Gafni A. & Taylor A. (2007) Case management community care for	<p><b>Type of Study:</b> A prospective single blind randomised trial.</p> <p><b>Aim:</b> To assess which group of PLHAs, case management or self-directed access to support services, benefited most.</p> <p><b>Method:</b> 79 PLHAs (69 men and 10 women) were randomised to one of the 2 study groups. The control group received the usual care and self-directed use of support services program at the clients request. The experimental group received self-</p>

	people living with HIV/AIDS (PLHAs) AIDS Care 19 (8) 1065-1072	<p>directed use of services augmented by case management using a strengths based model, which empowers the individual to achieve their goals. The social support questionnaire was used and depression scale. Risk behaviour assessment tool was also utilised. Data were analysed using descriptive statistics.</p> <p><b>Findings:</b> The very depressed PLHAs in the case management group had a 31% improvement in their mental health compared to a 1% deterioration in the control group. 45% improvement in social function was achieved in the case management group compared with 27% deterioration in the control group. The case management group was also cost-effective.</p> <p><b>Limitations:</b> A very small Canadian study. Very small female sample, therefore it may be inappropriate to generalise results.</p> <p><b>Key Messages:</b> Strengths-based Case Management for PLHAs can be an effective and cost effective way to increase access to available services and to improve quality of life for the very depressed.</p> <p><b>Themes:</b> strengths-based case management model, assessment, collaborative care, quality of life,</p>
21	Jaarsma T., Halfens R., Huijter Abu-Saad H., Dracup K., Gorgels T., Van Ree J. & Stappers J. (1999) Effects of education and support on self-care and resource utilisation in patients with heart failure. European Heart Journal 20 (9) 632-633	<p><b>Type of Study:</b> Exploratory study.</p> <p><b>Aim:</b> To test the effect of education and support by a nurse on self-care and resource utilisation in patients with heart failure.</p> <p><b>Method:</b> 179 patients hospitalised with heart failure were evaluated prospectively. Patients were randomised to the study intervention or "care as normal" groups. The supportive educative intervention consisted of intensive, systematic and planned education by a study nurse about the consequences of heart failure in daily life, using a standard nursing care plan. Education and support took place within a week of discharge as a home visit. Data were collected of self-care abilities, self-care behaviour, readmissions, visits to emergency dept and use of other health resources.</p> <p><b>Findings:</b> Education and support from a nurse in the hospital and home setting significantly increases self-care behaviour within 1 month of discharge.</p> <p><b>Limitations:</b> Small study – Netherlands</p> <p><b>Key Messages:</b> Organisational change such as longer follow-up would probably enhance the effects of education and support.</p> <p><b>Themes:</b> Specialist nurse, education, self-care.</p>
22	Jo Vetter M., Bristow L., Aprm BC. & Ahrens J. (2004) A Model for home care clinician and home aide collaboration: Diabetes care by nurse case managers and community health workers. Home Healthcare Nurse 22 (9) 645-648	<p><b>Type of Study:</b> Randomised clinical trial.</p> <p><b>Aim:</b> To determine whether multifaceted, culturally sensitive, primary care-based behavioural interventions implemented by a nurse case manager and/or community health worker could improve diabetes control.</p> <p><b>Method:</b> The study sample consisted of 186 African American adults in East Baltimore with type 2 diabetes. 149 completed the 2 year study. 77% female. Patients were randomly assigned into one of 4 groups. Control group receiving usual care. 3 intervention groups –1. Nurse case management group (NCM) + usual care. 2. Community Health Worker group (CHW) + usual care. 3. NCM + CHW Group + usual care.</p> <p><b>Findings:</b> The greatest improvements were seen with combined nurse case management and community health worker group 3 possibly due to home visits to facilitate preventive care.</p> <p><b>Limitations:</b> Small sample size limiting the ability to reach statistical significance in results. There was a wide variability in the elapsed time between baseline and 2 year data collection.</p> <p><b>Key Messages:</b> The integration of nurse case management and community health workers into the primary care setting can produce improvements in diabetic control and reduce excess burden of diabetes-related complications in African Americans.</p> <p><b>Themes:</b> Education, self-care, collaborative care,</p>
23	Kennedy C., Christie J., Harbison J., Maxton F., Rutherford I. & Moss D.	<p><b>Type of Study:</b> Integrative literature review.</p> <p><b>Aim:</b> To explore the evidence base for nursing in the community.</p>



	(2008) Establishing the contribution of nursing in the community to the health of the people of Scotland: integrative literature review Journal of Advanced Nursing 64 (5) 416-439	<p><b>Method:</b> Extensive literature search to find suitable systematic reviews and quantitative and qualitative papers for review with regard to community nurses' contributions to the health of the people.</p> <p><b>Findings:</b> 73 papers met the inclusion criteria. None merited a "high" quality rating. Results were organised under 5 headings</p> <ol style="list-style-type: none"> <li>1. Anticipatory care.</li> <li>2. Managing long-term conditions.</li> <li>3. Managing hospital admissions and discharges.</li> <li>4. Supporting informal carers.</li> <li>5. Reducing health inequalities.</li> </ol> <p><b>Limitations:</b> Scottish study.</p> <p><b>Key Messages:</b> There is little research evaluating the impact of community nursing.</p> <p><b>Themes:</b> assessment, collaborative care, trusting relationships, nurse-led intervention, anticipatory care.</p>
24	Krumholz HM., Amatruda J., Smith GL., Mattera JA., Roumanis RN., Radford MJ., Crombie P. & Vaccarino V. (2002) Randomised trial of an education and support intervention to prevent re-admission of patients with heart failure. Journal of the American College of Cardiology 39 (1) 83-89	<p><b>Type of Study:</b> Prospective, randomised trial.</p> <p><b>Aim:</b> To determine the effect of a targeted education and support intervention on the rate of re-admission or death and hospital costs in patients with heart failure (HF)</p> <p><b>Method:</b> 88 patients were randomised into 2 groups (44 intervention + 44 control) The study intervention was based on 5 sequential care domains for chronic illness, including patient knowledge of the illness, the relations between medications and the illness, the relation between health behaviours and illness, knowledge of early signs and symptoms of de-compensation and when and where to obtain assistance. Home visits were undertaken and regular phone contacts along with face-to-face in depth educational sessions.</p> <p><b>Findings:</b> Fewer patients in the treatment group experienced readmission or death.</p> <p><b>Limitations:</b> Small sample size. Analysis did not account for all costs.</p> <p><b>Key Messages:</b> Education and support intended to prompt patient participation in the management of chronic illness has independent effects on markedly reducing poor outcomes.</p> <p><b>Themes:</b> Education, patient/nurse relationship, self-care management,</p>
25	Long MJ. & Marshall BS. (1999) Case management and the cost of care in the last month of life: evidence from one managed care setting. Health care management review. 24 (4) 45-53	<p><b>Type of Study:</b> Randomised trial.</p> <p><b>Aim:</b> to examine the difference in the use and cost of care in the last month of life between functionally impaired elderly adults assigned to a case manager or to regular care.</p> <p><b>Method:</b> 317 enrollees in the Kaiser Permanente Medical care Program, Ohio, who were 75 years and over, were randomly assigned to a regular care group (RC) or a case managed group (CM) . Severe functional disability was measured. During the 2 year study period 34 clients in the CM group and 43 clients in the RC group died. This study was confined to these 77 subjects. The case management model employed in the study concentrated on team development and patient advocacy.</p> <p><b>Findings:</b> Use of this case management model resulted in higher use and cost of care.</p> <p><b>Limitations:</b> Ohio study. Small numbers of clients in each group made it difficult to achieve statistical significance and precluded analysis of costs that incorporated all of the independent variables.</p> <p><b>Key Messages:</b> Organisations planning to introduce case management as a cost-saving tool must be sensitive to the varying dynamics of the different case management models and implement a model that is consistent with this desired outcome.</p> <p><b>Themes:</b> patient advocacy,</p>
26	Malone SB., Workneh F., Butchart J. & Clark C. (1999) Team case management of chronically mentally ill veterans: a group therapy approach.	<p><b>Type of Study:</b> Qualitative exploratory study.</p> <p><b>Aim:</b> To determine if a team case management model using a group therapy approach can improve the lives of chronically mentally ill veterans.</p> <p><b>Method:</b> 275 enrolled in the case management system attended weekly groups led by 2/3 interdisciplinary staff, over a three year period. The group approach was utilised to promote self-discovery, self-realisation and self-direction.</p>

	Nursing Case Management 4 (3) 158	<p><b>Findings:</b> Patient participation in the case management group has achieved some gratifying results. They have become more compliant with medication, which has reduced the use of inpatient services. Quality of life has improved. Patients became more pro-active in their own treatment.</p> <p><b>Limitations:</b> Unclear methodology.</p> <p><b>Key Messages:</b> The case management model has improved the lives of those enrolled by improving quality of life, medication and treatment compliance, social relationships and general well-being.</p> <p><b>Themes:</b> Patient advocacy, self-care management, patient/nurse relationship, quality of life, collaborative care</p>
27	McClaran J., Lam Z., Franco E. & Snell L. (1999) Can case management be taught in a multi-disciplinary forum? The Journal of Continuing Education in the Health Professions 19 181-191	<p><b>Type of Study:</b> Quantitative exploratory.</p> <p><b>Aim:</b> To determine if perceptions of importance of the case management approach can be enhanced using an educational module designed for multidisciplinary teams and if change perception varies by profession and other selected characteristics.</p> <p><b>Method:</b> 8 Teams of professionals participated in an on-site workshop on case management. (n=50). Visual analogue scales measured pre and post-workshops perceptions of 4 components – assessing patient/family needs, educating patients and caregivers, linking to community agencies, and monitoring costs and developing alternative care plans.</p> <p><b>Findings:</b> Following statistical analysis it was found that educational modules suitable for multidisciplinary teams that address the case management approach can be designed and carried out and can affect educational outcomes.</p> <p><b>Limitations:</b> Small study. No control group. The ceiling effect inherent to visual analogue scales limits their ability to reflect degrees of improvement where baseline values are particularly high relative to other elements.</p> <p><b>Key Messages:</b> The need for health professionals to learn about and participate in multidisciplinary care and in the case management approach may initially need/demand an attitudinal change, with subsequent professional empowerment and change through case management education.</p> <p><b>Themes:</b> education, empowerment, assessment, collaboration</p>
28	MacKenzie A., Lee DTF., Dudley-Brown S. & Chin TM. (1998) Case management in Hong Kong: evaluation of a pilot project in community nursing. Journal of Clinical Nursing 7 291-292	<p><b>Type of Study:</b> Quantitative and qualitative Evaluation study.</p> <p><b>Aim:</b> To evaluate both the processes and the outcomes of the introduction of case management (CM) in two pilot centres in Hong Kong.</p> <p><b>Method:</b> A descriptive correlational design was used to assess and evaluate outcome variables from patients and carers. Outcomes measured using sickness impact profile (SIP), cost of care index (CCI), patient satisfaction scale, re-admission rates. Qualitative descriptive data were obtained by interviews, activity sheets and diaries. Convenience sample comprising 11 nurses acting as case managers, 2 nurses acting as case co-ordinators, 55 patients and 40 family carers.</p> <p><b>Findings:</b> Using t-tests for independent groups the SIP showed significantly lower scores and therefore less sickness following case management and no significant difference in CCI. Re-admission rates reduced in CM group. Qualitative analysis portrayed that case managers perceived CM as being of benefit to patients, particularly in areas of relationships, assessment, and continuity of care. Case managers felt greater autonomy and greater satisfaction with their role.</p> <p><b>Limitations:</b> Small study. Hong Kong. No randomisation of sample.</p> <p><b>Key Messages:</b> Implementing this case management model had benefits for patients and nurses.</p> <p><b>Themes:</b> assessment, patient/nurse relationship, collaboration, autonomy, satisfaction,</p>
29	McEvoy P. & Barnes P. (2007) Using the chronic care model to tackle depression among older adults who have long-term physical conditions.	<p><b>Type of Study:</b> Qualitative, exploratory case study approach.</p> <p><b>Aim:</b> To determine the effectiveness of using the chronic care model to tackle depression among older adults to tackle depression.</p> <p><b>Method:</b> Case study to illustrate some of the typical problems that arise when services that have an acute orientation deal with</p>

	Journal of Psychiatric and Mental Health Nursing 14 (3) 233-238	<p>patients who have long-term conditions.</p> <p><b>Findings:</b> Utilising the chronic care model as an approach to quality improvement and service redesign emphasising the engagement of patients as active partners in the management of their conditions, using evidence-based protocols, adequate information services, and community resources demonstrated significant improvements in outcomes.</p> <p><b>Limitations:</b> I case study, which highlighted problems of not using the chronic care model as a form of case management.</p> <p><b>Key Messages:</b> The World Health Organisation has endorsed the Chronic Care Model.</p> <p><b>Themes:</b> assessment, collaboration, autonomy, pro-active self-care management.</p>
30	Mistiaen P., Duijnhouwer E., Prins-Hoekstra A., Wynand R. & Blaylock A. (1999) Predictive validity of the BRASS index in screening patients with post-discharge problems. Journal of Advanced Nursing 30 (5) 1050-1056	<p><b>Type of Study:</b> Quantitative, descriptive, but used statistical analysis.</p> <p><b>Aim:</b> To test the predictive validity of the BRASS index (Baylock Risk Assessment Screening Score) in screening patients with post-discharge problems.</p> <p><b>Method:</b> 503 elderly patients were screened at admission with the BRASS index. Length of stay and discharge destination were measured on discharge in these same patients. Outcomes after discharge were gathered only in patients who were discharged home and with length of stay of more than 3 days (n=226); outcomes were measured by postal questionnaire at day 7 and day 30 after discharge.</p> <p><b>Findings:</b> Patients identified by the BRASS index as high risk are frequently not discharged home and have a longer length of stay. The BRASS scores correlate significantly with the outcome scores after discharge.</p> <p><b>Limitations:</b> Small study in Amsterdam. The sensitivity of the BRASS index was found to be low. The research has not investigated whether the BRASS index is more effective in particular groups of patients.</p> <p><b>Key Messages:</b> The expectations concerning the validity of the BRASS index were supported. The BRASS index is a good assessment tool for case finding. It contains 10 items – age, living situation, functional status, cognition, behaviour pattern, mobility, sensory defects, previous admissions, active medical problems and drugs. The instrument recommends that all patients with a score above 10 should be referred to the discharge planning team.</p> <p><b>Themes:</b> assessment, collaboration.</p>
31	Morales-Asencio JM., Gonzalo-Jimenez E., Martin-Santos F.J., Morilla-Herrera J.C., Celdraan-Manas M., Millan Carrasco A., Garcia-Arrabal J.J. & Toral-Lopez I. (2008) Effectiveness of a nurse-led case management home care model in Primary Health Care. A quasi-experimental, controlled, multi-centre study. BMC Health Services Research 8 (193) <a href="http://www.biomedcentral.com/1472-6963/8/193">http://www.biomedcentral.com/1472-6963/8/193</a>	<p><b>Type of Study:</b> Quasi-experimental, controlled, non-randomised, multi-centre study.</p> <p><b>Aim:</b> To determine the effectiveness of a new case management based, home care delivery model, which has been implemented in Spain.</p> <p><b>Method:</b> 463 subjects, patients and caregivers initiating the home care (HC) programme including terminally ill, dependent, immobile patients who require assistance for their daily activities, recently discharged patients requiring home care and main caregivers for any patients described in the previous subgroups formed the 2 groups – control group receiving care from community nurses and GP's and the intervention group receiving the same care supplemented by nurse-led case management with telephone pro-active follow-up. Data were compiled through a sheet designed <i>ad hoc</i> by the case management nurse and information from the healthcare centre in the intervention group. Data from the control group were gathered by telephone surveys and self-completing questionnaires. Data were analysed using descriptive statistics bivariate and multivariate analysis.</p> <p><b>Findings:</b> By incorporating a model based on case management for the delivery of home care services by specifically trained nurses the study has verified that the hypothesis that health outcomes for patients and caregivers can be enhanced. The study highlights that recovery of patients' ability to perform essential activities of daily living is significantly greater among patients receiving case management. Case management seems to rationalise the use of services by bringing providers into the home care setting.</p> <p><b>Limitations:</b> Small sample size. A complex data compilation process and different procedures used to obtain data from each</p>

		group may have led to differences in handling assessment criteria. <b>Key Messages:</b> A home care service model that includes nurse-led case management streamlines access to healthcare services and resources, while impacting positively on patients' functional ability and caregiver burden, with increased levels of satisfaction. <b>Themes:</b> assessment, planning, collaboration, advocacy, <b>Type of Study:</b> Descriptive, evaluative study.
32	Moran G., Coleman V., Heaney S. & Willocks F. (2008) An alternative model for case management in Flintshire. British Journal of Community Nursing 13 (5) 227-231	<b>Aim:</b> To evaluate the Flintshire model of care – a hybrid model possessing elements of both the Castlefields and Evercare models, focussing on nurse-led case management with the aim of improving quality of life, promoting self-management and reducing the pressure on acute trusts. <b>Method:</b> Cases for the nurse case manager intervention were, in phase 1, identified pro-actively through retrospective secondary case sourced data. In phase 2, after an evaluative process, it was recognised that the benefits of case management should be extended if patients were seen before an emergency or unplanned admission occurred, and the acceptance criteria were therefore adapted to include referrals and an assessment of those recently discharged from hospital. Medical Outcome Study (MOS) Short-form-12, which has 8 scoring domains, was utilised to score on general health, role physical, physical functioning, body pain, vitality, social functioning, role emotional and mental health. <b>Findings:</b> The statistical package for social sciences was used to analyse the data from 116 patients. The results indicate that the patients with whom this service works comprise a subgroup of older people. There was a reduction in the number of emergency admissions and length of stay. <b>Limitations:</b> Small study. Unclear methodology. Randomised controlled study is required. <b>Key Messages:</b> Models of primary care case management can and should be adapted to meet local needs. The Flintshire case management model is showing promising results. <b>Themes:</b> assessment, collaboration,
33	Morgans J. (2006) Case Management to cut non-elective admissions. Community Practitioner 79 (4) 133	<b>Type of Study:</b> Evaluation of pilot study. <b>Aim:</b> To reduce non-elective admissions in the elderly population of Epping Forest Primary Care Trust <b>Method:</b> Taking a two-pronged approach – case finding and case management – the Sherbrook questionnaire was applied to 74 people aged 75 or over. As a result 42 people received the single assessment process (SAP). <b>Findings:</b> During the 3 month pilot the case managed people were less likely to require hospital attendance or long-term care resulting in cost-savings. <b>Limitations:</b> Small study. Unclear methodology. <b>Key Messages:</b> Following its success, the pilot has been mainstreamed. The Nurse Case Managers are a single point of access to health and social care for patients, providing care co-ordination. They bring together a multidisciplinary team who provide a holistic service supporting patients and their families. <b>Themes:</b> assessment, collaboration, nurse/patient relationship, <b>Type of Study:</b> Phenomenological hermeneutic interpretation. <b>Aim:</b> To elucidate the meaning of district nurses experiences of encounters with people with serious chronic illness and their close relatives in their homes.
34	Ohman M. & Soderberg S. (2004) District nursing – sharing an understanding by being present.	

	<p>Experiences of encounters with people with serious chronic illness and their close relatives in their homes. Journal of Clinical Nursing 13 (7) 858-866</p>	<p><b>Method:</b> A purposive sample of 10 district nurses (female) aged between 50 and 62 years from two health care centres in Sweden was interviewed using a narrative approach. The interviews were taped and transcribed verbatim. The interpretation was in 3 phases – naïve understanding, structural analysis and interpretation of the text as a whole.</p> <p>: District nurses' (DNs') experiences of encounters with people with serious chronic illness and their close relatives in their homes can be understood through the identification of several themes- being in a close relationship, sharing an understanding and weaving a web of protection. Emerging sub-themes include DN's being available and committed, to have time for the patient and being accessible. Touch and active listening are vital to developing intimacy and understanding but it is also imperative to keep a protective distance along with the closeness of a caring relationship.</p> <p><b>Limitations:</b> The researcher was also a DN – leading to possible subjectivity and interview bias. Participants in this study are a homogeneous sample- perhaps a heterogeneous sample of DN's would have been better. Findings cannot be generalised.</p> <p><b>Key Messages:</b> Being "entirely present" in encounters between DN's and patients/carers is a key area for reflection on care interventions. This relationship facilitated patients/carers to cope with the situation of chronic illness more effectively.</p> <p><b>Themes:</b> nurse/patient/carer relationship,</p>
35	<p>Platt GA., Orchard TJ., Emerson S., Simmons D., Songer TJ., Brooks MM., Korytkowski M., Siminerio LM., Ahmad U. &amp; Zgibor JC. (2006) Translating the Chronic Care Model into the Community. Diabetes Care 29 (4) 811-817</p>	<p><b>Type of Study:</b> Randomised controlled trial.</p> <p><b>Aim:</b> To determine the effectiveness of an intervention based on the chronic care model (CCM) in primary care settings in an underserved urban suburb of Pittsburgh, Pennsylvania, and whether the use of the CCM leads to improved clinical and behavioural outcomes for people with diabetes.</p> <p><b>Method:</b> 11 primary care practices along with their patients were randomised to 3 groups – CCM intervention (<math>n=30</math>), provider education only (PROV group) (<math>n=38</math>) and usual care (UC group) (<math>n=51</math>). Patients receiving care from the CCM group were invited to participate in 6 diabetes self-management training sessions and monthly support groups, focussing on self-care education, and empowerment, until the time of their 1-year follow-up. The PROV group consisted of the providers attending 1 problem-based learning session and the UC group had no sessions. Survey instruments included the Modified Diabetes Care Profile, Diabetes empowerment scale, diabetes knowledge test, WHO quality of well-being index. Cholesterol levels and blood pressure levels were recorded.</p> <p><b>Findings:</b> Improved non-HDL cholesterol levels, and rates of self-monitoring of blood glucose in the CCM intervention group. CCM was also effective in improving behavioural, psychological/psychosocial and diabetes knowledge outcomes in patients with diabetes and improvements in empowerment scales.</p> <p><b>Limitations:</b> Small sample size. Future large-scale research studies are required to demonstrate the effectiveness of this approach.</p> <p><b>Key Messages:</b> A multi-faceted intervention such as the Chronic Care Model can improve diabetes outcomes.</p> <p><b>Themes:</b> patient and provider education, collaboration, self care, self management, empowerment,</p>
36	<p>Rich MW., Beckham V., Wittenberg C., Leven CL., Freeland KE. &amp; Carney RM. (1995) A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. The New England Journal of Medicine</p>	<p><b>Type of Study:</b> Prospective randomised trial.</p> <p><b>Aim:</b> To determine the effect of a nurse-directed, multi-disciplinary intervention on rates of re-admission within 90 days of hospital discharge, quality of life, and costs of care for high-risk patients 70 years of age or older who were hospitalised with congestive heart failure.</p> <p><b>Method:</b> 282 patients were randomised. (140 in the control group and 142 in the treatment group). The control group received the usual care, whereas the treatment group consisted of intensive education about congestive heart failure and its treatment, a teaching booklet, individualised dietary assessment by dietician, contact with social service personnel, an analysis</p>

	333 (18) 1190-1195	<p>of medications by a geriatric cardiologist, intensive follow-up through the home-care team, supplemented by home visits and telephone contact. Data were collected at time of enrolment. Patients were followed for 90 days. Chronic Heart failure Questionnaire was utilised.</p> <p><b>Findings:</b> Statistical analysis showed that the findings suggest that all components of the intervention were beneficial resulting in improved quality of life, reduced rate of re-admission, cost-effectiveness, better understanding of condition, in the group cared for by a nurse-directed, multidisciplinary strategy.</p> <p><b>Limitations:</b> Small study undertaken at Washington University. Because of the multidisciplinary nature of the intervention, it is difficult to ascertain which elements were most important in reducing readmission rates and improving quality of life. The follow-up period of 90 days was rather short.</p> <p><b>Key Messages:</b> This study demonstrates that a nurse-led multi-disciplinary treatment strategy can significantly reduce hospital re-admissions and improve the quality of life for elderly patients with heart failure.</p> <p><b>Themes:</b> Quality of life, cost containment, collaboration, patient education,</p>
37	<p>Riegel B., Carlson B., Kopp Z., LePetri B., Glaser D. &amp; Unger A. (2002)</p> <p>Effect of a standardized nurse case-management telephone intervention on resource use in patients with chronic heart failure.</p> <p>Archives of Internal medicine. 162 (6) 705-712</p>	<p><b>Type of Study:</b> A randomised controlled clinical trial.</p> <p><b>Aim:</b> To assess the effectiveness of a standardised telephonic case-management intervention in decreasing resource use in patients with chronic heart failure.</p> <p><b>Method:</b> Patients who had been hospitalised in Southern Californian due to heart failure were screened for eligibility. Although it was the physicians who were randomised it was the patients who were the unit of analysis for the study. The intervention group (n=130) was telephoned within 5 days after hospital discharge and thereafter at a frequency guided by the software and case manager judgement based on patient symptoms, knowledge and needs. Patients received an average of 17 phone calls and an estimation of 16 hours each of the case managers' time. Printed educational material was sent to the patients' monthly. Care for the patients in the usual-care control group (n=228) was not standardised and no formal telephonic case-management programme was undertaken. Data were collected from hospital records. Functional status was measured using the New York Heart Association classification system. Data were collected at 3 months and 6 months post-discharge.</p> <p><b>Findings:</b> Following statistical analysis using SPSS statistical software heart failure hospitalisation rates were 45.7% lower in the intervention group than the control group at 3 months. At 6 months the rates were 47.8% lower in the intervention group. Significant cost savings and increased patient satisfaction were demonstrated in this group.</p> <p><b>Limitations:</b> Small study. The randomisation of the physicians may have introduced a sample selection bias.</p> <p><b>Key Messages:</b> Standardised nurse case management provided to an ill heart failure patient population by telephone during the early months after a heart failure hospital admission can achieve significant cost savings, reductions in resource use and increased patient satisfaction.</p> <p><b>Themes:</b> patient education, patient satisfaction.</p>
38	<p>Sargent P., Pickard S. &amp; Sheaf D. (2007)</p> <p>Patient and carer perceptions of case management for long-term conditions.</p> <p>Health and Social Care in the Community 15 (6) 511-519</p>	<p><b>Type of Study:</b> Qualitative study.</p> <p><b>Aim:</b> To describe community matron (CM) case management from the perspective of patients and carers in order to develop a clearer understanding of how the model is being delivered for patients with long-term conditions.</p> <p><b>Method:</b> The patient and carer component recruited a purposive sample of 72 patients and 52 carers who had experience of community matron case management. The research was conducted in 6 primary care trusts and consisted of a 30 minute – 1</p>

		<p>hour long interview which took place in the patients' or carers' home. Interviews were structured according to a thematic interview guide which was developed by the research team, highlighting information regarding patients' patterns of health and illness, the types of care received from CM's and patient and carers attitudes towards this care.</p> <p><b>Findings:</b> Grounded theory methods guided the collection and analysis of data. Interviews were transcribed verbatim and independently coded to identify salient themes and concepts related to the care provided by CM's. 5 types of care tasks conducted by CM's were identified – clinical care, care co-ordination, education, advocacy and psychosocial support. It appears that CM's are delivering very advanced clinical care with a similarity to the skills of "Evercare" nurse practitioners, with role extension, care co-ordination, with education and advice at it's core. Advocacy was also identified as another key activity of CM's. Patients and carers highlighted a psychosocial support fulfilled by CM's and an extreme overall satisfaction with the components of the service.</p> <p><b>Limitations:</b> Small study. It may be that the selection process could lead to patients and carers being reluctant to criticise the service, and subsequent biasing of findings.</p> <p><b>Key Messages:</b> Patients and carers highly valued the case management intervention by community matrons in England. This study emphasises the importance of seeking patient and carer input when designing new case management programmes.</p> <p><b>Themes:</b> advocacy, self-care management, collaboration, education, advanced nursing practice, psychosocial support.</p>
39	<p>Schraeder C., Fraser CW., Clark I., Long B., Shelton P., Waldschmidt V., Kucera CL. &amp; Lanker WK. (2008)</p> <p>Evaluation of a primary care nurse case management intervention for chronically ill community dwelling older people.</p> <p><i>Journal of Nursing and Healthcare of Chronic Illness</i> in association with <i>Journal of Clinical Nursing</i>. 17 407-417</p>	<p><b>Type of Study:</b> A non-randomised, 36 month comparison of two geographically distinct primary care populations was conducted.</p> <p><b>Aim:</b> To test the effectiveness of a collaborative primary care nurse case management intervention emphasising collaboration between physicians, nurses and patients, risk identification, comprehensive assessment, collaborative planning, health monitoring patient education and transitional care on healthcare utilisation and cost for community dwelling chronically ill older people.</p> <p><b>Method:</b> In west central Illinois, 677 persons aged 65 and older were determined to be at high-risk for mortality, functional decline, or increased health service use. The treatment group (n=400) were assigned to receive intervention including home visits and assessment from a nurse case manager (NCM) who developed a plan of care and utilised ongoing assessment, education and collaborative care. The comparison group (n=277) received usual care. Study evaluation occurred at enrolment and annually at 12, 24 and 36 months.</p> <p><b>Findings:</b> Statistical analysis confirmed that, after adjustment for baseline variables, there were no significant differences between the treatment and comparison group in the percentage of patients hospitalised. However, among those hospitalised in the treatment group, the likelihood of being re-hospitalised was significantly reduced. The reduced hospital use in this group resulted in cost savings.</p> <p><b>Limitations:</b> The patients enrolled in this study were from both urban and rural settings of central Illinois, which may result in different responses to changes in primary care approaches. The analyses were limited to only those variables collected from patient self-report data by health questionnaires.</p> <p><b>Key Messages:</b> A collaborative primary care nurse case management intervention has the potential to be an effective alternative to current primary care delivery system practice.</p> <p><b>Themes:</b> collaborative care, assessment, education.</p> <p><b>Type of Study:</b> Quantitative evaluation.</p> <p><b>Aim:</b> To reanalyse data from 10 randomised controlled clinical trials of heart failure care management programs to discern how</p>
40	<p>Sochalski J., Jaarsma T., Krumholz HM., Laramee A., McMurray JJV., Naylor MD., Rich MW., Reigel B. &amp; Stewart S.</p>	

	(2009) What works in chronic care management: the case of heart failure. Health Affairs 28 (1) 179-189	<p>program delivery methods contribute to patient outcomes.</p> <p><b>Method:</b> The ten trials conducted from 1990 to 2004 in Australia, Netherlands, United Kingdom and United States comprised 2028 cases – 961 program patients and 1067 routine care patients. Two outcome measures were selected – hospital re-admissions and re-admission days. Each trial was evaluated using the taxonomy of disease management framework and the elements focused on with regard to the care delivery method was – personnel and method of communication.</p> <p><b>Findings:</b> Regression analysis using linear mixed models to capture the fixed effects of delivery method elements of the 100 trials were employed. Results showed that patients enrolled in chronic care management programs using a multi-disciplinary team approach had significantly fewer hospital admissions and re-admissions than for routine care patients. In-person communication also contributed to significant reductions in admissions rather than telephonic communication.</p> <p><b>Limitations:</b> The evidence base is surprisingly underdeveloped in chronic care management. Data limitations prevented assessing the cost implications. Study selection bias. As only studies regarding heart failure patients were used there may be limitations in generalizability to other chronic conditions.</p> <p><b>Key Messages:</b> Patients enrolled in case management programs using multi-disciplinary teams in programs using in-person communication had significantly fewer hospital re-admissions than usual care patients had.</p> <p><b>Themes:</b> collaboration, multi-disciplinary approach.</p>
41	Stanton MP., Swanson M., Sherrod RA. & Packa DR. (2005) Case Management Evolution: From Basic to Advanced practice Role. Case Management 10 (6) 274-284	<p>Type of Study: Qualitative exploratory study.</p> <p><b>Aim:</b> To provide an overview of nursing case management as an advanced practice role from a theoretical and practice basis.</p> <p><b>Method:</b> Information from current literature analysed to differentiate between <i>advanced nursing practice</i> and <i>advanced practice nursing</i>. Overview of case management undertaken through expounding practice examples.</p> <p><b>Findings:</b> <i>Advanced nursing practice</i> extends beyond traditional nursing practice through increased practice autonomy, application of nursing knowledge, and contribution to the development of nursing as a profession. Advanced nursing practice required the nurse to function as a change agent through collaboration with other providers. Advanced nursing practice involves the use of specific, specialised skills.</p> <p><i>Advanced practice nursing</i> focuses on defining and developing speciality areas of practice within the nursing profession and required the inclusion of core characteristics and competencies that are consistent with its' definition.</p> <p><b>Limitations:</b></p> <p><b>Key Messages:</b> There is a growing need for a case manager in the advanced practice role.</p> <p><b>Themes:</b> collaboration, education, leadership, autonomy.</p>
42	Thomas D. (2009) Case Management for long-term conditions. Nursing Management 15 (10) 22-27	<p><b>Type of Study:</b> Quantitative and qualitative evaluation.</p> <p><b>Aim:</b> To evaluate the chronic conditions management (CCM) pilot project in Swansea, Wales.</p> <p><b>Method:</b> Five experienced nurses undertook an 8-week induction program to become case managers. 5 volunteer general practices were identified and the main case management activities included creating personalised care plans that are based on need and reflect patients' choice, providing patients with care in the least intensive but suitable settings, supporting effective primary care, focusing on patients with the highest burden of disease, working in partnership with acute, social and voluntary sector services and implementing integrated care pathways.</p> <p><b>Findings:</b> Data on the number of emergency medical admissions among people over 50 years old and care of the elderly admissions for 2007/2008 demonstrated a 10.4 per cent reduction.</p>



		<p><b>Limitations:</b> Limited information with regard to data collection and analysis. Methodology unclear.</p> <p><b>Key Messages:</b> Case management is a method of pro-active care delivery in the community that involves people who are at high risk of unplanned admission and who have complex and enduring health and social care needs.</p> <p><b>Themes:</b> assessment, nurse/client relationship, collaborative care.</p> <p>Type of Study: Qualitative evaluation.</p> <p><b>Aim:</b> To investigate the needs of people with cancer, and their lay carers during discharge from hospital to home, and identify the role of district nurses' (DN's) in meeting these needs.</p> <p><b>Method:</b> 71 pre and post-discharge interviews were performed with cancer patients and their carers. Pre-discharge interviews focused on expectations and post-discharge interviews on experiences of discharge and aftercare. The interviews lasted approx 30 minutes and were undertaken in Greater Manchester, England. Patients and carers were interviewed separately and interviews tape-recorded, transcribed and subjected to thematic analysis.</p> <p><b>Findings:</b> DN referral did not meet the needs of several patients and carers in the study. It appears to be that patients and carers are unclear about the role of the DN and think that they deal only with physical tasks. Some cancer patients experienced unmet needs with regard to nutritional problems. Carers received inadequate help in terms of information, psychological support and practical input.</p> <p><b>Limitations:</b> Small study. Difficult to generalise results.</p> <p><b>Key Messages:</b> In this era of even shorter stays this study highlights the importance of major assessment of cancer patients' needs, which should take place in the home. The role of the DN must be clarified.</p> <p><b>Themes:</b> assessment, collaboration, patient/nurse/carer relationship.</p>
43	Wilson K., Pateman B., Beaver K. & Luker KA. (2002) Patient and carer needs following a cancer-related hospital admission: the importance of referral to the district nursing service. Journal of Advanced Nursing 38 (3) 245-253	<p><b>Type of Study:</b> Qualitative and quantitative evaluation.</p> <p><b>Aim:</b> To understand the process of targeted case management (TCM) utilised by nurse case managers (NCM). An evaluative study of the outcomes of the TCM service conducted with a group of post-discharged frail elderly patients of a rehabilitation hospital in Hong Kong in 2001-2002.</p> <p><b>Method:</b> Four NCM's were involved in the study, three of whom held nursing degrees. 2 were community nurses and 2 were from the community geriatric team. Their clients were patients who were randomised to the experimental group (n=45) of the trial including 92 patients. For quantitative data, the NCM's recorded their activities in their case management processes on activity log sheets on a daily basis. Interventions were entered in units eg 20 minutes to educate the patient = two units of patient education. Data analysis was performed with the computer software of SPSS. For qualitative data, opinions of the 4 NCM's on their perceived key factors of case management were collected using a semi-structured interview in a focus group meeting. Open-ended questions were asked and the information provided was taped and transcribed verbatim.</p> <p><b>Findings:</b> During the 12 month trial period, a total of 717 telephone calls were recorded. About 75% of these calls were related to medical problems. NCM's provided a total of 333 intervention units as a result of these calls. On the basis of the qualitative results the, NCM's were able to articulate the key components of the targeted case management process. These themes include screening, case finding, comprehensive assessment, care planning, service co-ordination, monitoring, reassessment at regular intervals, and discharge planning. NCM' found that the nurse/client relationship crucial for the planning and interventional functions of case management.</p>
44	Yau DC., Leung ACT., Yeoh C. & Chow NW. (2005) Global Case Management: Hong Kong: Care for the Hospital-Discharged Frail Elders by Nurse Case Managers: A Process of Evaluation of a Longitudinal Case Management Service Project. Case Management 10 (4) 203-212	<p><b>Type of Study:</b> Qualitative and quantitative evaluation.</p> <p><b>Aim:</b> To understand the process of targeted case management (TCM) utilised by nurse case managers (NCM). An evaluative study of the outcomes of the TCM service conducted with a group of post-discharged frail elderly patients of a rehabilitation hospital in Hong Kong in 2001-2002.</p> <p><b>Method:</b> Four NCM's were involved in the study, three of whom held nursing degrees. 2 were community nurses and 2 were from the community geriatric team. Their clients were patients who were randomised to the experimental group (n=45) of the trial including 92 patients. For quantitative data, the NCM's recorded their activities in their case management processes on activity log sheets on a daily basis. Interventions were entered in units eg 20 minutes to educate the patient = two units of patient education. Data analysis was performed with the computer software of SPSS. For qualitative data, opinions of the 4 NCM's on their perceived key factors of case management were collected using a semi-structured interview in a focus group meeting. Open-ended questions were asked and the information provided was taped and transcribed verbatim.</p> <p><b>Findings:</b> During the 12 month trial period, a total of 717 telephone calls were recorded. About 75% of these calls were related to medical problems. NCM's provided a total of 333 intervention units as a result of these calls. On the basis of the qualitative results the, NCM's were able to articulate the key components of the targeted case management process. These themes include screening, case finding, comprehensive assessment, care planning, service co-ordination, monitoring, reassessment at regular intervals, and discharge planning. NCM' found that the nurse/client relationship crucial for the planning and interventional functions of case management.</p>

		<p><b>Limitations:</b> Small sample size.</p> <p><b>Key Messages:</b> NCM's involved in TCM service need to possess basic competencies of interpersonal and communication skills, speciality knowledge, and a reasonable capacity to cope with work related stress.</p> <p><b>Themes:</b> assessment, collaboration, nurse/client relationship, care planning, patient education.</p>
45	<p>Allen S F (2007)</p> <p>Parents' perspectives: an evaluation of case management interventions in home visiting programs for young children.</p> <p>4 Children &amp; Schools</p> <p>29 (2) 75-86</p>	<p>Type of Study: Descriptive study.</p> <p><b>Aim:</b> To examine how the home-visitor-parent relationship, amount of contact and level of need affected the intensity of case management interventions received.</p> <p><b>Method:</b> Following interviews with 90 mothers to measure professional relationship, amount of contact, level of need, and extent to which they received and desired specific case management interventions, using telephone and in-person interviews, using a case management interventions scale, data were analysed using multiple regression.</p> <p><b>Findings:</b> the relationship between the parents and home visitor was the most important intervention received. Most families in the study wanted more intensive interventions than were provided.</p>

### **3. Case Management in Community Nursing – Model Development**

#### **3.1 Rational**

Based on action research principles, provide academic input into the development of a case management model to support the implementation of the Review of Nursing in the Community (RONC) in NHS Highland early implementation sites.

#### **3.2 Aim**

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

#### **3.3 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?

#### **3.4 Study Design**

Action research is a collaborative approach to research which aims to identify solutions to practical problems. Based on action research principles the research was conducted in 4 notionally discreet but interconnecting phases. Essentially these phases promoted a reflective and iterative process that encouraged participants to a) review and analyse their current practice and b) identify and evaluate approaches to case management that could be tested in practice. In the context of this study, data was used to establish what was known about case management and to identify challenges around implementation. Participants also considered the potential interventions and strategies that could inform approaches for embedding case management as one key component of Community Nursing. Collaboration is a key feature of action research and participants in this study contributed from the fact finding phase right through to the interpretation and verification of findings.

For the purposes of this study, four phases of action research were identified based on sequential, though connected phases that have been widely described in the literature (Kemmis 1993, Waterman *et al.* 2001).

1. **Fact finding** – This phase established Community Nurses' understanding of case management approaches. It also identified the benefits and challenges of case management implementation within primary care settings in NHS Highland.
2. **Planning** – This phase identified Community Nurses' preliminary recommendations that would help to progress case management implementation.
3. **Action** – In this phase, Community Nurses reviewed and considered the findings that emerged from the fact finding and planning phases.
4. **Evaluation** – Community Nurses' focused on the recommendations for practice development and identified mechanisms that would help to support case management implementation.

### 3.5 Population and Sample

Qualitative data was obtained through focus group interviews with Community Nurses in three locality areas within NHS Highland, these areas included Review of Nursing in the Community <sup>2</sup> (RONC) pilot sites and non RONC pilot sites. Nurse participants worked across remote and rural areas, several large towns and within a city, and were therefore broadly representative of the community nursing workforce within the NHS Board area. These areas included, North Highland (Thurso and Wick), Mid Highland (Tain) and South East Highland (Inverness and Badenoch and Strathspey). Interviews were conducted twice within each area 6-8, weeks apart. In total, six focus group interviews were conducted. Nurse participants were registered nurses in the community who worked within primary care, including, district nurses, staff nurses, health visitors, family health nurses, and school nurses. Experience of working with case management varied, from nurses who had limited experiences of case management approaches to nurses whose remit included case management as significant component of their role.

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<sup>2</sup> Scottish Executive, Visible, Accessible and Integrated Care: The Review of Nursing in the Community (2006)

### **3.6 Data Collection**

#### *Focus groups*

With reference to the tradition of action research, Melrose (2001) discusses how the community (or group) investigates their own condition and subsequently work collectively to improve it. This essentially describes the purpose of using focus group interviews within an action research framework. The focus groups needed to be flexible so that they were sensitive enough to capture the complexity of issues and approaches that were emerging around case management. The focus groups in the fact finding phase explored nurses understanding of case management, and the associated roles and responsibilities. With reference to the phases of action research, essentially participants were engaged in a process of fact finding and planning. The interview guide for this phase is located in Appendix 1.

The focus group discussions in the action and evaluation phase of the study revisited nurses' views of case management, the challenges to implementation and encouraged them to refine strategies that would assist in the integration of case management into community nursing practice. Before the second round of focus groups nurses were sent findings that had emerged from the first group of interviews to allow them the time to consider the findings and to work through potential solutions for implementation. In the second set of interviews, nurses roles and responsibilities relating to case management were further explored, particularly how case management could impact upon community nursing activities and patient care. Further clarification of the structures and processes required to support a case management approach were reviewed (Appendix 2).

### **3.7 Data Analysis**

Each group interview was digitally recorded and transcribed verbatim. The transcripts were analysed to identify emerging concepts and themes. A review of emerging themes by the researcher involved in the study contributed to the refinement of an emerging thematic framework which helped to inform understanding of key issues around case management. The interview content and the analysis were guided by the research questions, but also allowed open coding, to allow new themes to emerge. Constant comparison (checking experiences against each of the groups) ensured that the thematic analysis represented all perspectives and also specifically searched for

unanticipated themes (Pope and Ziebland 2000). Analysis of data focused on participant's perceptions of case management, the possible strategies for implementation and the integration as a key component of primary health care and possible strategies for implementation.

### **3.8 Findings**

This section provides an overview of the key findings which arose from the focus group discussions. In total 9 key themes were identified which can inform strategic implementation of case management as a core component of community nursing.

#### **3.8.1 Lack of clarity about case management approach**

There was mainly broad understanding about the principles and drivers behind case management. Nurses identified some of common elements they associated with case management including, assessment, planning and co-ordination of services as close to the patients' home as possible. Anticipatory care planning and promotion of self management approaches was also identified as a key strategy for reducing hospital admissions and improving health outcomes. There was some recognition that case management focused on individuals who were identified as high intensive users of health services, and notably included people with long term conditions and complex needs. Examples of perceptions of case management included,

*Close to home, they are close to home or in their own homes if possible, are suffering long term conditions. (FC1)*

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

*It's about working partnership with patients and carers as well, that's so you understand and build into the anticipatory care plan what they want. (FC1)*

Nurses recognised that although case management would entail different ways of organising and managing their work they were familiar with the principles that underpinned the aims of case management,

*It's just basically... you are going out to find your caseload, you are not waiting or your caseload to come to you, that's a really simple way of putting it. (FC2)*

*When I first started nursing one of the first lecturers we were given was...a health service to keep people healthy and it's become a sickness service now and it sounds as though we are trying to get back. (FC2)*

Drivers for implementation broadly fell into two categories, first the requirement to improve patients' health status and health outcomes, and second, the need to deliver a service that was financially sustainable.

Despite evidence of agreement about some of the underlying principles that reflect the ethos of case management, there was overall, an absence of clear consensus amongst some of the nurses about what this meant in relation to their working practices. Most notably, confusion was evident with the use of terminology. For example, case management was considered a problematic term as it was used interchangeably with care management,

*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)...*

The findings from the research may appear contradictory as there was an appreciation of the principles of care delivery which are increasingly fundamental to nurses working in primary care settings. However the translation of these principles within a defined case management approach appeared to be more problematic and illustrated a broad lack of both consistency and shared understandings about the components of case management and how these can be integrated into the realities of practice.

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### **3.8.2 Variable approaches to case finding**

Case finding was mostly recognised as a valid approach to help identify those at most risk of hospital admission and supported the process of planned interventions which would decrease patient's requirements for crisis intervention and would improve health outcomes. Nurses in this study described a variety of approaches to case finding that reflected both formal and informal systems of referral. They also highlighted effective referral systems and conversely, reported on some haphazard referral processes which gave them cause for concern. In all areas nurses received patient referrals from GP practices. However this system also varied. For example, in one GP practice referrals were based on hospital discharges, but that process varied from one practice to another, even when the same nurses worked across both practice areas.

There was significant variation in the perception of the patients who would be case managed and how they would be identified. In one practice area patients with neuro-degenerative disorders featured significantly on the nurses' case load. In another area

nurses were beginning to focus on the 'revolving door' patients who had high hospital readmission rates. Data from the Scottish Patients At Risk of Readmission and Admission (SPARRA) algorithm identified patients with chronic obstructive pulmonary disease (COPD) as part of that high risk group. The following example illustrates the potential complexity within the system,

*So, top 1% but having worked with one practice who has used that tool to generate caseload and one that didn't up until recently, 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)*

As highlighted in the previous extract, nurses also identified people in their care who were not formally case managed and were not currently high intensity users of services. However, they voiced concerns that case management was not being used for vulnerable populations and reference was made on a number of occasions to 'patients that slip under the radar'. Examples of patients who comprised this group included,

*We have one couple who...hold each other up...they are just absolutely fantastic but there is just no plan in place about what happens if one of them becomes ill. (FC1)*

*There's another old lady, very independent and lives at home but there is no care plan about what's going to happen if she suddenly becomes very ill. I think case management has to embrace these ones. (FC1)*

*They don't have COPD, they don't have heart disease, its different things, but they are long term...but not the ones that they are focusing on. (FC2)*

Referrals following hospital discharge also varied and hospital referral systems did not fully support planning activities. Nurses acknowledged that hospital staff had their own particular pressures and demands from service, but suggested that these can then impact on the ability of community nurses to plan their own workload. Furthermore it could be difficult to implement plans of care for discharged patients when these were not known in advance,

*It's just like, you know every weekend, Friday afternoon is just chocabloc with people phoning up 'this persons coming out tomorrow, they need a daily visit.' (FC1)*

*But there's countless patients who come home who, are already at home and when it's the GP that phones or it's the nurse because there is now a crisis. (FC2)*



### 3.8.3 Assessment is constrained by difficulties with documentation

Considerable concern was raised about documentation practices which were not fully complementary of case management processes. Boundaries between different agencies involved in care delivery and most notable between health and social care resulted in information sharing systems which were identified as being not fit for purpose. In particular the Single Shared Assessment (SSA) was criticised by nurses as being resource intensive, reliant on multiple photocopies, difficult to access, time consuming to complete, repetitive and at times lacking currency. One nurse, commenting on the time consuming nature of the document recalled a patient who fell asleep while the SSA was being completed. It was significant that while participants suggested that the comprehensive nature of the information contained within the assessment was helpful, the documentation itself lacked the nursing or health focus they required.

*If an SSA is done right, it is a wealth of information if somebody is going to go on long term and manage that patient. (FC1)*

*It just seems to have been something that's been used for a long time but it's not really fulfilling its purpose. (FC1)*

*Well it raises expectations because one thinks because you have completed a single shared assessment the patients are going to get the care or the need met...and what we find is we put in a single shared assessment and if and when it is looked at...and then sometimes re assessed. (FC2)*

*Nursing has lost its nursing assessment because of it, because we only really do single shared assessment if we need to refer on. (FC2)*

Nurses suggested that the SSA had more value for social work colleagues and some indicated that the assessments were not always shared with the nurses. There was widespread agreement that the current system of assessment could be re-designed to make it more fit for purpose. Nurses also identified the need to have access to compatible information systems whereby reliable and relevant exchange of information between hospital and community, and other relevant agencies occurs. In a more general though related issue, the amount of documents and the variation in documentation practices impacted on most aspects of the nurses work,

*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)*

Like their response to difficulties with the SSA nurses also proposed solutions to address some of the continuity issues with documentation,

*So wherever the patient goes the information is with them, it is available to either acute or primary care whoever is looking after them. (FC2)*

#### **3.8.4. Case planning influenced by interface between all stakeholders in care**

As previously discussed, nurses suggested that robust referral practices would help to improve systems that support case management. They also felt that it would help if all stakeholders were made aware of the developments around care delivery and particularly case management. Although they did not consider that the staff who worked in hospitals had a direct responsibility for case management it was recognised that their awareness of the model could help to support its implementation.

*You need to build up a relationship and trust with the staff...and understand how they work and how we work, because I'm quite sure the staff in the wards don't have an easy job. I think they've got their own set of worries and concerns. (FC1)*

*Because you have got to get all the disciplines involved and everybody there, just ready, listening, talking, getting all the same information. (FC2)*

The key role of the GP in supporting nurses to case manage was quite significant in focus group discussions. Those nurses who had close, supportive working relationships with the GP's found that this relationship enhanced case management practices. Additionally, when GP's were informed about the aims of case management and the key role of the community nurses, this information promoted further collaboration,

*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 and one GP had said it really would be very useful having a nurses' perspective. (FC2)*

### **3.8.5. Case intervention influenced by ways of working and availability of resources**

The different locations in which the focus group discussions were carried served to illustrate the diversity of working practices that exist across different areas within NHS Highland. This diversity was not surprising when the local context that community nurses work in was considered and nurses acknowledged the significant variations that can exist across the Health Board area. Population profiles, case loads, geographical area and availability of resources all influenced the organisation of nursing teams and either impacted on, or could impact on the way in which case management was implemented.

*The whole structure is different compared to what happens in... and maybe, you know, one size doesn't fit all. (FC2)*

*So, maybe, one of the challenges right at the start of other things that needs to be clarified even although one size doesn't fit all, is that there is underpinning philosophies or approach would be a better word. (FC2)*

While there was agreement that implementation of case management would vary depending on context, there remained some concern that considerable variation existed with planned working practices and that this variation had the potential to cause ambiguity and uncertainty.

*I think we are going down 2 different routes to practice and if I start talking about what we are doing where I work... then you are trying to explain this to somebody in...who is doing something else, I'm not 100% sure why it's so different a few miles apart. (FC2)*

*One of the difficulties I have is suppose in listening to everyone is that I personally find it quite difficult to grasp, I understand what's going on in one area but then it's very different in another area. (FC2)*

Nurses suggested that one solution to the problem of variation was to reach 'shared understandings' of what was meant by case management. In particular and as previously indicated in earlier sections of this report, nurses stressed the need to articulate clearly the aims of case management and roles and responsibilities associated with it.

To implement successful case management, nurses identified a range of resources that would help to support patients and carers to self manage their conditions. These resources included access to voluntary and statutory agencies, nurse specialists, occupational health and physiotherapy support. Nurses also highlighted differences with access to these resources, ranging from areas of good access where specialist input to support the patient could be more easily obtained, to other areas where access to resources was more challenging,

*Well, we don't have access to a physio or OT unless we can manage to be a bit creative, (FC1)*

*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)*

Home care was regarded as one of the most important support systems that allowed patients to remain in their own homes, supplemented the support given by informal carers and also played a key role in anticipatory care and prevention of hospital admission. Responsiveness and support facilitated by regular contact between case managers, carers and the community nurses was much valued by the nurses. However, concerns were raised about the supply of home care in some areas, because of lack of availability of home carers and the restrictions brought about by fiscal constraints.

As a related and significant issue, nurses commented on the way in which they were perceived within their practice communities and by their patients. Essentially, they described how they were considered to be the 'linchpin' or 'safety net' of community health care and were often the first point of contact for their patients, even when other care providers were more appropriate to support the patient.

And it might be not a nurse they need at all, it might be an OT or whoever... in fact one of my colleagues had has so many social work calls going back to her... she actually said to the person 'well it's not me, this is the phone number that you need' (FC2)

Furthermore, there was some evidence that the community nursing service was approached to provide support in the absence of other services. For example nurses described how they provided 'cover' when social work or social care could not be accessed over weekend periods. These situations reflected a very strong sense of

duty and commitment to ensure that patients were not exposed to unnecessary harm in the absence of other agencies providing care.

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

### **3.8.6 Case management approach is not static and is context related**

It is apparent that the local context in which case management operates has an impact on its implementation. Local factors include the geography, availability of resources and access to services, presence of statutory and voluntary agencies, caseload profile and size. For example, nurses noted that the nature and level of intervention required will vary between patients and nurses identified differences that occurred within and across areas that they work. As previously noted, differences were identified in the occurrence of conditions that led to complex needs and contributed to community nursing workload. They further recognised that this variance was also influenced by other factors, including levels of economic or social deprivation experienced.

*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 and different parts of the Highlands. (FC2)*

Importantly, nurses noted that areas where they work have changed, and will continue to change over time. They suggested that change will have subsequent impact on the care needs of patients in the community.

### **3.8.7 Workforce planning**

This section on workforce planning reviews two main issues relating to workforce that nurses identified as being important to help progress case management approaches.

#### **3.8.7.1 Changing mindsets**

The requirement to develop and demonstrate a consistent approach to case management and the structures and processes that support its implementation has been reiterated throughout this study.

Equally, nurses also highlighted the need to re-consider their own role and ways of working which will emphasise promotion of self management, the integration of self-care support and care planning into their clinical practice. They suggested that role development required a review both of the way they approach their patients and the aims of care delivery,

*You know we have to drop some things if we are going to take this up. At the end of the day resources are finite and you can't stretch them any further they are stretched already (FC2).*

While nurses broadly understood the need to change their approach to care, some also acknowledged that this was not always easy for them to do,

*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)*

Nurses also suggested that 'changing mindsets' included that of the patients and carers so that nurses could ensure that they played a crucial part in the decisions made about their care. It was important that patients and carers were informed about their goals and were encouraged to take control over aspects of that care.

*You know, you have to be very clear that self care doesn't mean no care and to get them to understand that you are still there and you want to support them (FC1).*

*No matter what is happening with the patient you need to be thinking, right, how can I get them independent even within giving their own care or someone in the family doing it so they are actually independent as a unit?(FC2)*

Even when nurses actively promoted self care, a number of challenges were seen to exist in relation to ability or motivation of some patients to self manage. The challenges of living with a long term condition could influence the enthusiasm of the patients to move from being a passive recipient of care to assuming a more active and decisive role in their care,

*A lot of it is motivation of the patient as well. A huge factor whether the patients do sign up to being a partner in the process (FC2)*

### **3.8.7.2 Who is the case manager?**

There were some diverse views amongst nurses about the identification and role of the case manager. There was general consensus that the case manager would be a senior member of the primary care team, who would have local expertise, advanced clinical skills and a well developed multidisciplinary network. In relation to the nursing teams that participated in this research, case managers were mostly identified from the team leads and in some areas, a number of nurses within the team were to be identified as deputy case managers. There were some different viewpoints about the role less senior grades had in relation to managing cases. For example, it was suggested that nurses who were in Band 5 were not sufficiently remunerated to be expected to carry out the duties of the case manager. However, this perspective had to be considered in conjunction with ongoing challenges, including sick cover, other forms of work leave and recruitment and retention challenges. Nurses acknowledged that it was therefore important to consider the efficient use of existing skill mix and experience of nurses to support case management implementation. Importantly, opportunities to promote workforce development and support succession planning were identified as issue for workforce planning.

One aspect of practice that was not clearly articulated was the difference between the case manager as a co-ordinator of care and the extent to which the case manager participated in care delivery. Nurses' views on this issue varied quite significantly, from the case manager being perceived as the key assessor and co-ordinator of care, to include a role which also incorporated care delivery. These perceptions of role varied between areas and for example, it was suggested that it was not always feasible for one nurse to act solely as a case manager when smaller teams work across more sparsely populated and diverse areas, and are dependant on each other to fulfil a number of responsibilities. It was apparent that the nurses who incorporated case management into their roles had a clear sense of what this role entailed, however nurses who did not have this focus in their day to day practice, were less certain about the role.

There was agreement that whoever the case manager was, that they should be the professional who had most contact with the patient and that this person would vary depending on the patients main needs. It was important to identify a member of the primary health care team as a fixed point of reference for the patient, a perspective that is summarised in the following observation,

*Ideally its the person who's most involved...and that could be a nurse, it could be an AHP, it could be a social worker, more likely to be the senior nurses or professionals rather than anybody in the team, (FC1).*

A number of key skills and attributes were identified as being helpful for the case manager. Nurses stated that the case manager should be 'well connected' with ready access to other health professionals systems, required to posses a very good understanding of existing care systems and needed to be resourceful with good negotiation 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 or other relationships and staff (FC2)*

### **3.8.8 Features supporting implementation**

During the timeframe that this research was being carried out, a number of initiatives were ongoing in NHS Highland which nurses identified as directly or indirectly supporting or influencing case management implementation. Additionally, nurses also asserted that particular ways of working within primary care settings impacted on their ability to adopt a case management approach.

As previously outlined in the sample information for this study, some participants worked in areas that had participated as RONC pilot sites and they indicated that participation in the pilot had helped to support implementation of case management. In a related initiative, participation in transition education through work based learning modules was also favourably regarded. The emphasis on team working, effective interagency communication and collaboration had been a recurring theme that emerged from the analysis. It was therefore not surprising that nurses considered their experiences of such effective practices pivotal to case management implementation. Finally, self management plans and anticipatory care plans were identified as valuable tools for promoting self management.



### **3.8.8.1 Team working**

Team working was viewed as extremely beneficial to supporting successful case management implementation. The definition of 'team' was not confined to the formal nursing team as nurses expanded their notion of team to include all the professional groups and carers who supported patients health and social care needs. It is important to highlight a number of supportive structures that nurses identified as being of particular value. First, nurses placed significant value on the caring, and supportive role that social care workers provided to patients. The provision of personal care was regarded as being fundamentally important to supporting rehabilitation, self management and preventing social or health crisis. Second, nurses referred to the added value of co-location of other primary care team members. Nurses who worked in close proximity with other primary care staff including, GP's, practice nurses and social workers found that the opportunity to share information, often on an informal basis, contributed to effective case finding and anticipatory care planning.

*Close teamwork within a primary care team really helps, like we have based, here but also in the wider team whoever might be involved*

### **3.8.8.2 Building therapeutic nurse-patient-carer relationships**

Nurses highlighted the need to form key relationships with the patients and their carers. The importance of continuity of contact that supported the development of therapeutic relationships between nurses and patients was highlighted as a core attribute that facilitated successful case management. Nurses suggested that a relationship which is characterised by a trusting relationship with a professional who is known to the patient and carer, will underpin all the elements of case management

*With people that are going to be wanting to stay at home...you need to know who is coming in the door, you know, it is not a time for strangers.*

*One of the most successful features of case management would be the building of relationships*

### **3.8.9 Education and training requirements**

This last section lists a number of education and training requirements which nurses identified as being important to support them to implement case management implementation.

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

### **3.9 Limitations**

This study focused on the views of community nurses and their perception and experience of case management. While the participants in this study provided insightful perspectives, it would be helpful to gain perspectives of other stakeholders in care. This includes other health and social care managers, and patients and their carers.

### **3.10 Summary of Results**

Over the time period that this case management research was being conducted, related policy and workforce developments were ongoing within NHS Highland. These factors in themselves illustrate the dynamic nature of primary care and the central role community nurses have both in delivering and progressing the service. Case management is one of many important initiatives that is influencing community nursing and therefore needs to be articulated alongside other changes and cannot be implemented in isolation from other developments. Similarly, implementation will impact on staff across the sectors and it is not just the case managers that are involved, but case management is part of an integrated service approach to care delivery within primary care which all members can make a contribution to.

The success of case management implementation will be influenced by the support structures, resources, processes and education provision that are put in place to underpin its integration into community nursing practice. In areas where some of these developments have been ongoing, the benefits have been identified by nurses. To be embedded into practice requires shared understandings of the principles and aims of case management, including articulation of the benefits for both patients and service. Of key concern to nurses was the need to ensure that a reliable and regular exchange of information about patients between key stakeholders was embedded into working practices. Delivering for Health (2005) emphasised the need to have common information and communications technology to deliver the integrated care services, including the electronic health record and electronic joint assessment processes.

It was apparent from this research that nurses identified with, and were committed to the principles that underpin case management. However nurses acknowledged that this ethos needs to be more widely integrated into ways of working across health and social care sectors. As a related issue, Community Nurses described how they were often seen as the linchpin for community services and suggested that in some circumstances, services would be more appropriately delivered by other agencies.

It has been recognised that community teams in remote and rural areas may be fragmented and disparate in terms of the care provided and the location of teams (Scottish Government 2008). The variations in team working were apparent and nurses favoured closer, more integrated teams where this was possible. Similarly, a recommendation to have in place an 'Extended Primary Care Team' (EPCT) which will encompass a partnership approach between agencies and multi-disciplinary teams has been recommended, with a preference for co-location (Scottish Government 2008) .

The patient was clearly identified as being at the centre of case management. Nurses maintained that it was important to identify a member of the primary health care team as a fixed point of reference for the patient. They also suggested that the case manager needs to be indefinable as the professional and should be the patients main contact and should be the link between the patient and access to services

It was apparent that there were practice variations between local areas and further recognition that areas are not static. Differences in patient demographic indicators will impact on case management and the way the model is delivered. Patient needs will change over time and policy drivers will continue to influence health priorities.

Furthermore staffing profiles will remain not static. Therefore, flexibility with case management implementation should reflect these variations and developments. Such flexibility reflects the recommendation by Long and Marshall (1999) who suggested that organisations planning to introduce case management must be sensitive to the varying dynamics of the different case management models and implement a model that is consistent with the desired outcome.

The iterative nature of this study was supported by the focus group interaction and the engagement of the nurses in reviewing the findings from the planning phase of the research. It is important to note that while the final themes highlighted a number of inhibiting factors to case management implementation, nurses also offered a range of solutions to address these factors. Importantly, solutions for practice development emerged from practice and this serves to illustrate the wealth of knowledge, experience and motivation that community nurses possess to support practice developments.

### **3.11 Recommendations**

- 1     There is a need to achieve a consensus and articulate the key principles and aims of case management and the type and level of intervention. This includes the need to promote consistent understanding of roles and responsibilities of the case manager and others within the nursing teams. The aims of case management need to be communicated between all areas involved in care delivery, including primary, secondary and partnerships areas.
- 2     Integration of case management into community nursing practice should take account of the context of practice, which includes the locality, client group, case load, skill mix and availability of resources.
- 3     Patients and their carers need to be informed about the principles and aims of case management, including heightening the awareness of patient and carer roles that focus on illness prevention and health promotion.
- 4     There is a need to evaluate the role, function and operational value of the SSA with a view to making assessment efficient and effective for supporting case management. Consideration should be given to compatible information systems that can be shared across the sectors.
- 5     Implementation of case management needs to be underpinned by access to relevant training and education provision.
- 6     An evaluation of the effectiveness of case management that includes consideration of the views of service users and carers will contribute to further enhancement of the model and will help to inform practice. Implementation of case management models may not be enough to ensure desirable outcomes. It is therefore important to continue to evaluate the impact of implementation.

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## **Appendix I: Topic Schedule for Focus Group Interviews (phase 1)**

1. What is the main aim of case management – check understanding
2. What is your understanding of the processes involved in a case management approach to care?
3. Can you identify the overall case management model you currently use in your practice?
4. Can you identify which features of case management you currently use in your practice?
5. What are the most helpful aspects of case management that you have used / or can identify?
6. In what way has case management been helpful?
  - In respect of patient care
  - In respect of organisation of care
  - In respect of positive patient outcomes
7. Which aspects of case management have you found least useful?
  - In respect of patient care
  - In respect of organisation of care
  - In respect of positive patient outcomes
8. Which aspects of case management would you like to see incorporated into this approach to care?
9. What did you think the benefits would be if these were to be used in your everyday practice?
10. What is required to be put in place to develop case management approach to care?
11. Who are the case managers currently?
12. Who should be (leading) case management?

Is there anything else you wish to add?

Thank-you

## **Appendix 2: Topic Schedule for Focus Group Interviews**

### **Situation**

Is the situation identified as anticipated?

Anything to add?

### **Background**

Are the findings from the analysis as you anticipated?

In respect of:

- patient care
- organisation of care
- positive patient outcomes
- professional practice

Can you identify how the principles of case management model have been implemented in your practice? (as identified in analysis)

Anything else to add in that reflects experience of use in NHS H?

### **Assessment**

Are the key challenges identified in the analysis as anticipated?

In respect of:

- referral
- assessment of care needs
- planning care
- delivery of care

### **Recommendations**

What actions can be taken to progress implementation of case management?

In relation to:

- definitions and terms
- Referral systems
- Assessment of care needs
- Planning of care
- Delivery of care

(\*case finding for identification (SPARRA)

(role of risk assessment tools – anticipatory care? )

### **Implementation**

Any other issues?

**What would like the next steps to be to support implementation?**

### **Research feedback**

How helpful has the feedback been to supporting case management implementation?



## **4. Practitioners with special interest (Heart care and Child care) Literature Review**

### **4.1 Aims**

The aims of this project were threefold: 1) To review databases of published medical and social work literature in order to identify existing tools that are available to nurses in the community to guide practice interventions in child protection and heart failure. 2) To assess any evidence supporting the development/implementation of these tools. 3) To examine how these tools map onto existing distinctions between generalist, specialist and advanced practitioners.

### **4.2 Research Questions**

What tools have been developed to inform community nursing practice in child protection and heart failure?

What evidence supports the development/implementation of these tools?

How far, if at all, do these tools map onto distinctions between generalist, specialist and advanced practitioners?

### **4.3 Methods**

Stage 1: Designing the search strategy

The search strategy (see 4.10 Appendix 1) was informed by telephone and video link interviews with colleagues at University of Stirling Highland Campus who had expertise in child protection and heart failure. These interviews helped to identify terms that would allow extraction of literature pertaining to child protection and heart failure tools from electronic medical and social work databases. Terms that would allow extraction of literature pertaining to: i) generalist, specialist and advanced practice nursing roles; ii) tools and protocols were identified by CG in collaboration with other RONC research team members. Appropriate electronic medical and social work databases were also identified by CG in collaboration with other RONC research team members. A narrative technique was adopted to perform the review because of the diverse nature of the literature being synthesised (Dixon-Woods M 2004).

Stage 2 Policy and Practice

[Social Services Abstracts](#) and [Sociological](#) Identifying existing tools and protocols.

Two types of searches, which complemented and informed each other, were undertaken:

**A.** Searches to identify the range of tools that could be used to guide community nursing practice in child protection and heart failure. We searched the following resources: A number of medical, sociological and social work databases: Medline, Embase, CINAHL, British Nursing Index and Archive, Social Care Online, [Social Sciences Citation Index](#), Social Work Abstracts, Social [Abstracts](#).

Websites that provide information on potentially relevant tools.

Books and reports that provide information about potentially relevant tools.

**B.** Searches of review-level evidence (e.g., systematic reviews).

Stage 3: Evidence supporting tool development

Every paper/report/guideline identified in Stage 2 was closely read to extract any evidence pertaining to the implementation and acceptability of the tool and any outcomes associated with its use. Websites were consulted for additional information were necessary and practical.

Stage 4: Mapping existing tools onto current nursing roles

Every paper/report/guideline identified in Stage 2 was closely read to establish whether the tool was designed for use by specialist, generalist or advanced practitioners.

## **4.4 Findings**

The database searches identified 504 and 155 potentially relevant research articles for child protection and heart failure respectively (see 4.10 Appendix 1). These references were imported into Reference Manager to allow an initial screening of the titles and abstracts of each article. Any reports that the researcher was unsure about were included at this stage. This initial screening produced 93 articles for child protection and 50 articles for heart failure that appeared to contain tools/guidelines/recommendations that might be relevant to the current review. These references were imported into separate Excel databases for child protection and heart failure to allow extraction of detailed data about the tools from the original articles. The detailed data included where the tools were used (country and setting), who they were used by, what they were used for and a description of any evidence supporting their development/implementation.

The database searches were supplemented with additional searches of the Internet and books. The researcher also emailed some authors to ask for additional information not included in the research articles. The extraction process led to the further exclusion of 65 references for child protection and 15 references for heart failure. The included articles are listed in Tables 1-3 (child protection) and Tables 4-5 (heart failure).

#### **4.5 Child Protection**

The review identified 34 articles/reports (Table 1) containing tools that might help guide community nurse practice interventions in child protection. The articles included the Common Assessment Framework and Lead Professional Working document issued by the Department of Health in England and Wales, and the Scottish Government's Getting it Right for Every Child document. Other tools included a well-child encounter flow sheet, an action if child abuse suspected flow chart, a six part needs/risk analysis tool, a dedicated child abuse page in the child personal health record, a manual for prevention of tertiary child abuse, a report writing pack, and a tool kit pertaining to the sharing of information with other professionals (e.g., social workers). Three tools related to professional development of any health professional involved in child protection cases and there were 11 scales that could be used for a) identification of at risk families, or b) assessment of abuse or neglect.

The review also identified 9 programmes that appeared to have at least one component relating to child protection. Seven of these programmes (including the Starting Well Initiative that initially targeted families in two deprived communities in Glasgow over a three year period from 2000) were primarily aimed at prevention of child maltreatment and the promotion of positive child development. The remaining programmes were concerned with the assessment and treatment of children who had experienced emotional abuse, and the educations of parents whose children had been neglected/abused. All of these programmes contained tools/guidelines/protocols that could be/were being used by nurse practitioners in community settings. The majority (22) of the articles were from the UK, 8 were from the USA, others were from Australia (1), Belgium (1), Canada (1) and New Zealand (1).

The review identified three booklets giving specific guidance on child protection issues to community nurses and midwives, and health visitors, and three more global guidelines containing recommendations and advice on child protection issues. The booklets and guidelines were all UK-based.

#### **4.5.1 Evidence**

The evidence supporting the development/implementation of the 34 child protection tools included in the review was varied. However, only 6 tools did not appear to have any evidence supporting their use, and 3 others were being evaluated [1 randomised controlled trial (RCT) and 2 operational evaluation/audits] at the time of publication. Two of the tools were supported by RCT evidence (220-468 participants in the intervention groups, 2-3 years duration), 11 had validity and/or reliability ratings (based on 54 to 15,100 cases), 1 had been tested in using a quasi-experiment (367 intervention families, duration 18 months), 6 had been included in a programme evaluation or audit (of 6 months-5 years operation), 4 had undergone feasibility studies (involving 18-177 health professionals or families) and a case study was reported as evidence for an assessment and treatment programme for emotionally abused children. Interestingly, the review identified a further 5 articles (not included in this report) that suggested that health visitors, community midwives and public health nurses in the UK, USA and Finland may be reluctant to use tools, preferring instead to rely on their own skills and professional judgement (Appleton 1997; Appleton & Cowley 2003 2004; Paavilainen & Tarkka 2003; Taylor, Baldwin & Spencer 2008).

#### **4.5.2 Roles – Child welfare**

The involvement of many different agencies (social work, education, the justice system, as well as the health service) means that half of the tools (17) and 1 of the booklets are difficult to map onto distinctions between generalist, specialist and advanced health practitioners. Of the remainder, 10 appear to be aimed at specialist practitioners (mainly health visitors) and 2 appear to be for generalist practitioners. Four other tools could be mapped onto either generalist or specialist roles, but it was unclear from the terminology used in the relevant articles which of these mappings would be most appropriate. It is noteworthy that very few (if any) child protection articles used generalist/specialist /advanced terminology, and none of the tools seemed to specifically for use by advanced practitioners.

## **4.6 Heart Failure**

The review identified 30 articles/reports containing tools that might help guide community nurse practice interventions in heart failure. 11 of these tools appeared to be primarily concerned with disease management, 8 had some element of patient education, 6 specifically promoted self care behaviours in patients and 5 were related to drug administration (beta-blockers or diuretics). The tools were mainly for use in patients' homes or community clinics, however some were also used in hospital settings, but were included in the review because they had a substantial home visiting component. Some tools included telemonitoring, which was generally used in conjunction with home visits. The majority (17) of the articles were from the USA, 9 were from UK-based authors, the others were from Canada (2), Australia (1) and the Netherlands (1).

The review also identified five, relatively recent, guideline documents that contained recommendations and advice for heart failure practice. Two of these guidelines were published in the USA, 2 in the UK, and the final set were published by the European Society of Cardiology.

### **4.6.1 Evidence**

The evidence supporting the development/implementation of the 30 heart failure tools included in the review was varied. Only 6 tools did not appear to have any evidence supporting their use; another was about to be audited at the time of publication. Twelve tools were backed by RCT (or similar) evidence (27- 505 patients in the intervention groups, duration 45-1000 days). One RCT also reported long-term (4 year) follow-up data. One teaching tool (and the telemanagement/home visit intervention it was used in) was evaluated using a quasi-experimental design (22 patients, 9 week duration). Nine tools had been included in an audit or programme evaluation (of 7 months-4 years operation). Finally, a short pilot study (1 month duration) was used to test a previously-audited diuretic treatment algorithm in a new setting.

#### **4.6.2 Roles – Heart failure**

The mapping between tools and generalist, specialist and advanced practitioner roles tended to be reasonably straightforward in heart failure. Advanced/specialist/generalist terminology was often used specifically in the articles, and there were only 6 cases where lack of specification of the role made the mapping hard to perform. Four tools appeared to be aimed at use solely by advanced practitioners, another was for use by both specialist (although this mapping was not entirely clear) and advanced practitioners, and 2 further tools were for either specialist or generalist practitioners with recourse to an advanced practitioner. Many of the tools (13) appeared to be aimed at use by specialist practitioners working independently of advanced and generalist practitioners, although one of the tools did involve a specialist nurse training a generalist nurse to use it, and another was for use by generalist nurses with recourse to a specialist nurse. A further tool was designed for use by both specialists and generalists, and only 1 tool was designed for use by generalist practitioners alone.

#### **4.7 Limitations**

The electronic databases used in the search appeared to be limited in their ability to capture the types of tools we wanted to identify in this project. This may be due to a number of reasons: the difficulties of developing a sensitive search strategy; the likelihood that information about, or evidence supporting, the tools may be held by the department/board/trust that developed the tool and may be more accessible to a non-systematic internet search. Unfortunately, a thorough search of local health board and primary care trust websites was not practical given the limited timescale of this project. The timescale also precluded a thorough examination of review articles to ensure that all the articles cited therein had been identified by the database searches. It is therefore probably that Tables 1-5 do not represent the complete list of tools available to guide practice interventions by community nurses in child protection and heart failure. It was also not practical to follow up initial email requests to authors of papers/reports for additional information where no response was forthcoming. Therefore the reported evidence supporting some tools is almost certainly incomplete. Finally, papers that were not written in English were not reviewed.

## 4.8 Tables

**Table 1 Tools for guiding practice interventions in child protection**

Name/Description of tool	Authors	Year	Country	Where used	Who used by	What used for	Description of evidence	Robustness of findings	Role
Common Assessment Framework - a holistic assessment of children's needs	Brandon M; Howe A; Dagley V; Salter C; Warren C; Black J	2006	UK	In community	Professionals who work with children including nurses and health visitors	To assess child health, safety, and potential to enjoy and achieve, make a positive contribution and achieve economic well-being in adulthood	General enthusiasm for CAF and Lead Professional working, there had been a positive impact on children's lives. Concerns about workload, lack of clarity and concept of holistic assessments. Some health visitors not convinced about CAF helpfulness	Feasibility study - interviews, workshops, telephone survey (142 lead professionals, practitioners and line managers). Qualitative study (6 health visitors)	Varied
Framework for the Assessment of Children in Need and their Families	Department of Health	2000	UK	In community	For all professionals involved with children	Assessing children's need and informing judgement and decision making	Contains validated scales	Reliability/validity	Varied
Getting it Right For Every Child - 8 Well Being Indicators, My World Triangle, Resilience Map	Scottish Government	2008	UK Scotland	In all settings	All practitioners involved with children and young people	Identifies needs and concerns in specific areas, provides a mental map of child's world, allows the balance between vulnerability and resilience/ adversity and protective factors to be weighed	Not clear	n/a	Varied

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
What to do if you're worried a child is being abused - describes how to act if child abuse is suspected and provides a numbers of scales that can be used	Department for Children, Schools and Families	2006	UK	In community	By all professionals involved with children	Gives professionals tools to assess cases of suspected child and confidence to act appropriately	Contains validated scales	Reliability and validity	Varied
Well-child encounter flow sheet for documenting child health for high risk infants - includes areas pertaining to child abuse and neglect	Moldanado SA	1991	USA	In community	Public health nurses	Documenting child health and facilitating implementation of nursing process	Satisfactory documentation for physical assessment, child abuse and neglect potential in the home, and safety. Poor documentation of anticipatory guidance or intervention provided. Outcome measures, expressed as goal statements, well documented	Evaluation of use of flow sheets in high risk infant encounters (N=31)	Generalist?
A six part analysis tool to recognise vulnerability, need and risk in children	Scott L	2003	UK	In community	Any child care professional - originally developed from health visitor practices	Assessing vulnerability, need and risk in children	Positive feedback from practitioner - tool is helpful and there has been a reduction in case reviews associated with serious injury or death	Testimony and audit (2 years duration)	Varied
A sharing information tool kit	Lynch B	2006	UK	In community	All professionals and volunteers working in child protection	Provides guidelines on when and how to share information about children with other professionals	Evaluation being carried out in 2006	n/a	Varied



<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Tool box of self-learning material on prevention of shaking and impact head injuries in babies	Coles L; Collins L;	2007	UK	In community	Health visitors	Gives information on how to prevent shaking and impact head injuries in babies	Barriers to use included lack of knowledge/perceived service limitations. Facilitators included a desire for using focused interventions. Development of evaluation methods needed. Consensus that fathers must be included	Qualitative feasibility study (22 health visitors)	Specialist
Getting it Right for Children and Young People: A self-assessment tool for practice nurses	Royal College of Nursing	2006	UK	In primary care	Practice nurses	To improve the care of children by allowing practice nurses to identify knowledge gaps	Not clear	n/a	Generalist
Self assessment tool - allows clinicians to monitor their own performance in child protection cases	Commission for Health Improvement	2004	UK	In community	All health professionals involved in child protection cases	Facilitates self monitoring of performance	None	n/a	Varied
A screening tool to identify at risk families in the post-natal period	Fraser JA; Armstrong KL; Morris JP; Dadds MR	2000	Australia	In community	Assessment tool is self-completed	The tool has been used here only in research context, but has potential for use by health providers	Homogeneous (Cronbach's alpha for domestic violence sub scale = .78) and low risk of response bias	Reliability/validity (636 questionnaires returned, 63.1% response rate)	n/a
20 item scale to assess abuse and neglect	Grietens H; Geeraert L; Hellinx W	2004	Belgium	In community	Home visiting nurses	Assessing risk of abuse and neglect in a newborn child	High internal consistency (Cronbach's alpha = .92) and good inter-rater agreement	Reliability/inter-rater agreement (373 nonabusive and 18 abusive/neglectful mothers)	Specialist?

Name/Description of tool	Authors	Year	Country	Where used	Who used by	What used for	Description of evidence	Robustness of findings	Role
Graded Care Profile Scale to measure neglect	Srivastava OP; Polnay L;	1997	UK	In community	Health visitor, nursery teacher or social worker	Provides a measure of care in four areas: physical, safety, love and esteem on a bipolar continuum	Good inter-rater agreement between health visitor, nursery teacher and social worker in all 4 scales	Inter-rater agreement (43 "normal" nursery children, 11 children at risk of neglect)	Varied
Minnesota SDM Family Risk Assessment of Abuse and Neglect	Loman A; Siegel GL	2004	USA	In community	Professionals dealing with child protection cases	To determine the probability that a family will continue to abuse or neglect their children	Good predictive validity: both subscales had reliability slightly below acceptable levels (Cronbach's alpha: neglect = .68; abuse = .65)	Reliability (477 families). Validity (15,100 families tracked over 24 months)	Varied
Child Abuse Potential Inventory	Milner JS	1986	USA	Suitable for use in community settings	Any professional who is trained in administering the scale	To screen for physical child abuse	High internal consistency for both controls and abusers (Cronbach's alphas > .90). Temporal stability estimates adequate	Reliability	Varied
Home Visitor Programme to prevent child maltreatment - delivered antenatally and for 12 months postnatally	Barlow J	2003	UK	In community	Health Visitors	Preventing child abuse in vulnerable families, includes a screening tool to identify at risk mothers	RCT in progress	n/a	Specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Child Assessment Rating and Evaluation [CARE] programme – includes Index of Needs assessment to identify child abuse/neglect	Browne K; Douglas J; Hamilton-Giachritsis C; Hegarty J	2006	UK	In primary care	Health visitors, social workers and paediatricians	Ensuring early prediction and prevention of child health, development and child protection problems during first year of life	96.2% of families correctly classified as referral or non-referral	Predictive validity (4351 infants screened at birth and followed for 13 months. 27 referred for child abuse/neglect; duration 2 years)	Varied
Early Start - home visitation prevention programme for preschool children and their families used throughout preschool years	Fergusson DM; Grant H; Horwood LJ; Ridder EM	2006	New Zealand	In community	Community health nurses or social workers	Pre-school home visitation programme to prevent child health, development and abuse/neglect problems in at risk families	Reduced rates of hospital attendance for injury/poisoning and reduced rates of severe parent/child assaults	RCT (220 families in intervention group; duration 36 months)	Generalist?
Assessment and treatment programme for child emotional abuse including a professional and practice checklist	Hancock P	1998	UK	In community	Specialist Health Visitor	Delivering assessment and treatment programme for child emotional abuse	Child became more confident and her functioning improved. Mother felt closer to child	Case study	Specialist
Starting Well - intensive home visiting programme during first 3 years of child's life (a child health package with a significant focus on child protection)	Mackenzie M; Shute J; Berzins K; Judge K	2004	UK Scotland	In community	Health visitors and paraprofessionals	To improve child health in deprived areas by supporting families and providing enhanced community resources	Depression (a risk factor of abuse/neglect) was lower in mothers 6 months postnatally and there was improvement in quality of home environment at 18 months (both findings not applicable to minority ethnic households)	Quasi experimental study (367 intervention families and 260 comparison families; duration 18 months)	Specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Early Intervention Programme Screening Guidelines and Semi-Structured Interview for identification of families at risk of infant maltreatment - part of a home visiting programme	Naughton A	2001	UK	In community	Health visitors	Identification of risk for and prevention of infant maltreatment - assessment done during antenatal period and intervention continued through early years of the child's life	75% of cases have successful outcomes	Evaluation of the programme that uses the checklist (duration 5 years)	Specialist
Prenatal and infancy home visiting programme (during pregnancy and first two years of life) includes guidelines	Olds DL	2002	USA	In community	Nurses or trained paraprofessionals	To improve the early health and development and future life trajectories of low-income mothers and children	Fewer injuries that might be associated with child abuse or neglect and fewer verified reports of child abuse/neglect. Reduction in child mortality between birth and 9 years	Two RCTs (a. 400 participants in four groups; duration 2 years, 15 year follow up: b. 1139 participants in four groups; duration 2 years)	Specialist?
Parenting Profile Assessment	Anderson CL	1987	USA	In community and hospitals	Nurses	Assessment of mother's parenting potential and possibility of child abuse	During development of scale 20 variables identified that discriminated between abusive and non-abusive mothers	Validity (30 abusive or potential abusive mothers and 32 non-abusive mothers: duration 9 months)	Not clear

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
An additional page raising issues rated to child abuse that is added to a child's personal health record	Glew A; Herron H	1998	UK	In community	Health visitors	Providing parents with knowledge about child abuse. Legitimising discussion of child abuse	Most health visitors who took part welcomed discussion of child abuse. Clients appreciated the information	Feasibility study (177 clients responded, but only 35% of health visitors; duration 1 month)	Specialist
Pack containing forms to give structure to writing case reports	Warner U	1993	UK	In community	Health visitors and school nurses	Guides child protection report writing. Fosters objective evaluation and effective presentations at case conferences	None	n/a	Varied
Manual with guidelines and resources for tertiary prevention of child abuse	MacMillan HL; Thomas BH	1993	Canada	In home and through phone calls	Trained home visiting nurses	Preventing recurrence of child abuse/neglect	Families will participate and the nurses involved found the work rewarding	Feasibility study [18 families (14 completed); duration 6 months]	Specialist
13 item health visitors' screening checklist	Browne K	1989	UK	In home	Health visitors and other health professionals	Routine screening of newborn infants for risk of child abuse/neglect	Correctly identified 82% of abusing or non-abusing families retrospectively, less discriminating prospectively	Retrospective validity (124 non-abusing/62 abusing families) Prospective validity (14,000 cases; 2 year follow up from birth)	Varied
Early Intervention Strategy Framework	Crompton K; Davies M; Humphris A	1998	UK	In home	Health visitors	Assessment of parenting problems and promotion of positive parenting to prevent child abuse/neglect	Audits of implementation, client satisfaction and outcomes underway	n/a	Specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Child sexual abuse procedure and action flow chart	Hall A; Harris RJ	1988	UK	In home	Health and social work professionals	Protocol for use when child sexual abuse is suspected or allegations have been made	Difficulties involved in implementing the guidelines are reported	Evaluation (81 cases of suspected child abuse; duration 12 months)	Varied
Cause for concern criteria	Nash C	1997	UK	Primary care	Health visitors and school nurses	Identification of child protection concerns	Staff found the criteria list useful and used it in referral to other agencies who say the tool improves the clarity of referrals	Audit (6 months operation)	Varied
Protocol for child maltreatment risk reduction	Nester CB	1998	USA	In primary care	Nurse practitioners	Assessment of risk factors and prevention of child abuse	None	n/a	Generalist
Family Crisis Care Programme: 12 week parental education programme	Amundson MJ	1989	USA	In home	Mental health nurses and psychiatric social workers	Improving dysfunctional parenting skills where children are suffering abuse/neglect	90% of children remained in home	Evaluation (42 families; six month follow up)	Specialist
Children of Alcoholics Screening Test	Scheitlin K	1990	USA	Not specific	Can be used by nurses	Identifying children of alcoholics to help prevent abuse/neglect	Validity and reliability has been studied in adolescent, adult and psychiatric populations	Validity and reliability	Varied
Assessment tool	Lupton C	1999	UK	In community	Health visitors	Identification of child protection cases	None - paper focuses on roles of health professionals in child protection rather than the tool itself	n/a	Specialist

**Table 2 Booklets for guiding practice interventions in child protection**

Name/Description of book	Authors	Year	Country	Where used	Who used by	What used for	Description of evidence	Robustness of findings	Role
What should I do? Guidance on confidentiality and under 16s for community nurses, social workers, teachers and youth workers	Brook Advisory Centre	1996	UK	In community	Community nurses, social workers, teachers and youth workers	Ensuring that professionals can provide confidentiality to under 16s	None	n/a	Varied
Protecting the child: an HVA guide to practice and procedures	Health Visitors Association	1994	UK	In community	Community nurses and health visitors	Identification, referral and information about the legal issues surrounding child protection cases	None	n/a	Generalist/ specialist
Child abuse: are you safe? A practical approach to child abuse for health visitors and community nurses, with information for others who work with children	Rochdale Health Visitors Education and Training Trust	1987	UK	In community	Health visitors and community midwives	Dealing with cases of child abuse in the community	None	n/a	Specialist

**Table 3 Guidelines for practice interventions in child protection**

Name/Description of guidelines	Authors	Year	Country	Where used	Who used by	What used for	Description of evidence	Robustness of findings	Role
Safeguarding Children and Young People - every nurse's responsibility - guidelines for nurses on how to recognise signs of abuse and where to find information and support	Royal College of Nursing	2007	UK	In all settings	For all nursing staff	Advice on how to recognise signs of abuse, and when and how to find further information and support	Not clear	n/a	Varied
Child protection: guidance for senior nurses, health visitors and midwives and their managers	Department of Health	1997	UK	In community and hospitals	Nurses, health visitors and midwives	Defines roles, responsibility and accountability of nurses, health visitors, midwives and their managers	Not clear	n/a	Varied
Child protection: guidance for senior nurses, health visitors and midwives - revised to take account of the provisions of the Children Act 1989	Department of Health	1992	UK	In community and hospitals	Nurses, health visitors and midwives	Child protection	Not clear	n/a	Varied



**Table 4 Tools for guiding practice interventions in heart failure**

Name/Description of tool	Authors	Year	Country	Where used	Who used by	What used for	Description of evidence	Robustness of findings	Role
Specialist nurse-led CHD management programme	Turner DA; Paul S; Stone MA et al	2008	UK	At GP practices	Peripatetic specialist nurses	Disease management	Improved patient quality of life, cost of programme acceptable	Cluster RCT (20 GP practices, 505 patients in intervention group; duration unclear)	Specialist
Care pathways and guidelines developed locally in Tower Hamlets, London, for management of heart failure patients	Ruddick L; McIver P	2007	UK	In home	Community heart failure nurses	Heart Failure management	None	Will be audited soon	Specialist
Protocol-driven Heart Failure Specialist Nurse Liaison Service	Hume A; Cranston A et al	2007	UK	In home but not entirely clear	Specialist nurses	Disease management	Improvement in clinical functioning, improvement in prescription and reduction in hospital admissions	Evaluation (1 year duration)	Specialist
Comprehensive heart failure guideline for primary care and primary care referral pathway	Shute H; Kirk M; Basso L et al	2006	UK	In community - mainly clinics	Various clinicians but nurses play an important role	Disease management	Lengths of hospital stays reduced	Audit (1 year duration)	Specialist
Comprehensive telephone-mediated intervention	Duffy JR; Hoskins LM; Dudley-Brown S	2005	UK	In home mainly via telephone but also some home visits	Registered nurses	Management of heart failure patient	None	n/a	Not clear

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Standardised nursing checklist for disease management	Young W; Rewa G; Goodman SG et al	2003	Canada	In home	Cardiac-trained nurses	Management of heart failure patients	Intervention group had lower hospital readmission rates	RCT (146 patients; duration 1000 days)	Specialist
Partners Heart Care Program	Di Salvo TG; Warner SL	2003	USA	In the home, local clinics and tele-monitoring	Nurse visitors, advanced practice nurses and primary care physicians	Stabilization of patients with heart failure	None	n/a	Specialist? and advanced
Covenant Home Health and Hospice Heart Failure Pathway	Gorski LA	2002	USA	In home	Home care nurses	Caring for patients with heart failure in the home	Still being developed, evidence that tool decreased hospital admissions	n/a	Generalist
Structured assessment of CHF patient and home context to inform a report with recommendations that is sent to patient's physician	Stewart S; Horowitz JD	2002	Australia	In homes	Cardiac nurses	Patient assessment aiming to reduce unplanned hospital readmissions and improve quality of life	Fewer unplanned readmissions or deaths and reduced healthcare costs in intervention group	2 RCTs (297 patients; median follow-up 4.2 years)	Specialist
Northwestern healthcare home care chronic heart failure pathway - part of a heart failure disease management programme	Knox D; Mischke L	1999	USA	In home	Trained nurses with recourse to an outpatient advanced practice nurse	Disease management	Reduced readmission to hospital (outcome relates to whole programme not just home-based element)	Evaluation (18 months duration)	Specialist and advanced

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Protocol: congestive heart failure	Duncklee JE	1984	USA	In community	Nurse practitioners	Management of heart failure patient	None	n/a	Not clear
Low-tech telehealth intervention combining structured home visits and telephone calls - includes a teaching tool for patient information	Quinn C	2006	USA	In homes	Home health nurses	Managing and educating patients with heart failure	Decreased rehospitalisation, decreased HF symptoms and increased patient quality of life	Quasi-experiment (22 patients; 9 weeks duration)	Specialist
The Darlington heart failure service model	Fuat A	2005	UK	Primary care heart failure clinic (held weekly)	GP specialist and heart failure nurse	Management and education of patients with heart failure	Improved uptake of beta blockers	Audit (217 patients; 1 year duration)	Specialist
Home 3 month follow up protocol for elders following hospital discharge	Naylor MD; Brooten DA; Campbell RL et al	2004	USA	In hospital and home	Advanced practice nurse	Education and support of patients and management of heart failure	Increased time to hospital readmission or death and decreased health care costs	RCT (239 patients; 52 weeks duration)	Advanced
Home follow up protocol for elders at risk for poor outcome after hospital discharge	Naylor MD; Brooten D; Campbell R et al	1999	USA	In hospital and home	Advanced practice nurse	Education and support of patients, and management of heart failure	Lowered hospital admission rates and health care costs	RCT (363 patients; 24 weeks duration)	Advanced
Standardised heart disease template and locally agreed guidelines (based on National Service Framework for Coronary Heart Disease)	Levie C, Findlay S	2002	UK	In primary care nurse-led clinics	Specialist and generalist nurses	Management and education of patient with heart failure	Cholesterol levels improved, and aspirin prescribing increased. Patients satisfied and had better understanding of condition	Audit (nearly 4000 patients; 12 month duration)	Generalist and specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
A home-based specialist nurse intervention in heart failure	Blue L; Lang E et al	2001	UK	Home visits and tele-monitoring	Specialist nurses	Patient education, and holistic management of heart failure patient	Fewer hospital readmissions in intervention group	RCT (165 patients; 1 year duration)	Specialist
Home Health Congestive Heart Failure Pathway for patients who have poor management skills	Graybeal K; Moccia-Sattler J	2001	USA	In home	Generalist nurse with recourse to advanced practice nurse	Disease management and patient education	None	n/a	Generalist and advanced
Teaching booklet for patient education and dietary assessment at hospital discharge, and 3 month follow up including home visits and telephone monitoring	Rich, MW; Beckham, V; Wittenberg, C et al.	1995	USA	In homes	Cardiovascular nurse specialist leading a multi-disciplinary team	Patient education and treatment	Lower rates of hospital readmissions and lower cost of care for intervention group	Prospective randomised trial (282 patients; 90 days duration)	Specialist
Just-in-time evidence-based e-mail 'reminders' in home health care, with prompts for nurses and patient education material	Feldman PH; Murtaugh CM et al	2005	USA	In home	Generalist home care nurses with recourse to clinical nurse specialist	Management of heart failure patient, and promotion of self-care behaviours	Improved clinical outcomes and functional status, improved quality of life, better medication knowledge, diet and weight monitoring	RCT (628 patients; 45 day duration)	Generalist and specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Health (Health Outcomes, Management and Evaluation) Plan	Feldman PH; Peng TR et al	2004	USA	In home	Nurses	Care of patients and support for patients' self management	Marginally significant reduction in number of skilled nursing visits	RCT (371 patients; 1 year duration)	Not clear
Partners in Care Model - to help HF patients manage their condition	Pugh LC; Havens DS; Xie S et al	2001	USA	In home	Nurse case manager	Monitor patients with HF in home and promote self-management	Trend towards improved quality of life for patients, cost-effective	Randomised pilot clinical trial (58 patients, 27 in treatment group; 6 month duration)	Specialist
Partners in Care for Congestive Heart Failure - patient education programme	Toman C; Harrison MB; Logan J	2001	Canada	Community and hospital settings	Not clear	Education of patients and their families about heart failure and how to self-manage	None	n/a	Not clear
Nursing care plan for older patients with heart failure	Jaarsma T; Halfens R; Abu-Saad HH et al	1999	Netherlands	Hospital then home	Nurses	Education and support of patients' self care behaviours	Self care behaviour significantly increased in intervention group	Prospective evaluation (179 patients randomised to intervention or control; 9 months duration)	Not clear
TGC Home Health Care cardiac specialty programme	Lazarre M; Ax S	1997	USA	In homes	Nurses with critical care backgrounds	Patient education about medication regimes, diet therapy and response to emergencies - active self management promoted	Reduced readmission to hospital	Evaluation (34 patients; 7 month duration)	Specialist

<b>Name/Description of tool</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
Diuretic treatment algorithm	Backe J; Wick LL	2007	USA	Tele-monitoring in the community	Registered nurses	Adjustment of diuretic dosage (based on Mueller et al's 2002 algorithm - below)	Increased patient satisfaction, decrease hospital admissions and increased efficiency	Pilot study (1 month duration)	Not clear
Diuretic treatment algorithm	Mueller TM; Vuckovic KM; Knox DA; Williams RE	2002	USA	Home	Advanced practice nurse	Administering appropriate doses of diuretics	Decrease in hospital readmissions and costs of care	Audit (271 patients; 4 year duration)	Advanced
Protocol for titration of beta blocker (carvedilol)	Moyer-Knox D; Mueller TM; Vuckovic K et al	2004	USA	In home setting with patients phoning in	Advanced practice nurse	Making sure patients get the right dose of carvedilol	96% of patients reached therapeutic dose, and no hospital readmissions during intervention	Audit (70 patients; 2 year duration)	Advanced
Nurse-led heart failure clinic in primary care delivering beta blocker therapy to patients. Computer programme used to prescribe beta blockers	Wald D; Milne S; Chinn R et al	2004	UK	At health centre	Nurses trained by a specialist nurse and a cardiologist	Delivering beta blocker therapy in primary care	13 patients started on beta blockers in clinic, 7 titrated up to maximum dose without adverse side effects. Patients happy with service	Audit (17 patients; 1 year duration)	Generalist and specialist
Strategies to increase beta-blocker use in heart failure	Ansari M; Shlipak MG et al	2003	USA	Primary care	Specialist nurse supervised by two cardiologists	Initiating and titrating beta blockers	More patients initiated and on target beta blocker dose in nurse facilitator group	RCT (209 patients; 1 year duration)	Specialist

**Table 5 Guidelines for practice interventions in heart failure**

<b>Name/Description of guidelines</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Where used</b>	<b>Who used by</b>	<b>What used for</b>	<b>Description of evidence</b>	<b>Robustness of findings</b>	<b>Role</b>
ACCF/AHA Guidelines for the Diagnosis and Management of Heart failure in Adults	Jessup et al	2009	USA	Multiple settings	Health professionals including nurses	All aspects of caring for patients with heart failure	Varied, but closely specified	Varied, but closely specified	Varied
ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure	Dickstein K; Cohen-Solal A; Filippatos G et al	2008	Europe	Multiple settings	Health professionals including nurses	All aspects of caring for patients with heart failure	Varied, but closely specified	Varied, but closely specified	Varied
Management of Chronic Heart Failure	Scottish Intercollegiate Guidelines Network	2007	UK	Multiple settings	Health professionals including nurses	All aspects of caring for patients with heart failure	Varied, but closely specified	Varied, but closely specified	Varied
Heart Failure Society of America 2006 Comprehensive Heart Failure Practice Guideline	Adams KF; Lindenfeld J et al	2006	USA	Multiple settings	Health professionals including nurses	All aspects of caring for patients with heart failure	Varied, but closely specified	Varied, but closely specified	Varied
Chronic Heart Failure National clinical guideline for diagnosis and management in primary and secondary care	National Institute for Clinical Excellence	2003	UK	Multiple settings	Health professionals including nurses	All aspects of caring for patients with heart failure	Varied, but closely specified	Varied, but closely specified	Varied

## 4.9 Conclusion

A number of tools are available to guide community nursing practice interventions in child protection and heart failure. The tools cover different aspects of practice, including: the assessment of children/families and professional development in child protection; disease management, patient education and drug administration in heart failure. Most child protection tools were found in UK-authored articles, whereas most heart failure tools were identified from USA-authored papers. The reason for this difference in provenance is not clear.

There was a difference in the type of research that has been conducted to support tool development/implementation in the two areas. Randomised controlled trials were commonly used to evaluate heart failure programmes and tools, whereas the fact that a number of scales were identified in child protection meant that validity and/or reliability measures were more prevalent. Feasibility studies also featured in child protection, but not in heart failure: this may reflect the fact that some health professionals may be reluctant to use child protection tools, so acceptability is a real concern here.

Finally, mapping the tools onto generalist, specialist and advanced practitioner roles often proved difficult in child protection as generalist/specialist/advanced terminology was rarely used in the articles published in this area. In contrast, the mapping between tools and role distinctions was relatively straightforward in heart failure. This difference most likely reflects the assumption that all professionals working with children have a responsibility towards child protection, as well as the fact that care of patients with heart failure in the community may often involve only health professionals, whereas child protection cases tend to be multi-agency.



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## 4.11 Appendix 1

### Details of searches performed for the practitioners with special interest literature review (June 2009)

Database	Search terms (combined with OR or AND)	Limits	Hits
<b>Medline, British Nursing Index and Archive, EMBASE, Social Work Abstracts, Social Policy and Practice (OVID)</b>	<p><b>ROLE:</b>(community and (midwife or midwives)) or (extended adj1 scope adj1 practitioner\$) or (child adj1 protection adj1 (lead\$ or advisor\$)) or (health adj1 visitor\$) or ((specialist or advanced) adj1 practitioner\$) or (nurse-led adj1 heart adj1 failure adj1 service) or (lead adj1 professional\$) or (home adj1 care adj1 nurse\$) or (heart adj1 failure adj1 nurse\$) or (primary adj1 care adj1 nurse\$) or (child adj1 protection adj1 nurse\$) or (family adj1 health adj1 nurse\$) or (clinical adj1 nurse adj1 specialist\$) or (advanced adj1 practice adj1 nurse\$) or (cardiac adj1 rehabilitation adj1 nurse\$) or (nurse adj1 generalist\$) or (nurse adj1 specialist\$) or (nurse adj1 consultant\$) or (registered adj1 nurse\$) or (visiting adj1 nurse\$) or (district adj1 nurse\$) or (nurse\$ and community) or (nurse adj1 practitioner\$)</p> <p><b>TOOL:</b>(quality adj1 standards) or (care adj1 plan) or toolkit\$ or checklist\$ or tool\$ or guideline\$ or protocol\$ or algorithm\$ or package\$ or framework\$ or resource\$ or (nursing adj1 process\$) or (care adj1 plans) or (clinical adj1 pathway\$) or (care adj1 bundle\$) or (how adj1 to adj1 guide\$)</p> <p><b>CHILD PROTECTION:</b> (child adj1 protection) or (abuse and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or (neglect and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or (risk and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or ((unmet adj1 needs) and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or ((holistic adj1 assessment) and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or (child adj3 welfare) or (child adj1 advocacy) or (child adj1 custod\$) or (battered adj1 child adj1 syndrome) or (child adj1 health adj1 services) or (shaken adj1 baby adj1 syndrome) or (child adj1 molestation) or parenting or (child adj1 rearing) or (vulnerable adj1 (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or ((domestic adj1 violence) and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or ((sexual adj1 abuse) and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or (guidance and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) or ((harm and (child\$ or infan\$ or young or adolescen\$ or teenage\$ or youth or baby or preschool\$ or p\$ediatric\$)) not (self adj1 harm))</p> <p><b>HEART FAILURE:</b> (heart adj2 failure) or (cardiac adj1 failure) or (cardiac and palliative) or (cardiac and terminal) or (left adj1 ventricular adj1 failure) or (pump adj1 failure) or (grown-up adj1 congenital adj1 heart adj1 disease) or cardiomyopathy or (vascular adj1 disease) or (decompensation and (cardiac or heart)) or (end adj1 stage adj1 cardiac adj1 disease)</p>	English Language 1984-2009 Human Removed duplicates	<b>CHILD PROTECTION:</b> 789 <b>HEART FAILURE:</b> 150
<b>CINAHL</b>	<p><b>ROLE:</b>(+community+AND+(+midwife+OR+midwives+))+OR+(+child+protection+lead\$+)+OR+(+child+protection+advisor\$+)+OR+(+extended+scope+practitioner\$+)+OR+(+health+visitor\$+)+OR+(+specialist+practitioner\$+)+OR+(+advanced+practitioner\$+)+OR+(+nurse+led+heart+failure+service+)+OR+(+lead+professional\$+)+OR+(+home+care+nurse\$+)+OR+(+heart+failure+nurse\$+)+OR+(+primary+care+nurse\$+)+OR+(+child+protection+nurse\$+)+OR+(+family+health+nurse\$+)+OR+(+clinical+nurse+specialist\$+)+OR+(+advanced+practice+nurse\$+)+OR+(+cardiac+rehabilitation+nurse\$+)+OR+(+nurse+consultant\$+)+OR+(+nurse+generalist\$+)+OR+(+nurse+specialist\$+)+OR+(+registered+nurse\$+)+OR+(+visiting+nurse\$+)+OR+(+district+nurse\$+)+OR+(+nurse\$+AND+community+)+OR+(+nurse+practitioner\$+))</p> <p><b>TOOL:</b>((+quality+standards+)+OR+(+care+plan+)+OR+(+toolkit\$+)+OR+(+checklist\$+)+OR+(+tool\$+)+OR+(+guideline\$+)+OR+(+protocol\$+)+OR+(+package\$+)+OR+(+framework\$+)+OR+(+resource\$+)+OR+(+clinical+pathway\$+)+OR+(+nursing+process\$+)+OR+(+care+bundle\$+)+OR+(+how+to+guide\$+))</p> <p><b>CHILD PROTECTION:</b>((child\$)+and+(protection\$))+OR(((child\$)+and+(welfare\$))+OR((child\$</p>	No Limits	<b>CHILD PROTECTION:</b> 805 <b>HEART FAILURE:</b> 127

	<p>)+ and+(advocacy))+OR+((child)+and+(custod*))+OR+((battered)+and+(child)+and+( syndrome))+OR+((child)+and+(health)+and+(services))+OR+((shaken)+and+(baby )+and+(syndrome))+OR+((child)+and+(molestation))+OR+(parenting))+OR+((child )+and+(rearing))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teena ge*)+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+(abuse))+OR+ (((child*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teenage*)+or+(youth)+or+( baby)+or+(preschool*)+or+(p*ediatric*))+AND+(neglect))+OR+(((child*)+or+(infan*) )+or+(young)+or+(adolescen*)+or+(teenage*)+or+(youth)+or+(baby)+or+(preschoo l*)+or+(p*ediatric*))+AND+(risk))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*) )+or+(teenage*)+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+ ((unmet)+and+(needs))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*) )+or+(teenage*)+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+((h olistic)+and+(assessment))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*) )+or+(teenage*)+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+(v ulnerable))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teenage*) )+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+((domestic)+and+( violence))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teenage*) )+or+(youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+((sexual)+and+(ab use))+OR+(((child*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teenage*)+or+( youth)+or+(baby)+or+(preschool*)+or+(p*ediatric*))+AND+(guidance))+OR+(((chil d*)+or+(infan*)+or+(young)+or+(adolescen*)+or+(teenage*)+or+(youth)+or+(baby )+or+(preschool*)+or+(p*ediatric*))+AND+(harm not (self and harm)))</p> <p><b>HEART FAILURE:</b>((+cardiac+AND+palliative+)+OR+(+cardiac+AND+terminal+)+OR+ ((heart)+and+(failure))+OR+((cardiac)+and+(failure))+OR+((left)+and+(ventricular) )+and+(failure))+OR+((pump)+and+(failure))+OR+((grown+up)+and+(congenital)+a nd+(heart)+and+(disease))+OR+(cardiomyopathy)+OR+((vascular)+and+(disease) )+OR+((cardiac)+and+(decompensation))+OR+((heart)+and+(decompensation))+ OR+((end)+and+(stage)+and+(cardiac)+and+(disease)))</p>		
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Database	Search terms (combined with OR or AND)	Limits	Hits
<b>Social Care Online</b>	<p><b>CHILD PROTECTION:</b> ("community nurses" or nurses or "health visitors" or midwives or "district nurse") and ("child abuse" or "child sexual abuse" or "vulnerable children" or "child neglect" or "domestic violence" or "child protection" or "child protection services" or "children in need" or babies or "preschool children" or "young people" or "child custody" or parenting or "family support" or incest or babies)</p> <p><b>HEART FAILURE:</b> ("community nurses" or nurses or "health visitors" or midwives or "district nurse") and "heart diseases"</p>	No Limits	<p><b>CHILD PROTECTIO N:</b> 344 <b>HEART FAILURE:</b> 3</p>
<b>Social Sciences Citation Index</b>	<p><b>ROLE:</b>Topic=(nurse and consultant*) OR Topic=(registered and nurse*) OR Topic=(visiting and nurse*) OR Topic=(district and nurse*) OR Topic=(nurse* and community) OR Topic=(nurse and practitioner*) Topic=(community and (midwife or midwives)) OR Topic=(extended and scope and practitioner*) OR Topic=(child and protection and (lead* or advisor*)) OR Topic=(health and visitor*) OR Topic=((specialist or advanced) and practitioner*) OR Topic=(nurse-led and heart and failure and service) OR Topic=(lead and professional*) OR Topic=(home and care and nurse*) OR Topic=(heart and failure and nurse*) OR Topic=(primary and care and nurse*) OR Topic=(child and protection and nurse*) OR Topic=(family and health and nurse*) OR Topic=(clinical and nurse and specialist*) OR Topic=(advanced and practice and nurse*) OR Topic=(cardiac and rehabilitation and nurse*) OR Topic=(nurse and generalist*) OR Topic=(nurse and specialist*)</p> <p><b>TOOL:</b>Topic=((how to guide*)) OR Topic=((care bundle*)) OR Topic=((clinical pathway*)) OR Topic=((care plans)) OR Topic=((nursing process*)) OR Topic=(resource*) OR Topic=(framework*) OR Topic=(package*) OR Topic=(protocol*) OR Topic=(guideline*) OR Topic=(tool*) OR Topic=(checklist*) OR Topic=(toolkit*) OR Topic=((care plan)) OR Topic=((quality standards))</p> <p><b>CHILD PROTECTION:</b> Topic=((vulnerable or (domestic and violence) or (sexual and abuse) or guidance) and (child* or infan* or young or adolescen* or teenage* or youth or baby or preschool* or p*ediatric*)) OR Topic=(harm and (child* or infan* or young or adolescen* or teenage* or youth or baby or preschool* or</p>	No Limits	<p><b>CHILD PROTECTIO N:</b> 359 <b>HEART FAILURE:</b> 99</p>

	<p>p*ediatric*) not (self and harm)) Topic=(child and protection) OR Topic=((child* or infan* or young or adolescen* or teenage* or youth or baby or preschool* or p*ediatric*) and (abuse or neglect or risk or (unmet and needs) or (holistic and assessment) )) OR Topic=(child and welfare) OR Topic=(child and advocacy) OR Topic=(child and custod*) OR Topic=(battered and child and syndrome) OR Topic=(child and health and services) OR Topic=(shaken and baby and syndrome) OR Topic=(child and molestation) OR Topic=(parenting) OR Topic=(child and rearing)</p> <p><b>HEART FAILURE:</b> Topic=(heart and failure) OR Topic=(cardiac and (failure or palliative or terminal)) OR Topic=(left and ventricular and failure) OR Topic=(pump and failure) OR Topic=(grown-up and congenital and heart and disease) OR Topic=(cardiomyopathy) OR Topic=(vascular and disease) OR Topic=(decompensation and (cardiac or heart)) OR Topic=(end and stage and cardiac and disease)</p>		
<a href="#">Social Services Abstracts &amp; Sociological Abstracts</a>	<p><b>ROLE:</b>KW=((community and (midwife or midwives)) or (extended and scope and practitioner*) or (child and protection and (lead* or advisor*)) or (health and visitor*) or ((specialist or advanced) and practitioner*) or (nurse-led and heart and failure and service) or (lead and professional*) or (home and care and nurse*) or (heart and failure and nurse*) or (primary and care and nurse*) or (child and protection and nurse*) or (family and health and nurse*) or (clinical and nurse and specialist*) or (advanced and practice and nurse*) or (cardiac and rehabilitation and nurse*) or (nurse and generalist*) or (nurse and specialist*) or (nurse and consultant*) or (registered and nurse*) or (visiting and nurse*) or (district and nurse*) or (nurse* and community) or (nurse and practitioner*))</p> <p>KW=((quality and standards) or (care and (plan or plans)) or toolkit* or checklist* or tool* or guideline* or protocol* or package* or framework* or resource* or (nursing and process*) or (clinical and pathway*) or (care and bundle*) or (how and to and guide*))</p> <p><b>CHILD PROTECTION:</b> KW=((child and protection) or ((abuse or neglect or risk or (unmet and needs) or (holistic and assessment) or vulnerable or (domestic and violence) or (sexual and abuse) or guidance) and (child* or infan* or young or adolescen* or teenage* or youth or baby or preschool* or p*ediatric*)) or (child and welfare) or (child and advocacy) or (child and custod*) or (battered and child and syndrome) or (child and health and services) or. (shaken and baby and syndrome) or (child and molestation) or parenting or (child and rearing) or ((harm and (child* or infan* or young or adolescen* or teenage* or youth or baby or preschool* or p*ediatric*) not (self harm))</p> <p><b>HEART FAILURE:</b> KW=((heart and failure) or (cardiac and (failure or palliative or terminal)) or (left and ventricular and failure) or (pump and failure) or (grown-up and congenital and heart and disease) or cardiomyopathy or (vascular and disease) or (decompensation and (cardiac or heart)) or (end and stage and cardiac and disease))</p>	No Limits	<p><b>CHILD PROTECTION:</b> N: 73</p> <p><b>HEART FAILURE:</b> 1</p>
<b>Total</b>	Total after de-duplication within and between databases		<p><b>CHILD PROTECTION:</b> N: 504</p> <p><b>HEART FAILURE:</b> 155</p>



## **5: Practitioners with special interest – child welfare and heart care**

### **5.1 Introduction**

This part of the study explores generalist and specialist community nursing roles, and the tools to support them, for two specified client groups: child welfare, and heart care (representing the management of long term conditions). Both client groups have attracted Government policy initiatives (Scottish Government 2008a, NHS Scotland 2007). These areas were chosen for consideration by nurse managers from NHS Highland as representative of issues around generalist/ specialist practice generated by the implementation of the Review of Nursing in the Community (RONC). Specifically, generalists taking on some aspect of specialist work as part of the community health nurse role identified in the Review (Scottish Executive 2006). The following description of “specialist” provides a useful context for the study:

*... it is increasingly widely accepted that ‘Specialist’ should be considered as one pole of the ‘Specialist – Generalist’ continuum rather than on the developmental continuum from novice to expert. This approach defines ‘specialist’ practice as that which is particular to a specific context, be it a client group, a skill set or an organisational context (Scottish Government 2008b p13).*

*... a ‘specialist nurse’ is regarded as someone with in-depth knowledge and skills in the speciality ... (ibid p14).*

### **5.2 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.

### **5.3 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?

## **5.4 Study Design**

The action research approach is discussed in chapter 5. Initial semi-structured focus group interviews were conducted with nurses working in child health and nurses about to take on the cardiac link health practitioner role. One researcher conducted the focus groups but two researchers were involved in the data analysis and report writing. All interviews were digitally recorded and transcribed prior to data analysis. Thematic analysis on all four transcripts was undertaken by the two researchers. The central themes from the first two group interviews were documented in short summaries used to structure further discussion in a second focus group interview approximately a month after the first. This was done in order to clarify and confirm these emerging themes to increase validity of findings. The four focus group interviews generated all the data and analysis discussed in this section of the report.

The researcher recruited the participants independently of central management intervention, except for knowledge that the study had been commissioned by NHS Highland. The ethics of the study are discussed elsewhere in this report.

For the child health group, four public health nurses attended the first interview and two of these were able to attend the second interview. Both health visiting and school nursing were represented. All had responsibilities for child health / welfare and all practitioners worked in an urban setting.

For the heart care group, four practitioners attended the first interview, and three of these were able to attend the second interview. All were community nurses with an interest in cardiac care, but with a generalist community role. One had a team leader role. The cardiac link health practitioner role had not yet been introduced, but all had extra cardiac experience and / or education compared to other generalist colleagues. Some practitioners worked in an urban setting, and some in a rural setting.

The focus group interview schedule is included in Appendix 1. The schedule helped structure the enquiry into views on generalist and specialist roles, knowledge, skills and tools in the designated areas.

## 5.5 Findings

The groups were considerably different in several respects. The practitioners in the child health group were established specialists in child health and child welfare. Their practice had, over the past two years or so, been affected by the adoption of the “Getting it Right for Every Child (GIRFEC) framework (Scottish Government 2009)<sup>3</sup>. The practitioners in the heart care group were on different bands, but were all generalist community nurses. Three out of the four had completed the Heart Manual (NHS Lothian 2009) facilitator training, and were practicing as facilitators. All had agreed to consider taking on the cardiac link practitioner role, but this was not as yet defined, and no tools other than the Heart Manual had been identified. Because of these marked differences, the findings for the child health group and the heart care group are reported separately, followed by a brief resume of common themes.

### 5.5.1 Child health focus group

Working with children in the community has three distinct levels of practice; child health, child welfare and child protection, and these are related to tiered intervention within the GIRFEC framework. In a community nursing context, child services are primarily health services, but GIRFEC has shifted the role of the child health nurse specialist more towards managing child welfare. Child welfare comes within the remit of specialist child health nurse practitioners because the health focus is inclusive of nurturing, development, safety and preventing harm. When child protection is an issue, nurses will still be involved, but the lead remit passes on to other agencies. As established specialists, the nurses in the child health focus group had views on what skills, knowledge and tools were needed to deal with child welfare issues, and on the transferability of these to their more generalist colleagues.

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<sup>3</sup> In England, the equivalent of GIRFEC is “Every Child Matters” - <http://www.dcsf.gov.uk/everychildmatters/>

### 5.5.1.1 Role shift

This section, and the following one on role blurring, establishes the context for specialist and generalist roles in community nursing child health and welfare.

The roll out of the GIRFEC framework in Highland from mid-2007<sup>4</sup> had resulted in a shift of role for these specialist nurses, in which the role of caseload holder took on a greater significance. In addition some, but not all, had taken on the role of lead professional. All were involved in working with other agencies on a regular basis. This had resulted in a changed workload and a higher workload; for example, documenting evidence in the GIRFEC framework and preparing for and running multi-agency meetings. Nurses identified that they had not been prepared for the level and complexity of multi-agency working. In addition, they reported that administrative support for the lead specialist professional role had not developed in parallel. The child-centeredness of the GIRFEC framework was readily accepted as an advance in practice, but there had been knock-on effects of these changes in workload.

The shift in role for the specialists had meant that the public health nurses had become more reliant on the generalist nurses to step in to more of their work in child health, but participants talked about the fear they had that some generalist nurses did not have the experience to pick up on early warning of child welfare problems. Weighing a baby was given as an example. Participants were keen to stress that, in child welfare work, there was far more to assess in this process than a baby's weight, for example checking skin condition, communication and the relationship between the baby and its carers. In another example a participant shared this interaction she had had with a non-specialist about picking up on potential warning signs:

*...[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 ...*

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<sup>4</sup> See <http://www.forhighlandchildren.org/htm/girfec/girfec-jccyp-papers/girfec-project-management-highland-210306.pdf> for a description of the Highland Pathfinder Project (2006)

There were a number of reasons given why some generalists might have difficulties shifting their role. For example, staff nurses were being employed who did not have experience with children. Many came from acute adult services with a focus on ill health and the opportunities to develop knowledge base and skills in practice before being expected to deliver care had been reduced.

#### **5.5.1.2 Role blurring**

There did not seem to be a simple division between specialist and generalist roles in child welfare. Health visitors and school nurses were the case load holders, but there were also specialisms or special interests within specialist and generalist roles, so there were different layers of specialism. Working as a team, and pulling in generalist practitioners with specialist knowledge and skills, was common practice for advice and co-working and even consulting on decision-making in relation to child welfare and protection. Early years workers were one example, or:

*...whoever is the most appropriate person to consult about the needs of the child...*

However, judgement might be shared, but responsibility could not be. Being the caseload holder also carried with it the final responsibility for decision-making, something the participants were acutely aware of. It was this that really seemed to provide the clearest demarcation of roles between specialist and generalist practitioners.

#### **5.5.1.3 The specialist role and skill set**

Early discussion suggested that use of assessment tools was almost entirely preceded by utilisation of advanced communication and relationship/partnership building skills when approaching discussions with a parent about a child. Practitioners stressed that these initial communication were very important and needed to be based on asking open questions, active listening and sensitivity.

Observation was another key skill that was described as essential by these specialist practitioners. Years of professional experience was viewed as invaluable in supporting the development of specialist observational and communication skills. One participant talked about the way she approached observation when working from a child welfare focus:

*We are looking for the breadth of care that is going in between the parent and the child, the level of care.*

Knowledge of the norms of child development was also viewed as essential so that observation would be able to pick up on, for example, child/parent interactions and whether child behaviour matched expected developmental norms.

There was acknowledgement that formal tools, such as GIRFEC, could create barriers if used in an overt way during the initial communication, observation or assessment stage. Participants did not feel that it was appropriate to go in into such settings with a fixed agenda or “list”. Instead, practitioners described working up to using the GIRFEC tool, again using the advanced communication and observational skills described above.

Having a child and family / parent centred approach was described as the foundation for specialist practice in this field. This meant providing support and asking parents or carers what they needed to help them in a situation. It also meant finding out what had been going on in the family as background and context. Participants spoke about the importance of non-judgmental attitudes in child health and welfare assessments where they tried to be as open as possible from the outset to avoid parental barriers going up. This was noted to be particularly important in the context of perceived substance use or mental health issues with parents.

While GIRFEC will be discussed in more detail below under the tools section, it is important to highlight here the view that GIRFEC had made a considerable difference in supporting or encouraging professionals to put the child right at the centre of their work.

If there was cause for concern, professionals said they needed to be very clear about whether the threshold “between ok parenting and not ok parenting” had been crossed. If it had, there would be a need to gather and organise evidence in a rigorous way in order to inform effective and likely multi-agency assessment and decision-making.

The value of the tools within the GIRFEC framework became clearest at this point. Using the GIRFEC framework could reveal concerns that had not been recognised before without such a systematic approach to assessment and recording the results of this assessment.

Building a case and presenting it to other agencies was seen as part of the specialist role, involving some complex skills. For example, the lead professionals had had to learn how to set up and run multi-agency meetings, and learn how to ensure the health voice was heard. Maintaining good relationships, sometimes in challenging cases where agencies disagreed about actions to be taken, was described as very important. Nurses suggested that having confidence in their skills, knowledge and competence was key, not only to speaking out in multi-agency meetings, but also facilitating these meetings. Information sharing between agencies was also a very important skill. Being able to determine their professional and individual role in a case, and the limits of their role, was also deemed essential.

In building a case and presenting it, generalists were seen to have contributions to make, especially if they knew the family well, but caseload holders stated clearly that they were not able to delegate responsibility at this level of decision making.

#### **5.5.1.4 Lack of framework to support role**

All participants felt that the professional and practice framework for child health was well established, for example, lines of communication between agencies were now much clearer. However, participants stated that the systems that were needed to support specialist roles had not caught up with the recent role changes created by GIRFEC. For example, specialists had to rely more and more on generalist staff for the generic child health work, as well as them becoming more involved in child welfare issues. Linked to this was the participant's discomfort with the increased use of bank staff, where they felt one of the consequences was care becoming more task orientated.

Participants proposed that the enlarged administrative role associated with GIRFEC had not been recognised in the “system” as a whole:

*...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...*

In particular, the extra administration needed to support good multi-agency working and effective multi-agency decision making was almost entirely done by the specialist nurses.

#### **5.5.1.5 Preparation for and maintenance of role – what was needed from generalists**

The education and clinical supervision for those moving into this area was described as being ad hoc rather than fully part of the system. In terms of bringing new staff on board, training for GIRFEC had been provided by the Highland Pathfinder project, but with that project having come to an end, it was up to the existing practitioners to take on the role of training up newcomers. Such was the complexity of the specialist role, regular clinical supervision was described as essential, but there seemed to be was no systematic allowance for this, other than: “a rushed five minutes at the coffee table”. A desire was also expressed for more time for clinical supervision as a way of helping junior colleagues develop their knowledge and practice.

At the most basic level, what specialists in our focus groups sought from junior colleagues was knowledge of the norms of family and child development, knowledge of the GIRFEC framework, or at least the wellbeing indicator tool, SHANARRI – an acronym of the indicators - and observation skills which alerted practitioners to something that needed to be re-examined more closely.

How newcomers, generalists or junior colleagues learned or might learn the skills of child welfare assessments, under the guidance and supervision of specialists, was discussed at some length in the groups. The ideal seemed to be early one-to-one mentoring support. One child health practitioner described in detail how she helped junior colleagues develop skills in assessment through processes of support, rehearsal, modelling/shadowing and reflection on practice. The expectation was that the non-specialist colleague would



already have learnt about GIRFEC and topics such as child development in more formal settings and then practice putting their knowledge and skills under the supervision of the specialist. There would, for example, be some opportunities for rehearsal and discussion before seeing a family: the record would be looked at and the issues teased out from a written referral.

The GIRFEC Wellbeing Indicator tool (SHANARRI) would then be used after coming away from the family to aid the assessment process, to document the meeting and observations and make a judgement about whether the child was safe or whether any action needed to be taken. The junior colleague would be required to reflect on the visit and asked questions to encourage reflection on the situation and on their practice including the identification of next steps:

*How did that go? What do you think? ... What do you think the next steps are?*

If concerns remained about the family visit, practitioners said this would trigger the next stage of GIRFEC, using the My World Triangle, and involve the inclusion of other agencies.

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. This intensive work was reported to have paid off because it was felt to have resulted in a colleague who was regarded as competent to undertake a specialist child welfare role. However, the participants stated that neither the structure nor the time was now available for such comprehensive 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.

### **5.5.1.6 Tools**

Initial discussion in the focus groups emphasised existing knowledge, skills and experience over the use of specific tools. But over the two interviews the importance of the GIRFEC framework was stated several times, and practitioners agreed wholeheartedly that it had transformed their practice. Four tools within the framework were mentioned as being most useful: the Wellbeing Indicators (SHANARRI), the My World Triangle, the Resilience Matrix and the Child Plan.

Whilst the power of the GIRFEC framework was acknowledged, what was also made clear by the participants was that knowledge, skills and experience interacted with the framework. Indeed, the framework could not be used without them. Participants felt that the GIRFEC framework should be learnt in formal education settings but then needed to be applied in a practice context to reinforce that learning. Specialists talked about reflecting on their observations, assessments and decisions constantly when applying this tool. More junior colleagues needed the help and guidance of their mentoring colleagues to help with such reflection, and to support them until they were confident doing assessment alone.

Long-term documentation and record keeping were also essential for identifying, understanding and presenting child welfare and protection issues, indeed they were discussed as tools in their own right. For example, older style health visitor records could be used to identify a pattern if they had recorded the existence of problems for a child or family going back a number of years. Unfortunately, the opinion was that documentation had increased in quantity but decreased in usability; practitioners were finding the newer documentation “difficult” to use.

### **5.5.2 Heart care focus group**

For the heart care group the interviews were, in some respects, somewhat speculative, as the details of the cardiac link health practitioner role had not been circulated:

*I don't think there's been enough information or discussion about it ... I feel that we are talking about something we don't really know an awful lot about.*

However, the focus group interviews did enable the practitioners to explore how they saw this role developing. What was also of interest was that they were seeing a specialist role from a very different perspective than the child health participants: more a role to move into rather than one that already existed.

#### **5.5.2.1 Role shift and role strain**

This section outlines some of the context for the cardiac link health practitioner role. The sections on role conflict and role clarity, that follow, also help to establish context.

The theme of how the community role had already changed, over an unspecified time span, was very clear, as was a degree of discomfort with these changes. The traditional community nurse role of dealing with basic needs of housebound patients was described as being “eaten away”, passed on to social services and healthcare assistants. Participants stated that the focus of the traditional role had been lost, and there had been no opportunity to regroup, as one person said:

*...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 ...*

In place of the traditional role, was increased time caring for patients who were still in a phase of needing acute care. For example, participants said that early discharge after surgery and prevention of hospital admission during acute illness had increased the knowledge, skill and technical demands on generalist community nurses. This was across a range of conditions: it was not just heart care that demanded a greater skill level. Linking with other agencies and “signposting people” also constituted a large part of the current role. In general, the group did not feel they had been prepared for these changes, but were reacting to them. They were taking higher level decisions, like telling a doctor that a patient needed to be admitted to hospital and were diagnosing where they had not done so before. One participant said of the changed role:

*...you can walk into anything and you have to react and do the best you can with the resources you have about you...*

### **5.5.2.2 Role conflict**

Participants in the heart care group stated that there would be difficulty accommodating the proposed specialist role because of the current range and demands of their existing role:

*You are seeing everyone from children to 100 years old.*

The increased complexity and acuteness of care for a wide range of conditions, discussed above, meant that there were feelings of being under pressure to be up to date in “everything”. Indeed, there was a suspicion that the specialist cardiac role could be just another addition to “everyone and everything”:

*I just feel that all it does is add on, add on and add on. There’s nothing been put in place to take away anything else.*

Certainly there was much doubt expressed by those attending the heart groups as to how a specialist link role could be developed given existing pressures. There was also a general concern expressed over the perception that some health conditions were getting considerably more attention than others, for example heart disease compared to Parkinson’s disease. There was a view that specialism could be accentuating inequalities in the allocation of very scarce resources.

### **5.5.2.3 Lack of role clarity about the new role**

The heart care group recognised that these changes signalled an opportunity to develop new and valuable skills in a specific area of practice. However, the way the link role was being introduced was impacting on the positive feelings about this opportunity. Indeed, ambivalence was clear when discussing this new link role. There was also a palpable scepticism amongst these professionals who spoke about feeling aware of government and management agendas, believing these to be stronger drivers for change than the desire for improvements in practice or patient care.

Participants described feeling pushed into taking on the specialist role, rather than the role having a natural attractiveness for them. They described that there had been much “chopping and changing” around the role. Even the title of the role changed from one interview to the next, from practitioner with special interest to cardiac link health practitioner. Indeed, many aspects of the specialist practitioner role, including the way that the role was planned to be implemented, were revealed to the participants for the first time at these focus group interviews. For example, work on new documentation for the cardiac role was close to completion, but this was the first time most at the interview had heard about this. Some comments express the ambivalent feelings this created:

*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 ...*

*I feel a bit ambivalent about the role to be honest, I really do, because I don't have a good feeling about it. Every so often there is something else coming up that we don't know about it. It's like there's a whole piece in the dark.*

#### **5.5.2.4 The specialist role and skill set**

The view of the role was influenced to a degree by observation of the role of the Heart Failure Nurse (HFN), who followed up on patients discharged from hospital. Participants asserted that if they got involved in heart care as a specialism they too would need to spend the majority of their time with working with patients with heart conditions, as the Heart Failure Nurse did. The HFN role was also believed to have a significantly greater knowledge base, from formal education as well as experience. Participants felt that that having a specialist role meant needing to keep your professional knowledge up to date, as well as being involved in more advanced levels of decision-making, including advising GPs and medical consultants.

They also considered specialist practitioners as being involved in changing or adjusting medications but this was not something these practitioners could see themselves doing, even in the new role: this was perceived as GP or consultant territory. Being a source of advice, teaching and support to nursing colleagues was another aspect of the HFN role.

Participants also commented on the higher pay that they felt should be part of increased specialism.

Current work with patients using the Heart Manual (NHS Lothian 2009) was not thought of as specialist work because, for complex care not covered by the manual, assistance from other professionals would commonly be sought. For example, for a patient who had had quite a complex cardiac history, the Heart Manual had not been that helpful a guide, so advice was sought from the GP quite frequently:

*...we are all used to working up to where we are comfortable and referring on when we feel they need more specialist input .*

There was a set of skills that were associated with the use of the Heart Manual that revolved around communication with, and education of, patients, something the nurses described as the “bedrock” of lifestyle management. Motivational interviewing was one such method the nurses spoke about. These skills brought something distinctive to heart care that was, they asserted, not provided by a medically focused GP service:

*I think we are more holistic, you are looking at the whole ... whereas a doctor would visit about one thing we're looking at the whole situation that that person's in, and speaking to social work, speaking to doctors, speaking to whoever. I see that we're linking a lot more of the care, the total care.*

*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.*

Facilitating patient involvement in decision making, was part of the nursing role, both generalist and specialist, and involved listening to what the patient had to say and acting on it. Participants did feel that patient involvement in decision-making could be prioritised further, however.

More advanced communication with colleagues was highlighted as part of the specialist role. Establishing networking with peers was deemed to be essential for mutual support to underpin the specialist role in heart care. Being available for advice, education and support for generalist staff members was part of the role, as was dissemination of information.

Mentioned but barely explored were the challenges that could arise from taking on a case finding role, producing anticipatory care plans, and utilising a case management approach. These concepts were relatively new to most of the group participants.

One group participant talked about the potential of specialisation to help standardise practice which currently seemed to vary considerably. She sums up what she hoped would be the overall outcome of implementing the link role here:

*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. It's very much driven by individuals, and we need to have something that's standardised. All link nurses will be giving this kind of information and be doing this kind of thing.*

#### **5.5.2.5 Lack of framework and structures to support the new 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 re-allocation of generalist work and lack of space in their workloads.

Participants stated that access to patient records was problematic and information on discharge from hospital was noted to be particularly thin ("very limited information"). There was no right of access to GP records so while access could usually be negotiated, but this was considerably different from routine and timely access which was considered to be the ideal:

*... if you had access to the GP system you can see how their blood pressure or their cholesterol is on a graph form over a period of time ...*

The nurses also understood the need for privacy for staff to also be maintained.

The role of the Heart Failure Nurse illustrated the importance of recognition of the specialist role. According to the group, she could contact a consultant and expect to be heard, whilst this did not seem to be nearly as straightforward for the community nurse:

*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, apart from when we speak to people at the hospice.*

The easier access of the HFN may have been familiarity, but was also thought to be related to formal recognition of the post.

The need for ongoing peer networking and support was also raised. This was particularly important to practitioners working in remote and rural areas, who were felt to have fewer opportunities to network compared to colleagues in urban areas.

One vitally important issue was having a large enough client base to maintain specialist knowledge and skills. This might only be achievable if the specialist role covered a wider area than the typical generalist role.

There was an expectation from the heart care group that some of the generalist work they currently held would need to be reallocated to give time in their workload for a specialist link role. Significant pressures and not having enough time to get everything done in one's workload was mentioned several times during the groups. While introducing the link role was intended to be resource-neutral, nurses clearly found it difficult to imagine how this could be achieved.

#### **5.5.2.6 Preparation for and maintenance of role**

The experience of most of the group was of acquiring their education in heart care from their own efforts, largely unsupported by employers ("we have had an interest and developed ourselves"). They were worried that the education on offer as an incentive to take on the link role would also occur on a similar basis. Nurses described how they had often been given education in distance learning format without having been given the time to do it, but this also meant missing out on networking:

*.. 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 ...*



The group stated a preference for face-to-face study days for formal learning as opposed to only distance learning. Shadowing and mentoring opportunities were also very welcome, and included working with someone who already had an established role. One participant had gone to CCU and cardiology clinics to shadow staff, and described the experience as being invaluable.

### **5.5.2.7 Tools**

Tools for heart care were much less in evidence than with the child welfare group. The only tool currently in use for heart care by practitioners was the Heart Manual. There were now three versions of the Heart Manual for patients discharged from hospital with different presentations of ischemic heart disease (NHS Lothian 2009). Participants said it could be a useful tool to structure patient-centred care, but could be used just as 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.*

Two tools were shortly to be introduced to support the heart care link role: New heart care documentation from Argyle and Bute was about to be trialled with the aim of creating something more concise and focused than what currently existed. A self-directed learning portfolio was also about to be introduced for practitioners taking up the link role which will be used to organise, document and evidence a person’s development in the link role.

## **5.6 Conclusion**

The data reported in this chapter of the report suggests that existing roles and past experience of role change have a considerable influence on the perception of new and developing roles. In addition, the framework to support new roles can lag behind their introduction, and this can continue for some time into the life of the new role. Handled well, the acceptance of change may be achieved fairly readily, as with the well-resourced introduction of GIRFEC in the child welfare field. Tools can have a major, even transforming, effect on practice. But the potential for tools needs to be understood in the

context of the existing knowledge, skills and experience of the practitioners. One of the main differences between the specialist child health nurses and the generalist community nurses with the proposed new heart care link role was that the specialists were secure in their practice, whereas the generalists seemed to be in a state of flux in a service that was having difficulty defining itself. The practitioners recruited for the heart care role had not been involved early on in the development of the new role and thus had become somewhat sceptical of the potential for this role and their desire to be involved. When practitioners develop ambivalent feelings towards change, it may be difficult to predict what the outcome might be. Even an apparently successful change like the introduction of the child welfare policy GIRFEC has had unpredictable ripple effects, such as the relatively unplanned and under-resourced transfer of some of the specialist role to generalists.

We shall now address each of the research questions in turn to pull this chapter towards a conclusion.

1. Which aspects of practice in relation to child welfare and heart care do nurses identify as falling within the generalist / specialist continuum?

Advanced communication and relationship building skills, based on a holistic view of an adult, child or young person's health needs, were a key set of skills for specialist practice. Elements of a specialist role for both groups included greater responsibility as case finder, caseload holder/ manager, and for overseeing the work of other staff. Facilitation / mentoring of other staff and dissemination of new practice were important, as well developing and maintaining a network with similarly tasked or interested colleagues. Linking and working with other agencies was already part of generalist roles, but the organisation and chairing of meetings, and the presentation of an evidential health case in the child welfare field at least, took the specialist role to another level. Being a caseload holder, and the responsibility that went with it, gave the strongest demarcation between generalist and specialist. With this role came the responsibility for decision-making, at least in a single agency case. In multi agency cases this could mean playing a significant part in large decision making meetings and case conferences including sometimes taking on a chairing role.

2. What are the key factors that support generalist / specialist roles in these areas of practice?

Clear role definition and involvement in decision making regarding role changes, certainly seem to promote confidence. A supportive framework with formal recognition of the role, and a full analysis of the changes brought about by the role, is likely to also help. Reallocation of resources to match these changes was raised as a significant issue that needed to be addressed. According to participants, an educative process for practitioners that enables role development should be in place. This should include formal preparation as well as mentored / shaped educative practicum that provides mentoring or shadowing opportunities. A sufficient client base to maintain practice was felt to be needed, with appropriate structural or logistic changes to make this possible. Tools that have been tested in practice can be of great assistance in supporting practice decisions, as illustrated by GIRFEC. Access to documentation and records that are fit for purpose is important. Networking, peer support and advice are vital support elements, and regular clinical supervision was deemed to be extremely desirable in supporting specialist practice.

The discussions around communication for relationship building, health education and decision-making suggest that there are a set of skills concerned with patient / client engagement and involvement. These skills can help to facilitate self care. Many of these skills can be effectively gained in practice mentoring / shadowing scenarios. However, there are also ways of accelerating acquisition of skills, for example, much can be learnt about Motivational Interviewing (Tomkins and Collins 2006 p25), mentioned in the heart care interviews, from a combination of learning materials and intensive workshops. The pedagogy of acquiring essential specialist skills, in parallel with assimilating the role, would seem to be a prime area for action.

### 3. How do tools contribute and interact with other factors?

Use of tools relies heavily on existing skills and knowledge of practitioners. For example, participants stressed that GIRFEC is best applied after positive open relationships have been formed; with the child, with parents and other agencies. Without knowledge of normal child development, and the ability to see its application in a practice setting, situations where the GIRFEC child welfare model should be applied might not be recognised. On the other hand GIRFEC facilitates rigorous examination of the evidence, revealing issues that might not be identified without its use. GIRFEC also seems to have

brought a greater child-centredness to child welfare work. Tools for heart care do not seem to have had as great an impact as yet, although the Heart Manual was described as a useful tool for self-directed rehabilitation.

## **5.7 Limitations**

There was one major limitation to this part of the study. The focus group interviews included small numbers of practitioners. This was due service workload pressures, despite efforts to find a suitable date for maximum participation. In addition, not all participants were able to attend both sessions due to service commitments that arose between the first and second meetings. Participants may not have been representative of practitioners in NHS Highland with similar practice interests and experience. This should therefore be taken into consideration in reading these findings, conclusions and recommendations.

## **5.8 Recommendations**

1. Careful consideration needs to be given to the educational provision which underpins development of specialist practice, both in child welfare and heart care. In particular, a balance between formal education and in practice education needs to be achieved. The use of a portfolio for organising practitioner development should not result in a “do-it-yourself” approach.
2. The reported time lag between introducing a role and providing an adequate support framework needs to be analysed and mitigated as far as possible.
3. Networking, peer support and clinical supervision should be recognised as essential to the success of developing specialist roles, and be resourced effectively.
4. When establishing specialist roles, some effort should be expended on securing early recognition of the role by other practitioners. Shadowing allows networking, and other measures such as leafleting and business cards may accelerate understanding and acceptance of new roles.
5. Engagement and involvement of practitioners should be sought as soon as possible in a transparent change process. The roles should be tested first, not implemented immediately, to allow learning, feedback and adaptation.
6. New tools also need to be tested and evaluated before implementation. For generalists to develop their use of more specialist toolkits, introducing the tools in a pilot project, where their utility is effectively evaluated, may help identify the supporting skills needed for full implementation.

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## 5.10 Appendix 1

### **Topic Schedule for Focus Group Interviews**

1. Can you identify the key approaches you use when conducting an assessment around child welfare / patient with heart conditions?
2. What is your understanding of the different levels of knowledge and judgment required by generalist and specialist practitioners to support child welfare issues / patients with heart conditions?
3. What is your understanding of the generalist nursing roles around child welfare / patients with heart conditions?
  - Different levels of clinical decision making
  - Monitoring and improving standards of patient care
  - Audit, supervision, teaching and support
4. What is your understanding of the specialist nursing roles around child welfare / patients with heart conditions?
  - Different levels of clinical decision making
  - Monitoring and improving standards of patient care
  - Audit, supervision, teaching and support
5. What key areas of knowledge should nurses' possess to support child welfare / patients with heart conditions?
  - Review generalist knowledge required
  - Review specialist knowledge required
6. Which key skills should nurses possess to support child welfare issues/ patients with heart conditions?
  - Review generalist skills required
  - Review specialist skills required
7. What additional areas of information would you find helpful for developing nursing guidance to support child welfare issues/ patients with heart conditions?
8. What are the main challenges that exist for the community nurse to support child welfare issues/ patients with heart conditions?

## **6. Skills Transition to Support Shifting the Balance of Care**

### **6.1 Introduction**

Growing healthcare demands as populations change, and services move from hospital to community have been identified by Hurst (2006) as posing challenges for practitioners and managers. Notably nurses are at the forefront of the drive to modernise NHS services and in particular the shift in the balance of care from acute hospital orientated services to service development within the local community. In addition the move to provide more services within local communities requires increased numbers of primary and community nurses (Buchan 2007). The supply of these additional nurses has been identified as likely to come from staff currently employed in the acute sector (Office of Manpower Economics 2006)

### **6.2 Self Efficacy Development**

One of the major explicit goals of nurse education is to equip practitioners with a sense of confidence (self-efficacy) that they can succeed in becoming a competent nurse. The notion of self-efficacy grew out of social cognitive theory (Bandura 1977). According to Bandura's theory, the perception of self-efficacy among students depends greatly upon four principal sources of information:

- performance accomplishments of similar tasks,
- vicarious experience (observation of tutors, other nurses' performance),
- verbal persuasion (lectures, suggestions, advice), and
- self-evaluation of physiological state (before, during and after attempts at tasks) (Harvey & McMurray 1994).

Bandura proposed that individuals who perform unsuccessfully are likely to do so, not necessarily because they lack the skills and knowledge, but because they lack the sense of self-efficacy to use skills effectively. Self-efficacy influences academic motivation, learning and skill development (Pajares 1996) and career progress in nursing (Harvey & McMurray 1994).



Self-efficacy is a complex phenomenon which appears to interact with both gender and exposure to life experiences. Women have been reported to have lower self-efficacy in relation to mathematics performance (Pajares & Miller 1994). This may explain the previous research which suggests that nurses have poor numeracy skills (Wilson 2003). Hammond and Feinstein (2005), in their secondary analysis of data from a large sample in the National Childhood Development Study, suggest that self-efficacy in adult life may improve with exposure to opportunities for self-development and formal education (Hammond & Feinstein 2005). In a secondary sub-sample of 15 women with poor school attainment, sampled from the National Childhood Development Study Cohort, Hammond and Feinstein report that perceptions of achievement in adult education increase self-efficacy and that adult education may lead to more challenging occupations, which in turn builds self-efficacy. They also suggest that, whilst learning on the job can build self-efficacy undertaking training provided by employers may not.

### **6.3 Skill Development**

In studies of motor learning, Welford (1987) concluded that, for some type of skills, learning practice effects are proportional to the time taken to learn and for other skills it is not proportional. In a study of pianists Williamson and Valentine (2000) found that the overall quantity of practice was not related to quality of performance. Pianists who spend longer time segments at particular stages (middle segments) produce better outcomes.

In a meta-analysis of behaviour modelling training Taylor et al. (2005) identified longer training times as one predictor of effective skill development. Similarly, in a study of simulator training for laparoscopic skills there was a positive correlation between hours of practice and improvements in the skill performance of surgeons (Hanson & Mitchell 2001).

High levels of self-efficacy are associated with effective learning in nursing (Chacko & Huba 1991, Colquitt et al. 2000). Given most studies are cross-sectional, it is not clear whether this is a causal relationship or even the direction of the relationship. In their study of palliative care nurses, Fillion et al. (2005) found that educational needs were negatively associated to perceived self-efficacy when providing good palliative care

Farrand et al. (2005) reported that students in .Fitness For Practice curricula, with their reportedly greater emphasis on practical skills learning, had higher confidence in their competence levels than students in Project 2000 curricula. Sewell and St George (1999) succinctly sum up the potential importance of self-efficacy to pre-registration programmes when they argue that self-efficacy may be a better predictor of performance than capability.

Self-efficacy may moderate the relationship between on-the-job training and levels of anxiety and stress (Saks 1994). Students who begin a clinical placement with previous experience as a nursing assistant or good clinical experiences as a student would have less anticipatory anxiety and see the new placement as a less threatening experience. Self-efficacy therefore exerts an indirect effect on performance by mediating the relationship between prior exposure and action. Social cognitive theory hypothesises that self-efficacy has a mediating effect on performance (Bandura 1986). Support for a mediating role is provided by Zimmerman et al. (1992) who report that self-efficacy mediates the influence of self-regulated learning on academic achievement. Pintrich and De Groot (1990) suggest such mediation offers a target for educational intervention. A virtuous cycle can be created by increasing students' self-efficacy which in turn facilitates greater use of cognitive strategies. More effective use of cognitive strategies results in improved student performance.

Self-efficacy levels are higher in those individuals who are exposed to more diverse sources of efficacy information. Sources of efficacy feedback can come from mentors, peers, academic support teachers, patients and ward staff (Laschinger & Tresolini 1999).

A small qualitative study by Anderson and Kiger (2007) undertaken with 10 final year student nurses who were given the opportunity to visit patients and clients in their home on their own demonstrated that this built confidence. Students reported that they saw this as evidence that their mentors trusted them to deliver the care appropriately but their experiences of managing in different situations served to enhance their belief in themselves and their abilities.

In a small scale evaluation of a course on community nursing with mostly newly qualified nurses Wright (2005) reports that students felt the course had improved their key community nursing skills. Amos (2001) identified that newly qualified nurses perceive they do not have the necessary skills (Amos 2001). Newly qualified child health nurses who obtain their first post in the community were also not thought to have the necessary skills (Hickey 2000).

High self-efficacy is associated with effective learning in nursing (Chacko & Huba 1991, Colquitt et al. 2000). Students undertaking a competency based pre-registration nursing curriculum reported high levels of confidence in the provision and management of care, holistic orientation, lifelong learning, addressing quality standards and being a safe and competent nurse (Farrand et al 2006). These students appeared to have higher levels of confidence in their clinical skills than nursing students in non-competency based curricula.

#### **6.4 Transfer**

The concept of transfer, much overlooked in nursing and midwifery, has a fundamental role when considering the extent to which performance in one skill or skills developed in one setting transfer to another skill or another setting. Lauder et al. (1999) have suggested transfer may be more complex and problematic than often assumed. Lave (1988) has articulated a widely held view that there is overwhelming evidence that transfer frequently does not occur. The distinction between low road and high road transfer may illuminate this issue. Skills within skills clusters that are sufficiently similar to allow low road transfer in which skill transfer of relatively well-practiced skills takes place in what is an almost automatic fashion (Schunk 2004). High road transfer is required for transfer between different skills clusters as these require decontextualisation and abstract knowledge. This necessitates much time for exploration and the investment of mental effort (Salomon & Perkins 1988).

## **6.5 Aims**

The overall aim of this element of the project was 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

## **6.6 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?

## **6.7 Study Design**

1. Conduct a review of the literature exploring self-efficacy (confidence) development and sustainability of clinical skills
2. Undertaking a scoping exercise via telephone interviews with community hospital nurses and community nurses to gain information on the following:
  - a) Identification of the skills they believe they require linked to the above brief
  - b) Identify the frequency that they use the above skills – (comparing community hospital and community nurse exposure)
  - c) Generate a 'top 10' of skills basket
  - d) Identify from the practitioners challenges they perceive in sustaining these skills and retaining confidence
  - e) Elicit their opinions of what types of interventions may be of benefit to them

## **6.8 Population and Sample**

Participants were drawn from across three geographical locations in NHS Highland; Baddencoch & Strathspey, Thurso and Tain. It was also hoped to secure recruits from Argyll and Bute, however no volunteers were forthcoming. Therefore findings relate to only three of NHS Highland locations.

Participants were self selecting and included District Nurses, Health Visitors, Community Staff Nurses, School Nurses, Community Hospital Based Staff Nurses.

The age range of participants was between 25-59yrs with the majority of participants within the 55-59yrs age group. The length of time in post ranged from 2 years to 20 years. Educational qualifications ranged from RGN as the minimum qualification to Degree level qualification

## **6.9 Data Collection**

An interview schedule was developed, piloted and refined (Appendix 1).

Data were collected by telephone interviews (n = 14). Interviews lasted on average 35 minutes.

As participants were providing their answers to the question the interviewer typed the answer directly into the template. At the end of the interview the questions and the interviewee answers were read back, giving the interviewee the opportunity to amend their response but more importantly for them to verify the accuracy of the interviewers recording of the answers.

Data were collected between October 2009 and December 2009.

## 6.10 Data Analysis

An adapted narrative analysis approach was utilised. This involved completing a stage 1 analysis. This required the researcher to complete an initial impression reading of all data and memo record emergent ideas. The researcher then conducted a thematic content analysis and finally a detailed analysis with illustrative verbatim quotes. A number of broad themes emerged from the data at this point.

## 6.11 Findings

A key element of this project has been to determine the core skills practitioners currently use on a daily basis in order to generate a 'top 10' skills basket but equally to determine skills that are used less frequently but viewed as important to the practitioner delivering care to a wide variety of patients with varying needs.

### 6.11.1 Commonly used skills

Practitioners were asked to identify the 5 most common skills they use on a daily basis. Below are illustrations of the wide variety of skills possessed by practitioners and used on a near daily basis

*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)*

*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)*

In determining how confident practitioners felt in using these skills all participants felt confident stating that when using on a daily basis this assisted with maintaining their confidence.

### 6.11.2 Skills, frequency and maintenance

Practitioners identified 5 skills that they used but not on a daily basis and their subsequent levels of associated confidence

*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)*

*I'm a Heart manual facilitator and not a lot of patients to do that (Health Visitor)*

*I get anxious at thought of doing an ECG, especially with the machinery. I have not had official training on the machines. As far as cannulation it's a shame we have done our training but we cannot utilise with either GPS not allowing us, and not getting enough exposure to it to make us skilled (Staff Nurse Community Hospital)*

As can be seen from these excerpts there are a broad range of skills, however there are clearly challenges around sustaining these skills linked to having sufficient exposure to patients in order to maintain these skills. Furthermore there are clearly constraints experienced by the Community Hospital staff that experience resistance by medical colleagues to them undertaking some of these skills.

A range of strategies were identified by practitioners in relation to how they maintain skills and competence when not using skills frequently. These ranged from 'shadowing' colleagues, accessing specialist nurses at Raigmore Hospital, accessing the Internet for information

*Read up on things. Attend study days and updates from clinical skills unit at Highland campus. If in doubt we would speak to for example the specialist in the area (Community Staff Nurse)*

*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 driver I will go to maintain exposure (Community Staff Nurse)*

*Use policy to guide my practice. Good communication with the specialist nurse on the ward. Get lots of updates, colleagues for support, checklists and specialist nurses. We can also phone Raigmore wards for advice (Staff Nurse Community Hospital)*

From these initial questions around common everyday skills used and those skills used less frequently we can see that regular exposure is crucial in maintaining confidence in undertaking skills. A majority of participants across the interviews identify undertaking training in either 'advanced' or 'specialist' skills but often do not get the opportunity to routinely practice these skills thus a lack of self-efficacy becomes evident.

A key area in which NHS Highland were keen to elicit further information on skills were around the following domains:

- Providing Palliative Care
- Administering IV Analgesia
- Administering IV Antibiotics
- Administering IV Hydration
- Administering Blood Transfusions
- Administering Bisphosphonates

Across Community hospital staff and Community Staff all practitioners detail providing Palliative care on a very regular basis

*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)*

*When we have patients we go in on a daily basis possibly 2-3 times per day and we can also organise Marie Curie nurses and equipment, do syringe pumps (Community Staff Nurse)*



A majority of practitioners also detail administering hydration therapy. This is strongly linked to the provision of palliative care.

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

*We administer these on a regular basis (Staff Nurse Community Hospital)*

*Sub cuticular fluids for palliative patients (District Nurse)*

In relation to the remaining skills identified no practitioners interviewed administered Bisphosphonates. Of note in relation to the Administration of IV Analgesia, IV Antibiotics and Blood Transfusions was the variation identified between Community Hospital staff and Community practitioners with Community Hospital staff having some exposure compared to their community practitioner counterparts. However exposure remains varied.

*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)*

*We do this (IV Antibiotics). We all did the course and we remind each other regular, check BNF and if not happy whoever has prescribed will give it i.e. GP (Staff Nurse Community Hospital)*

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

One of the key requirements in the commissioning of this study has been to identify from the practitioner perspective what skills they would envisage requiring to develop in order to contribute and take forward the policy agenda around SBC. A significant number of suggestions were provided by practitioners

*Chemotherapy treatments. Management I think are making inroads but its not happened yet. I think that's only new skill we would need that would benefit the community (Staff Nurse Community Hospital)*

*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)*

*Just had an up date on PIC Lines. Think this will be something we will do more commonly in the future. Possibly IV antibiotics and injections (Staff Nurse Community)*

*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 ausilation 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)*

*Alcohol dependency and drug abuse are things we are seeing through the door now. We link with the psychiatric nurses who guide us (Staff Nurse Community Hospital)*

*IV and bolus drug administration. PIC Lines we know how to flush but we need skills in IV...Child protection, further skill development in this (Community Staff Nurse)*

As can be noted from these excerpts the range of skills identified are similar across Community Practitioners and Community Hospital Practitioners. Of note is the willingness of practitioners to extend and expand their skill sets in order to contribute to the policy agenda locally. However there were also some perceived obstacles identified in developing new skills.

*The job is satisfying but its the timescales to do it and lack of support. Always felt we have never been recognised as a service. No funding to develop the role further. Job is only term time and really feel with the diversity for example child protection, GIRFEC there is work we could be doing during the holidays that would help (School Nurse)*

*GPs and time of the ward to undertake training. I,m not comfortable asking for study time as the ward is always short staffed so it takes a back seat (Staff Nurse Community Hospital)*

*Time and workload issues. How you get the time, back up and resources to back fill. There are not the people on the ground or the human resources available to backfill. People at my stage of my career should continue to be specialist nurses and which we have experience for and nurses in training currently should be having the training to become a Community Health nurse and mentored by us experienced nurses (Health Visitor)*

*Time off to train and then not getting opportunity to maintain new skills is the biggest obstacle (Community Staff Nurse)*

Of note was the recognition of practitioners who are currently part of the RONC Pilot sites of having additional resources at present but that this may not be the case in the future

*At the moment its good as we are a RONC Pilot site so we have plenty of staff but in future may not be so easy. I'm well supported and doing my District Nurse Degree (Community Staff Nurse)*

#### 6.11.4 Top 10 Skills Basket

In order to illustrate the top 10 skills, Table 1 below provides an overview from the practitioner perspectives of where there are existing core cross cutting skills that are important to both community based and community hospital based practitioners, skills infrequently used but which practitioners across both domains require maintenance and exposure, and cross cutting new skills that practitioners in both domains perceive they will require in the future to support the Shifting the Balance of Care agenda.

**Table 1. Skills**

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 ausilation
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

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

Across both practitioner groups similar suggestions were offered as to how practitioners could be supported to sustain, transfer and develop their skills. These suggestions centred around education and training, resources and organisational support.

*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)*

*We need training and we need the opportunity to use these skills.....It would be beneficial if a 'skills' person came to us on a regular basis and kept us up to date. This would help as its difficult for us to get to Inverness (Community Staff Nurse)*

Across both groups of practitioners there was a real sense of the need for a shift in culture, as detailed below

*The interface between secondary and primary care. There is a culture shift required by secondary care to understand what we can and cannot do and not get dictated to by secondary care (Community Staff Nurse)*

A potential solution to this perception could be in more cross reciprocation of sharing skills and knowledge as suggested by practitioners in the idea of 'shadowing', with Secondary care staff shadowing community staff also.

## **6.12 Limitations**

A key limitation of this element of the study were the small numbers recruited and the disproportionate number of Community nurses (11) compared to Community Hospital nurses (3), hence consideration must be taken in how generalisable these findings are. However across all practitioners who participated there were extensive similarities identified.

## **6.13 Summary of Results**

The range of skills currently utilised are varied and vast. These range from what we would consider 'core' nursing skills i.e communication, Vital signs, wound dressings. Many of these are skills learnt at the undergraduate level as part of a practitioner's initial nurse education preparation. What we would consider as additional or in some cases advanced skills pertained to venepuncture, prescribing, catheterisation (male and female and supra-pubic), syringe drivers.

The most commonly shared skills were those of Venepuncture, Catheterisation (male & female), IM injections, Wound care, TPR & BP, Physical assessments, Palliative care and Medication administration provision.

In addition to these commonly shared skill sets practitioners from both Community hospital and community carry a range of additional skills. However these additional skills are not utilised on a day to day or even month to month basis, they are dependent on the current patients they care for. This poses significant problems for practitioners in relation to retaining these skills and the associated confidence and competence to practice these safely.

The ability to practice some of what could be perceived 'advanced skills' when training has been undertaking is hampered by a number of factors: other professionals, exposure and length of time between practicing.

NHS Highland practitioners have a desire to enhance their skill sets further. But they acknowledged there is a need for training and education and new ways of delivering this due to geographical rurality, resource implications and the need to ensure that future skills development, education and training take account of the frequency with which practitioners will have exposure to maintain skills and confidence.

## **6.14 Conclusion**

In concluding this element of the project, one of the most striking features noted was the willingness of all staff to participate in contributing to NHS Highlands requirements to Shift the Balance of Care. A very positive attitude was portrayed by all staff to both maintain and extend their skills base. However there were very insightful challenges articulated but these were, in the majority, followed by offering practical solutions.

From the researchers perspective what was of note was the self selecting nature of the participants, in particular, that they all came from an 'Adult' nursing background. Given the policy agenda around Mental Health it would have been interesting to have captured this perspective to inform future service provision and role development as part of the Shifting the Balance of Care agenda. Equally it would have been valuable to have considered the inclusion of the Community AHP Practitioners within the project.

## **6.15 Recommendations**

1. To strengthen and enhance the findings of this element of the project a larger scale survey with a greater number of participants should be considered. This would offer NHS Highland a wider variety of practitioner experiences to inform future workforce planning and development needs.
2. Cognisance should be given by Practice Development in relation to practitioners undertaking skills training and the links in the local clinical area as to the feasibility of practitioners having exposure on a regular basis in order to maintain the skill but equally importunately their level of confidence to practice the skills.
3. Consideration should be given to developing and providing knowledge packages for clinical skills and that these are accessible to practitioners via NHS Highland Intranet site for easy access.
4. Consideration should be given to the feasibility of regular 'drop in' skills session being provided locally whereby practitioners can have the opportunity to practice skills for example using manikins to maintain skills taught.
5. Consideration should be given to reciprocating the 'shadowing' experience Community Practitioners experience with their 'specialist' colleagues in the Secondary Care Sector. This has potential to foster a greater understanding of the roles, skills and challenges experienced by practitioners and may in some way alleviate some of the cultural tensions perceived by Community Practitioners.

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## 6.17 Appendix 1

Title: Skills Transition to Support Shifting the Balance of Care

Telephone Interview Schedule      Version 2 –

LOCATION	PARTICIPANT NUMBER	COMMUNITY HOSPITAL BASED (CHB)	COMMUNITY BASED (CB)	LENGTH OF TIME IN POST	POSITION	HIGHEST QUALIFICATION

### AGE GROUP

20-24      25-29      30-34      35-39      40-44      45-49      50-54      55-59      60+

1. Can you provide me with examples of the 5 most common skills you use on a daily basis?
2. How confident do you feel in using these skills?
3. Can you provide me with 5 skills that you use but not on a daily basis?
4. How confident do you feel in using these skills?
5. In general terms can you give me examples of how you maintain these skills when you are not using on a daily basis?
6. What exposure do you have to the following skills:
  - Providing palliative care
  - Administering IV analgesia
  - Administering IV antibiotics
  - Administering hydration
  - Administering blood transfusions
  - Bisphosphonate administration
7. How often do you practice these skills
8. With new treatments and services being developed in your area of practice can you identify for me new skills you may be expected to develop?
9. How confident do you feel about taking on new skills?
10. What do you perceive as obstacles for you in developing these new skills?
11. Do other people's attitudes towards you wanting to develop further your Skills base hinder you
12. What would help you to develop new skills and confidence