An in-reach nurse role for managing individuals with long-term conditions. Experience of a new role and impact of the role

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Evaluation of in-reach nurse role for managing individuals with long-term conditions. Experience of a new role and impact of the role.

Aim: To evaluate a new nursing role designed to contribute to the management of care of individuals with long-term conditions

Background: The number of individuals who will suffer with long term conditions is predicted to rise significantly and managing the care of individuals effectively is a current challenge facing health services across the world. Although using rotational posts is not a new idea, there is little evidence discussing rotational posts which cross the community and acute care interface.

Design: A small scale qualitative exploration of the new role and nurse's perception of its impact on the care of those living with long-term conditions.

Method: Data was obtained between March 2008 and November 2008 from the in-reach nurses (n=4) and from their managers (n=5). Data sources were focus groups, semi-structured interviews and nurse's reflective diaries. Analysis of data was via a thematic approach. This article refers to data collected from the nurses only.

Results: There was consistency associated with the challenges and rewards of a newly created post. Information from reflective diaries showed the difficulties faced by patients across health and social care systems, as perceived by the nurses. The evaluation showed the growth of individual nurses in their understanding of these difficulties and the problem solving approach required enabling patients to have a smooth journey across health and social care providers.

Conclusion: Although there were mixed responses to the rotational posts by the post holders and their colleagues, there is some strong qualitative evidence to support new ways of working.

Relevance to clinical practice: Although a small initiative, through using rotational posts, nurses are able to gain a wider perspective of the patient journey which may benefit effectiveness and quality of care available to individuals living with long-term conditions.

Key words: Patient discharge, rotational nursing posts, long-term conditions, home nursing.

Summary = 300 words exactly

Introduction

There are 17.5 million people in the United Kingdom living with a Long-term condition (LTC) (DH 2005) and 15 million in England alone (DH 2008). While long-term conditions are not entirely the domain of the older person. 17% of those aged under 40 have a long-term condition, but this is in comparison to 60% of over 65s(DH 2008). By 2031, the population of over 75s will be 8.2 million, an increase from the 4.7 million at the time of the article's writing. It was argued that this older age group use a disproportionate amount of NHS resources: an individual aged over 85 is fourteen times more likely to be admitted to hospital than a 15-39 year old (DH 2008). The UK is not alone in experiencing this increasing trend. Long-term conditions now account for more than 50% of the disease burden across the world (WHO 2004). As the ageing population grows, so does the population with long-term conditions. With this in mind, the need to effectively manage the individual needs of those with long-term conditions is pressing. Care needs to be rooted in community settings and underpinned by vastly improved communication and new partnerships across the whole health and social care spectrum (Colin-Thorne 2006).

Background

The in-reach project considers the patient journey in relation to the health care system. Patient journey, in this context, describes living with a long term condition. This includes the patient's ability to self-care and self manage as well as to negotiate their requirements in managing their condition with health care professionals who work in both community, hospital and in social care. Peretz and Bright (2007) report that where case management has worked well, experienced health care professionals have worked to redesign patient pathways across whole systems. Communication, though an integral part of life, is a key reason for failures affecting patients (Grover 2005). Milligan, Gilroy *et al*. (1999) highlight how different professional groups can have different patterns of communication, hence the importance of finding common ground to ensure effective communication. Without this, they argue that the unique contribution of individual disciplines may be missing in co-ordinating a patients care. Grover (2005) maintains that collaborative interactions

are the result of individuals work together in a co-operative manner in which communication is open. Davis (2007) reports the growing importance of nurses working across acute and community care settings. Some literature reports about changing roles, (While & Dyson 2002, Greenwood, Ryan et al 2007) and are in agreement about the challenges such change can invoke in the workforce.

UK research of student nurses indicates that community care has not always been viewed as positively as acute care in terms of career options (Happell 1999). There is a suggestion that rotational posts are useful for newly qualified nurses who are new to community care (Drennan *et al*. 2006). Bellot & Baker (2005) report on a rotational model to recruit and train senior nurses using a rotational model.

In-reach is used within the project reported in this paper to describe a different way of working, whereby, the individuals employed in these roles were encouraged to go into acute care settings (hospitals) even though their main job was in community care settings. It also encompassed rotational working in both community and acute care settings. It is not uncommon to find breakdown in communication across the acute and community care interface often resulting in poor discharge. The individual with a long-term condition often bears the brunt of these system failures. Implementation of the role of Community Matron (DH 2004) case managing individuals with complex health needs was seen as a pivotal means of improving the patient journey. An individual service, such as the Community Matron service is likely to have significant impact if it can work in an integrated way. Changing ways of working through pilots such as the “in-reach project” has the potential to increase knowledge about how to effectively manage those with long-term conditions across boundaries. Such integration should help to reduce areas working in silos, thus benefitting the patient experience (Parker and Glasby 2008).

In-reach nurse is a name attached to posts created by collaboration between a Primary Care Trust and an acute hospital in response to the Modernising Nursing Careers agenda (DH 2006). The posts were developed for staff nurses and were rotational posts across acute and community health care

settings. The purpose of the posts was to follow a patient's pathway, so moving away from traditional roles, with a greater emphasis on long-term conditions. The posts included an educational element. Each post holder undertook two modules on long-term conditions at an institute of higher education. These new roles allow band 5 nurses to work across acute and community services in several key areas:

- 48 hour acute admission ward
- Community hospital
- District nursing
- Intermediate care

The rotations were managed by four nurse managers and overseen by the Deputy Director of Nursing for the Primary Care Trust. As with all innovation, it is important to undertake ongoing evaluation of new roles and also the educational requirements, which underpin them (Hughes 2005): hence this evaluation of an innovation in service provision.

Aim

To evaluate a new nursing role designed to contribute to the management of the care of individuals with long-term conditions

Design

A broad qualitative base underpins this evaluation. Denzin and Lincoln (2005:3) state that: "qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them." In this work, focus groups, semi-structured interviews and nurse's reflective diaries were used with the nurses who had recently taken up their roles as in-reach nurses. Selected findings are reported here associated with data collected from the post holders.

Participants

Participants were 4 registered nurses (n=4), who had been qualified between 1 and 2 years and who came from a variety of clinical backgrounds in community and acute care. They constituted a purposeful sample comprising the entire number of nurses employed in this new role. The participants took part in individual and group interviews and kept reflective diaries.

Conrad (1990) has argued that no definitive formula exists to determine the number of study participants and that on occasions, n=1 may be enough. Conversely, Morse (1994) suggests that at least 6 participants are required in studies which attempt to understand an experience. As 4 participants comprised the total possible sample this was deemed acceptable in order to proceed in evaluating the innovation.

Data Collection

Data was collected between March and November 2008. For the nurses this comprised one focus group and 2 semi –structured interviews each. The first semi- structured interview was undertaken within 2 months of being employed and the second six months later, which was 2 months into the second rotation. One nurse left the project and before her second interview, so data from 7 interviews was analysed. The nurses were also asked to keep reflective diaries over the period, and this was done by three out of four. By completing reflective diaries, the patient journey was considered in relation to the impact of the new role.

The focus groups and interviews were transcribed verbatim, including para-language such as “ums and ers”. Once early data analysis was complete, the participants were called together to consider the main findings and to add any final comments as a participant verification process (Guba and Lincoln 1989)

Data Analysis

The starting point in the process of analysis was to read and re-read the transcripts. In working with the transcripts, the researchers used some mixed elements of data analysis rather than following

one particular pathway. Ryan and Bernard (2004) state that no one technique may be adequate for all data analysis and that mixing analytic approaches can be a strength. Overall, the result was a thematic analysis in which the data analysis moved from description through analysis to interpretation (Dickie 2003).

In order to enhance rigour, some coding of data was undertaken separately by both members of the team. A "map" was drawn as a means of visually displaying keys aspects from the analysis (see figure 1) as suggested by Miles and Huberman (1994) who state that data display forms a part of data analysis. Microsoft Excel was used to manage the data as it allowed the data to be transferred between both members of the team, and ease of access to all data.

Ethical Considerations

As this work constituted an evaluation of a service innovation, ethical approval was not sought. Service evaluation is undertaken to benefit those who use a particular service and is designed and conducted solely to define or judge a current service. Such evaluation is justified on the basis that health service provision ought to be based on best available evidence and not tradition (Stevens *et al* 2001). Participants in service evaluations are usually those who use or deliver the service and no randomisation of care is undertaken as part of the evaluation (Kings College London 2008). Although ethical approval was not sought, ethical principles were applied: informed consent, confidentiality, data protection, right to withdraw, potential benefits and harms (RCN 2009).

The project had funding from the Strategic Health Authority and was a collaboration between a Primary Care Trust and an acute provider.

Findings

The following themes emerged from the data analysis: liaising with fellow professionals and patients and their families, referring to other professionals, having time to build up a rapport with patients and carers and admission and discharge issues

Liaising with fellow professionals and patients and their families

Liaison occurred across many professional groups. These included GPs, District Nursing teams, rapid response, Social Services, Continuing Health Care, continence service and family members. Of note in the reflections is the move to cross boundaries from community to acute care. Several patients were visited in acute hospital settings, maintaining their link with the in-reach nurse and allowing the in-reach nurse to attempt to work with ward staff to ensure needs would be met on discharge.

An example of liaison benefitting a patient is apparent in this case:

> *When I first called [name] was rarely taking her blood sugar as she found it difficult to read the monitor. Her notes showed that calls had been made to the diabetic specialist nurse to obtain a monitor for the partially sighted. I contacted the specialist nurse who advised that she had sent [name] a form to apply for the monitor. [name] would have been unable to read the form and we could not find it in her house. I obtained a further copy, completed it with [name] and she received the monitor within two weeks. She was thus able to monitor her blood sugar levels more regularly and titrate her insulin dose accordingly.*

This highlights key issues of partnership working and support to ensure an outcome which will allow the patient independence and the ability to manage their own condition with greater effect. This is an important part of managing a long-term condition for both the professional and the patient. It also emphasises the importance of continuity of care and following through on an action which had been instigated, but not achieved.

Another example considers the discharge of a patient with very complex needs from a community hospital. The in-reach nurse reflects:

> *having good communication skills has helped in this situation & also listening skills to what people want & what people can provide..... This is a very unique discharge & has shown me how much support & care is available in the community. If we all work together as and MDT to make it possible for paitents & families to continue to care at home.*

Referring to other professionals

From the reflective diaries, it is clear that referring to other professionals has developed as a key role for the in-reach nurses:

I arranged an immediate referral to Social Services & an assessment date was arranged .

The data indicated that through establishing a strong rapport with patients, nurses were often the key people to ascertain what referrals need to be made to ensure that individuals with long-term conditions had timely care, in an appropriate setting.

Having time to build up a rapport with patients and carers

From the numerous mentions in the nurse's reflective diaries, building a rapport with patients and their carers was clearly important to the in reach nurses. The nurse's comments also show how the continuity of care aspect was also valued by patients and their families/carers. Some examples are given:

> *Over a period of weeks I was able to fully assess [name] and develop the full range of palliative care plans for his needs. I developed a rapport with him and his close family and was able to work with them to ensure that he was able to remain at home. He and his family felt that the continuity of care provided by myself, the District Nurse and the team was of great benefit to them all, gave him a better quality of life in the last few months of his life and helped to make it as pain free as possible .*

And:

> *I was soon able to develop a rapport with [name]..... [name] had been offered respite care & night sits as part of Continuing Health Care (CHC), but had consistently refused believing he was the only person who could care for his wife.....I liaised with CHC on his behalf & as soon as the night sits commenced, he could see the benefits for himself & [name] & quickly agreed to extend to 7 nights a week. [name]' skin is now considerably improved & [name] is benefitting from the additional rest.*

And:

> *On my return, I visited regularly to review the situation...By more regular visits I was able to develop a better rapport with [name] and [name] and help them to maintain a balance between independence and support.*

Admission and discharge issues

There are several examples in the reflective diaries of issues around admission and discharge. The first shows the importance of understanding the wider picture and communicating with other professionals and how this, in turn, prevented an acute admission:

> *A referral came from a Residential Home via intermediate care. There was resistance to the admission as it was perceived that the community hospital couldn't do more than was being offered for the patient. The physios explained that we could provide a more intense physio programme that would speed up rehab. The Residential Home was unable to cope with immobility therefore acute admission prevented by admission to the community hospital. Able to see the wider picture for the patients who was with us for less than 2 weeks. We upped her mobility back to what it was, if not better.*

The next examples show areas where improvements are needed, firstly in communication between acute and community to improve the patients' journey:

> *The discharge summary from the hospital was very poor & gave no information on the treatment he had received in hospital or of any follow up appointments.*

Secondly, an example of how communication had broken down within a multi disciplinary team, and how the in reach nurse was able to address the issue:

> *having a patient on the ward who has been a delayed discharge for a while due to funding issues for Residential Home.....and due to a lack of communication between social worker, family & nursing staff. Could see a real purpose of having an in reach nurse with this case.....because someone new came in & had a goal to facilitate discharge.*

Finally, in an example of in reach, whereby the in reach nurse crossed into the acute sector in an attempt to increase communication and promote the patient's journey running smoothly:

> *During this second hospital admission I visited [name] on the ward when she was transferred to [hospital] and attempted to liaise with the ward staff with regard to her situation prior to discharge and her pain relief. I was dismayed to find that she had been treated for dementia at [hospital], had been catheterised and was taking only paracetamol for pain relief. The ward doctors and nursing staff were always very busy and reluctant to listen to a band 5*

nurse in a community nurse's uniform. However, I was able to have a little influence and she was eventually discharged.

Although, this proved a less than ideal experience perhaps because of the nurses lack of seniority in the NHS hierarchical system, a regular pattern of in reach may breed familiarity and an expectation from senior staff of closer working relationships across the community and acute care interface may improving the quality of journey for patients with long-term conditions.

In addition to these themes the interviews with nurses highlighted a number of themes (see table 1). These themes focused on the patient journey but also gave the context of the working arrangement of nurses and the challenges of working across community and acute settings.

Table 1

Themes from interviews with nurses: new role considerations and skills	
Communication	• Engaging staff • Delayed discharges • Involvement of other key health professionals • Changing views
Opportunities	• Enhancing own skills • Benefits to patients with LTCs • Different ways of working • referrals
Barriers	• firmly held beliefs of other health care professionals • geography of placements • poor knowledge of project by other team members • short term placements (6 months)
Knowledge	• increasing skills • increasing experience • improving self management for patients • transferring knowledge
Time	• difficult to make an impact
Nursing skills	• community skills helpful
Feelings	• “out of comfort zone” • Pride in role • enjoyable

Discussion

The findings of the evaluation highlight evidence of good practice as well as areas where improvement is required. Communication is a central concept within all themes which emerged. The evaluation highlighted the central role of communication between professionals, and with patients and carers. Grover (2005) found a similar focus and concludes that where there is a need for interdisciplinary practice (as was highlighted in this in reach project around long-term conditions), an appreciation and understanding of the important role of communication is mandatory. The in reach nurses had to be able to communicate and co-ordinating care across boundaries within the health care system and across other organisations such as social care, in order to keep the patient as the main focus. Dawson (2007) suggests that such ways of working requires territory to be conceded and a positive view to be held about diversifying roles. As such, individuals, teams or organisations may feel threatened and effective leadership and change management strategies will be required to ensure success (Marquis and Huston 2006). Hudson (2007) suggests that co-location of different professionals can aid collaboration, which will be an increasingly new means of working as care shifts from hospital based to patient centred home (Barr and Ross 2007).Within the in reach project, co-location was not achieved and should be a consideration if the programme was to be expanded. Reporting on integration, Workman and Pickard (2008) conclude that integration improves the flow of information, understanding and co-operation as a result of the introduction of new roles without existing roles being reduced or marginalised. The in reach project showed steps towards integration with the high priority placed on closer working relationships between hospital and community. Seemingly attempts at changing traditional roles and ways of working can improve staff satisfaction and patient experience.

Aspects of the in reach role may appear to mirror those of case management undertaken by Community Matrons. An aim of case management has been defined by Banks (2004) as developing cost effective and efficient ways of care co-ordination across health and social care to improve the quality of patient's lives. As such this innovation may be considered a "cheap alternative" because

the in reach nurses were on a lower pay scale than Community Matrons normally command. Peretz and Bright (2007) found that where case management worked well, it involved highly experienced clinicians. The in reach nurses had only been qualified between 1 and 2 years, but their understanding of key issues such as communication, co-ordination, collaboration which grew as a result of these roles can only strengthen the quality of patient experience as increasing numbers of nurses have a "whole systems view" and are not at risk of being complacent as a result of working in one area for a protracted time (Kelly 2006). However, further economic evaluation of the in reach role will be required to determine whether the status of in reach nurses affects their ability to negotiate the health and social care systems in comparison to higher status Community Matrons

Study Limitations

The study was small but used a number of points of data collection which may give some triangulation of data over time, although not reported here there was also some triangulation of person as data were collected from managers as well as in reach nurses (Polit and Beck 2004). The use of reflective diaries and interviews added to the richness of the data. However, no views of patients and carers were sought and as such, this should be seen as a limitation. Future studies should include health outcome measures, the project reported here is based upon nurses perceptions of care delivered, it would be helpful to determine whether the in reach role affected patient outcomes such as the number of days spent in hospital or medication use

Implications for Clinical Practice

Although a small initiative, this evaluation holds patients at the centre of its philosophy. In using rotational posts, nurses are able to gain a wider perspective of the patient journey which may benefit the effectiveness and quality of care available to individuals living with long-term conditions. With the implementation of Transforming Community Services (DH 2009), most primary care trust provider arms will be expected to integrate with acute or mental health trusts. This will provide an ideal opportunity to develop new nursing roles and ways of working such as the in-reach role for the benefit of individuals with long-term conditions.

Conclusion

The evaluation of this new nursing role has considered the opportunities and barriers which are commonly seen when new ways of working are introduced. It has also considered the perception of nurses of the experiences, good and not so good, of patients with long-term conditions and their carers. It highlights how following the journey of patients across the community – acute divide has shaped the understanding of nurses and given them a desire to improve the quality of services received by individuals with long-term conditions across traditional barriers.

Contributions

Study design: NM, SR; data collection and analysis: SR, AD; manuscript preparation: SR, AD, NM

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