

Study of the Implementation of a
New Community Health Nurse
Role in Scotland

STUDY OF THE IMPLEMENTATION OF A NEW COMMUNITY HEALTH NURSE ROLE IN SCOTLAND

Professor Lawrie Elliott
Edinburgh Napier University

Professor Catriona Kennedy
Edinburgh Napier University

Andrew Rome
Figure 8 Consultancy

Dr Shona Cameron
Queen Margaret University

Dr Margaret Currie
Centre for Rural Health
UHI Millennium Institute

Dr Janette Pow
Research Fellow
Edinburgh Napier University

Maheshika Mackenzie-Baker
Figure 8 Consultancy

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ABBREVIATIONS

| | |
|--------------|---|
| RONIC | Review of Nursing in the Community in Scotland known fully as „Visible, Accessible and Integrated Care: Report of the Review of Nursing in the Community in Scotland. Scottish Executive November 2006. |
| SEHD | Scottish Executive Health Department. Now known as The Scottish Government Health and Social Care Directorates. |
| CHN | Community Health Nurse. The new role which is the subject of this study |
| NHS | National Health Service |

1 EXECUTIVE SUMMARY

Introduction

1.1 In 2006 the Scottish Executive, as part of the modernisation of the National Health Service (NHS), began a radical and far reaching review of nursing in the community. The Review of Nursing in the Community (RONIC) proposed the absorption of district nursing, health visiting, school nursing and family health nursing into a single community health nurse (CHN) role (Scottish Executive 2006). The new role was piloted in three Health Boards across Scotland namely Highland, Borders and Tayside. The following seven core elements identified by the Review of Nursing in the Community formed the basis of the new role:

- Working directly with individuals and their carers
- Adopting public health approaches
- Co-ordinating services
- Supporting self-care
- Multi-disciplinary and multi-agency team working
- Meeting health needs of communities
- Supporting anticipatory care

1.2 In 2010, the Scottish Government commissioned the research team to conduct an evaluation of the new role and an updated literature review (published as an annex to this report). This was the third study commissioned by the Scottish Government on this particular topic. The first was a literature review conducted by Kennedy et al (2008) which identified the contribution made by nurses in the community. The second was a baseline study and literature review which was conducted by Kennedy et al (2009).

Aims

1.3 The original aims of the study were to:

- Evaluate the impact of the new model of practice on both staff and patients (including carers),
- Provide evidence to inform a future decision on the use of the CHN in Scotland.

1.4 Early indications from our field work suggested a strong sense of inertia around the new model of practice. There was a strongly held view among nurses that in many instances it was not implemented and in the few places where it had been implemented the effect had dissipated. A decision was made by the commissioners to focus on the implementation of the new role and this resulted in a change to the first aim.

Revised aims:

- Provide insight into the structural and other issues which affect the uptake and implementation of the Community Health Nurse role
- Provide evidence to inform a future decision on the use of the CHN in Scotland.

Method

1.5 The evaluation comprised focus groups and interviews in the three pilot areas with nurses who completed the transition education for the new role (known as transitioned nurses) and nurses who did not transition. The nurses' managers were also included. Those transitioned were mainly Health Visitors, District Nurses and Public Health Nurses. Staff nurses were included in the study because indications from data collected early in the evaluation suggested that nurses thought staff nurses would have been more suited to the new CHN role. A total of 75 respondents took part in the research: 20 nurse managers and 55 nurses.

Findings

1.6 Nurses and their managers participating in the study questioned the strategic vision of the new Community Health Nurse role or to be more precise the model of nursing upon which the role was based. For many it represented a return to a previous model which in their view had „failed“ i.e., double and triple duty nurses. Furthermore it was strongly associated with the extended family which was thought to be outdated and no longer fitted modern family structures. The CHN role challenged more traditional nurse boundaries which formed strong professional identities and were highly valued. Some concerns were raised regarding the effectiveness of transition education in helping nurses change their identity and sustain their new role. Another important issue was that of critical mass. Many nurses returned to their original teams after the transition education and experienced opposition to the new role. In some instances they also lacked managerial support.

1.7 There were, however, some favourable reports. The transition education helped heighten nurses' awareness and re-engagement in the wider aspects of health and social care. This was particularly so in public health, including community health profiling and health promotion. It also helped them to reflect upon their role and led some to change their practice. Notable examples included district nurses, public health nurses and health visitors conducting immunisation programmes; health visitors taking on district nurse duties such as taking bloods and changing dressings; and health visitors and public health nurses visiting schools. However these were often viewed as opportunistic rather than systemic changes and there was little discernible impact on patient experience. There was support for the notion that the new role could be more easily accommodated in nursing teams that already worked with a range of health professions and other disciplines.

1.8 There was little doubt that the introduction of the CHN gave rise to extensive debate within the nursing professions in Scotland. There was broad support for the core elements such as promoting self-care, adopting a public health approach to nursing, developing community profiles, and preventing unnecessary hospital admissions. However nurses thought that, rather than focussing on changing nurse roles, more should be done to improve interagency working and foster better collaboration among the existing nursing disciplines. Some examples were offered including identifying a single point of access to health and social care, greater liaison with nursing colleagues to improve patient management, and multidisciplinary team meetings to improve communication. There was a strong sense that the new role was introduced from the top and had not fully considered the views of nurses to which it was directed. Thus, many felt the need for greater consultation before new policies were introduced.

Key conclusions

Education

1.9 Whilst nurses in the current study valued the education they received there were some concerns about its effectiveness in helping them change and sustain their new role. The main issue was around the depth and scope of education required to meet the diversity of the role. The resulting tension between specialisation and breadth is not easily reconciled. Recent research indicates that improvement in knowledge and also competence is necessary to help change nursing roles in the community. The issue of competence links well to the educational programme which was designed for the Family Nurse Role in Scotland where students highly valued the skills based parts of the course specifically those which focussed on communication, assessment and health promotion (Scottish Executive 2003).

Managing change

1.10 Changing existing roles is difficult and there were three areas which we think proved extremely problematic in doing so: critical mass, the strategic vision of the new role and ownership of the new role.

Critical mass

1.11 We noted in the baseline study that approximately one-third of nurses supported the new community nurse role (Kennedy et al 2009). It is probably reasonable to conclude that the lack of widespread support for the new role continued after the baseline. For instance, many nurses returned to their original teams after the transition education and experienced opposition to the new role. In some instances they also lacked managerial support. Therefore support did not reach a level necessary for its implementation. Building critical mass was also recognised as important for the future development of the Family Health Nurse role in Scotland (Scottish Executive 2003).

Strategic vision

1.12 There was uncertainty around the strategic vision of the new role which, as we have demonstrated, was framed in terms of an older approach to community nursing that was thought to have „failed“ i.e. double and triple duty nursing. This failure was linked to the breadth and depth of knowledge and skills required to carry it out. Critically, the diverse nature of the new model also represented a challenge to the existing professional boundaries. We think success depends on a shared vision of the new role and an understanding of how it works within the health care setting.

Ownership

1.13 We think our findings fit very well with a more macro theory of role development as described by Aranda and Jones (2008). They explain how new nursing roles are essentially socially and politically constructed. Critical to this theory of development is the mechanism by which new roles are adopted (or rejected) by nurses. Here, nurses are viewed as being actively involved in the process of „re-constructing boundaries, identities and social relations in healthcare“.

Leadership and organisational support

1.14 It would be misleading to suggest that there was a total lack of support for the new role. There was clearly a strategic commitment to the policy by the Scottish Government and from the health boards which piloted the new community nurse role. Some local managers and the nurses who took part in the programme were also supportive of it.

1.15 Nurses also thought they should take a stronger lead in developing their public health role, encouraging anticipatory care and self care. They envisaged adopting extremely proactive roles in working alongside services users to help them improve their health, avoid unnecessary use of more intensive healthcare and live independent lives. Key to these developments however is the working dynamic of the nursing team (including managers) and other health professionals. It was noted that nurses who undertook the transition education were better supported by teams with a history of multidisciplinary working across nursing professions and other health

professions. This connects well with the notion of critical mass which needs to be developed before a new role can be successfully embedded into a team (Scottish Executive 2003).

Research

1.16 There are methodological limitations to the research which appears in this report. First, the views outlined in this report represent nurses and their direct managers and not strategic managers and policy makers. Second, it represents the views of those who volunteered to take part in the transition education and those who did not undertake the education from the three pilot areas, which means the views of those from the remaining Health Boards in Scotland are not considered. Third, there were nurses who declined to participate in the research and it is possible that the voices of those who held contrasting views were missed.

1.17 There are also strengths of the research. Every effort was made to include nurses from a range of disciplines which were affected by the Review of Nursing in the Community in Scotland. We also, after a preliminary analysis of our data, included nurses thought to be indirectly affected by the role i.e., community staff nurses. We included nurses who had undergone the transition education, members of their immediate nursing team and those from non-transitioning teams. Thus, the data presented in this report represent the views of those most directly affected by the new policy, those who work along-side them and those who were given the opportunity to adopt the new role and declined.

Recommendations

- The model of nursing and the related attributes were viewed as highly problematic by nurses participating in the study and became important territory upon which the implementation of the new role rested. Thus, future consultations could focus on co-constructing new nursing roles particularly in developing critical mass which will secure support for a new policy. A crucial part of this is how the roles fit with existing teams particularly within the multidisciplinary team setting.
- We would also agree with the recommendations which appeared in the evaluation report of the Family Health Nurse in Scotland (Scottish Executive 2003) which suggested that before introducing new roles developers devise a detailed plan which facilitates and sustains such roles.
- Nurses valued the education which was designed to prepare them for the new role although any gains were confined to an improvement in knowledge. However competency is also necessary to help change nursing roles and thus designers should consider how both skills and knowledge are best promoted in their training programme.

- Tension surrounding the introduction of new nursing roles tends to dominate the scientific literature, however there are studies which point to new developments within nursing which merit closer scrutiny and may lead to more effective care. This includes the co-construction of therapeutic nurse patient relationships; the co-construction of nursing roles (as highlighted above); and partnership working with other nurses and other health professions. Future research could focus on evaluating the impact of the new nursing practices on the end users as well as providing insight into how new roles work.

2 INTRODUCTION

Background

2.1 In 2006 the Scottish Executive, as part of the modernisation of the National Health Service (NHS), began a radical and far reaching review of nursing in the community (Scottish Executive 2006). The review responded to the health challenges faced by Scotland and many other countries, namely an ageing population, degenerative or chronic diseases, rapid technological developments and the need to change the emphasis from acute care to community care (Scottish Executive Health Department 2006). Scotland is a small country, has a range of population profiles which demand differing approaches to healthcare provision and comprises areas which are densely-populated, sparsely-populated and remote.

The new model

2.2 The Review of Nursing in the Community (RONIC) proposed the absorption of district nursing, health visiting, school nursing and family health nursing into a single community health nurse role (CHN) role (Scottish Executive 2006). The new CHN role was distinct from the generic staff nurse role as it had a wider range of responsibilities and specialist skills. Within the proposed model the community health nurse would be supported by advanced practitioners and consultant nurses to provide expertise and advice, and by community staff nurses, health care support workers and administrative support to deliver care to patients and clients as illustrated in Figure 1.

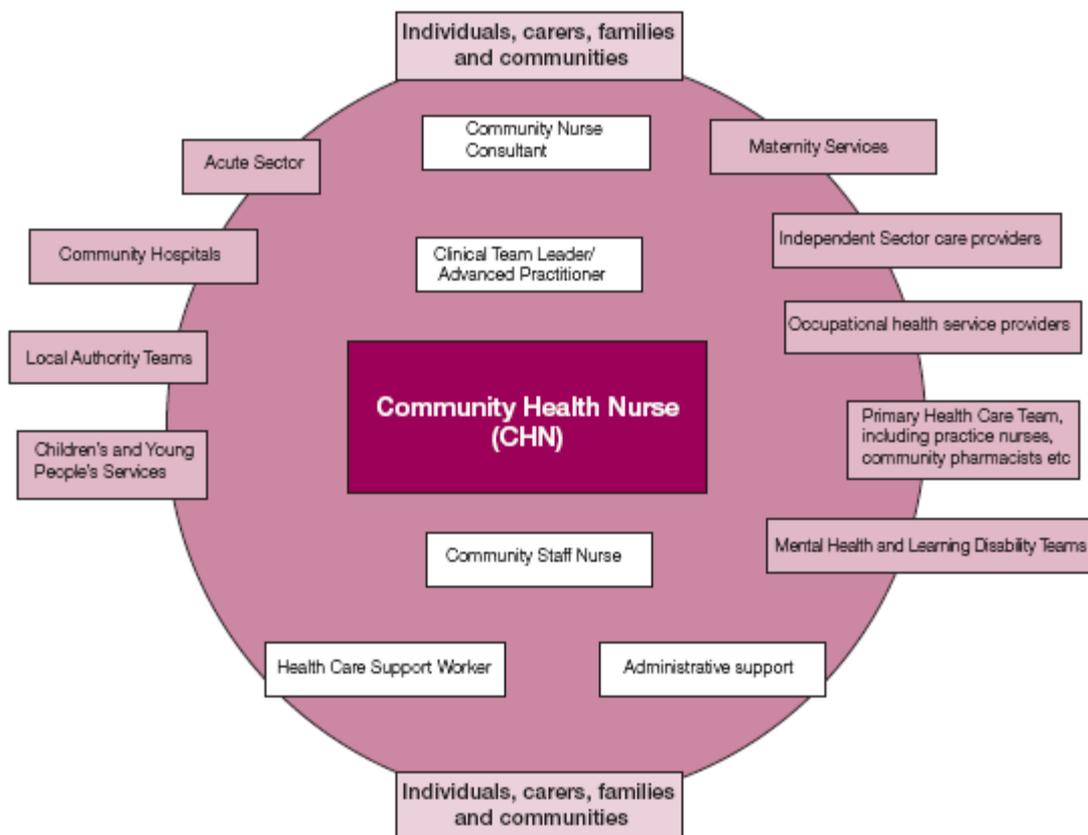


Figure 1.1 New Community Nurse Model
 (From *Visible, Accessible and Integrated Care 2006*)

2.3 The following seven core elements identified by the Review of Nursing in the Community formed the basis of the new role:

- Working directly with individuals and their carers
- Adopting public health approaches
- Co-ordinating services
- Supporting self-care
- Multi-disciplinary and multi-agency team working
- Meeting health needs of communities
- Supporting anticipatory care

The transition education programme

2.4 By the end of 2009 a total of 48 nurses completed the transition education programme across all areas (Table 1). NHS Education for Scotland consulted on and then formulated an education framework which informed the development of the transition education. The transition education programme was designed and implemented by higher education institutions (HEIs) in partnership with NHS boards. It was based on the seven core elements and was grounded in a work-based learning approach that enabled the application of theory to practice. Each student had access to an educational supervisor from their host HEI and a local work-based facilitator. HEIs set a prescribed time for the achievement of learning objectives and assessment of portfolios of evidence, or adopted a flexible approach that reflected individual learning needs. Annex A provides a breakdown of those completing the transition by area.

Table 2.1 Number of Nurses completing Transition Education by the end of 2009*

| Post | Number |
|---------------------|---------------|
| Health Visitor | 10 |
| District Nurse | 26 |
| Public Health Nurse | 12 |
| Total | 48 |

*Based on figures provided by the NHS Boards

2.5 The education programme was designed to be delivered over five-stages:

Stage 1 involved the practitioner completing a personal development plan with his or her manager, using the national capability framework to identify his or her strengths and gaps.

Stage 2 linked students to their local HEI where they then created a personal learning development plan. This identified outcomes specific to their individual learning needs, the activities necessary to meet the outcomes and the evidence of their achievement.

Stage 3 led to the creation of a personalised education programmes. For example at Queen Margaret University, students were offered four study days that focused on work-based learning, public health approaches, anticipatory care and person-centred approaches, at undergraduate and postgraduate level. The Universities of Dundee and Abertay jointly offered two modules, one at undergraduate and one at postgraduate level, and four study days. The University of Stirling used a mix of portfolio based learning and website support for students who lived in remote areas.

Stage 4 involved work-based activities which were identified in the previous stages. This included “shadowing” opportunities with experienced practitioners in areas where they had a specific learning need.

Stage 5 focussed on developing a portfolio of evidence which highlighted the students' achievement. Students were required to link theory to practice and record personal and professional growth over time. The portfolios were assessed by the host HEI and verified by an external examiner.

Evaluation

2.6 The Scottish Government commissioned two research studies to help inform the development of the Review of Nursing in the Community. The first was a literature review conducted by Kennedy et al (2008) which identified the contribution made by nurses in the community in shifting the balance of care identified in the Kerr Report (SEHD 2005a) and Delivering for Health (SEHD 2005b). Little evidence was found which directly indicated the effectiveness of different models of community nursing. The second was a baseline study conducted by Kennedy et al (2009) which indicated that whilst nurses worked along fairly traditional lines there was some evidence that their teams possessed the right balance to work across areas such as child protection, coordinating services on behalf of those with complex needs, and addressing health inequalities.

2.7 Following discussions between the Scottish Government and the relevant trade unions, a new approach was announced in 2009 to modernise community nursing in Scotland. This focused on all parties working together to modernise community nursing within team settings throughout NHS Scotland. The new approach no longer centred on the generic community health nurse model, however the CHN role continue to be piloted in: NHS Borders, NHS Highland, and NHS Tayside. It is this evaluation which appears in the present report.

2.8 In 2010 the Scottish Government commissioned the research team to conduct the evaluation. It was envisaged that the results of this research would help to inform the development of future policy for the provision of community-based healthcare services and practice in relation to community nursing in Scotland.

This report

2.9 Chapter Two of this report provides details of the aims, objectives and key questions addressed in the evaluation study. Chapter Three details the design and methods. The findings are reported in Chapter Four. The final Chapter, Five, identifies conclusions from the study.

3 AIMS AND OBJECTIVES

3.1 The original aims the study were to:

- Evaluate the impact of the new model of practice on both staff and patients (including carers),
- Provide evidence to inform a future decision on the use of the CHN in Scotland.

3.2 The original objectives were:

- A. To identify the impact to date that the CHN role has made in:
- Working directly with individuals and carers throughout the lifespan
 - Adopting public health approaches
 - Co-ordinating services
 - Supporting self care
 - Working effectively within a multi disciplinary and multi agency team
 - Meeting the health needs of the communities
 - Supporting anticipatory care
- B. To determine the positive or negative aspects of the implementation of the role on practice, in particular:
- Organisation of teams and workload
 - Services delivered compared to those previously delivered
 - The identification of service gaps
 - Staff satisfaction with their new role
 - Views of staff and their clients on the new model of community nursing
 - Comparison with non-transitioning teams within the Pilot areas
 - Identify common lessons from the teams transitioning in terms of what works and what doesn't, and where appropriate disseminate these lessons to each of the pilot sites as the work progresses.

3.3 Why were these aims and objectives changed? Early indications from our field work up to March 2011 suggested a strong sense of inertia around the new role. There was a strongly held view among nurses that in many instances it was not implemented and in the few places where it had been implemented the effect had dissipated. We were obliged by our contract to report any potential risk of the study and we did so at the next available advisory group meeting. The risk in this instance was not being able to demonstrate the impact of the new role on nursing practice and patient experience.

3.4 We thought there would be strong grounds for enhancing the other parts of the study which examined the implementation of the new role and there was still a need to provide evidence which informed a future decision on the use of the CHN in Scotland. The resulting evidence would provide insight into the underlying issues which explain uptake of the role such as managerial support, education, professional identity and professional boundaries. We

also thought it wise to provide a more complete data set thus avoiding the risk of reporting part of the picture. For example there was some evidence in our early data of the potential importance of staff nurses in developing the role and thus merit in gathering their views.

3.5 An agreement was reached with the Advisory Group in June 2011 to set out our plans (including costs) which involved removing the parts of the study which assessed the impact of the new nursing role on patient experience.

3.6 Revised aims

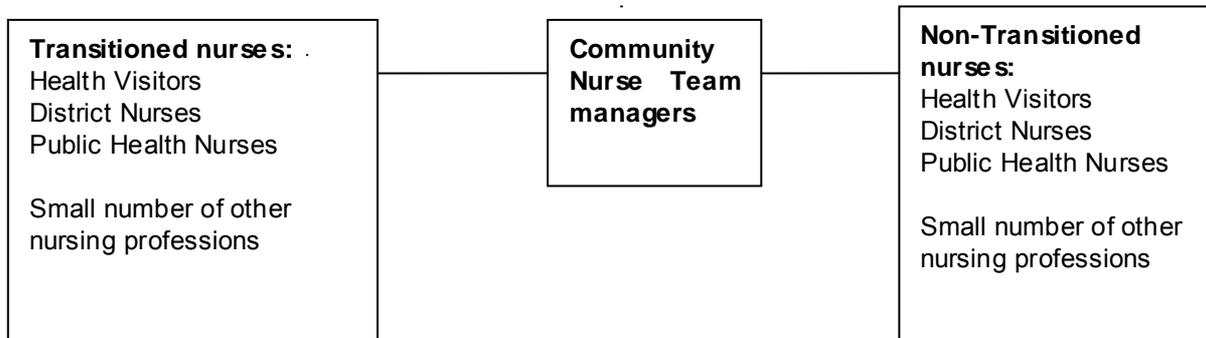
- Provide insight into the structural and other issues which affect the uptake and implementation of the Community Health Nurse role
- Provide evidence to inform a future decision on the use of the CHN in Scotland.

4 DESIGN AND METHODS

4.1 The Research was conducted in two phases:

- **A literature review** which updated that presented in the baseline line study and helped to inform the design of the evaluation. The review appears in Annex C and includes a detailed description of the searches used to identify the relevant papers.
- **The evaluation** which comprised focus groups and interviews with nurses who transitioned (those completing the transition education) and nurses who did not transition in each of the three pilot areas. The nurses' managers were also included. The transitioned nurse sample comprised mainly Health Visitors, District Nurses and Public Health Nurses (Figure 2). NHS Boards were given flexibility to determine how to test the model to meet the needs of their local populations and, as a result, a small number of other nursing professions were included (Table 3). The non-transitioned sample also comprised mainly of Health Visitors, District Nurses and Public Health Nurses. Staff nurses were included because indications from data collected early in the evaluation suggested that nurses thought staff nurses would have been more suited to the new CHN role. Please refer to Annex B for definitions of nursing disciplines.

Figure 4.1 Evaluation Design



Methods

The fieldwork

4.2 The total number of nurse and manager focus groups and interviews appears in Table 2 and the professional disciplines appear in Table 3. Annex A provides the number of nurses taking part in the evaluation in each area, but to protect their identity, does not give their profession.

Table 4.1 Focus groups and interviews

| Focus Group/interviews | Attendees |
|---|-----------|
| 3 Manager's focus group | 19 |
| 1 Manager interview | 1 |
| 4 Transitioned nurses focus groups | 20 |
| 3 Working with transitioned nurses focus groups | 11 |
| 3 Non transitioned nurse focus groups | 15 |
| 1 Non-transitioned nurse interview | 1 |
| 1 Staff nurse only focus group* | 5 |
| 3 Staff nurse only interviews* | 3 |
| Total | 75 |

*Staff nurses were also included in other focus groups

Table 4.2 Professional Disciplines

| Post | Number |
|---------------------|-----------|
| Health Visitor | 8 |
| District Nurse | 16 |
| Public Health Nurse | 9 |
| Manager | 20 |
| Staff Nurse | 17 |
| Other* | 5 |
| Total | 75 |

* Not listed to protect identify

How nurses and managers were chosen and recruited for the study

4.3 We liaised with the lead nurse in each pilot site to identify the nurses and managers. This was a highly iterative process which involved the lead nurse approaching managers and asking whether they would like to take part in the study. All managers agreed to take part. Managers were then asked to approach all of the transitioned nurses in their area and ask if they were interested in joining the study. The number of nurses who took up the transition education across all three areas was 48 (Table 1) and we recruited 20 (Table 2) which gave a 42% response rate. Reasons given for not taking part were: general reluctance to participate, not turning up for focus group or interview or moving post. We also thought that the delay in gaining ethics permission for the study could have led to a loss of interest early in the field work phase.

4.4 Research indicated that new roles need time to become established (Bonsall and Cheater 2008). We recognised this and recruited those who transitioned early and those who did so more recently. We also recruited from

different teams. Together this helped us gain a range of views and experiences of the new role.

4.5 Research indicated that new nursing roles were dependent on the reaction of others in their immediate team (Senior 2008). Therefore, the focus groups offered transitioned nurses the chance to discuss issues with their transitioning peers. In doing so we aimed to form a shared understanding of the central influences which shaped practice including the delivery of health care. Members from their teams were offered the opportunity in a separate focus group to discuss their views of the new roles. Those in non-transitioned teams, including staff nurses, were also offered the opportunity to take part in separate focus groups and in doing so given a space to provide their views of the role as well as their own methods of working. Staff nurses were also offered the opportunity to provide their views in a separate focus group. Individual interviews were conducted when respondents felt uncomfortable about taking part in a focus group or when a focus group was difficult to arrange e.g., geographical constraints. The topic guide used for focus groups and interviews appears in Annex D.

Data Collection and Analysis

4.6 All focus groups and interviews were audio recorded and transcribed verbatim. An initial analysis of the data was conducted by all members of the research team and this resulted in a number of initial themes. These themes were discussed at a series of team meetings and refined to give four main categories:

- What nurses know of the Review of Nurses in the Community and how it was implemented
- The extent to which it has impacted on their role
- The benefits and barriers to its influence in two key areas: i) nursing practice ii) patients and carers
- Staff nurses being the focal point for the future development of such roles

4.7 Members of the team then checked these against their more detailed interpretation of the data and further team meetings were held to discuss and refine the analysis. The following themes emerged from this more detailed and iterative approach. These themes underpinned respondents' perspectives of the new community nurse role and provide a deeper understanding of its implementation. The themes were used to structure the findings chapter.

Refined themes

- Strategic vision
- Changing professional boundaries
- Structure and organisation
- Staff nurses working as generalists
- Impact on knowledge, awareness and working practices
- The future

Ethics

4.8 Ethics approval for the study was granted by the East of Scotland Research Ethics Service REC 2: Fife and Forth Valley Committee on Medical Ethics

5 FINDINGS

5.1 Nurses and managers who participated in this evaluation reported that the new CHN role had not been implemented as originally envisaged in the policy. There were a number of reasons given by respondents. These appear under the headings in the present chapter and will be discussed in more depth in the final chapter. As noted in the methods chapter these headings represent the dominant themes which emerged from our analysis. The quotes presented in this chapter are typical in that they represent the views and experiences of nurses across the three pilot sites.

Strategic vision

5.2 There were a number of prominent concepts which underpinned respondents' strategic vision of the Community Health Nurse Role. The issue is not whether these are factually correct. Rather it is how these concepts were used by nurses to construct a narrative of how the policy was implemented and their subsequent response to it. Three concepts emerged: Double and Triple Role Nurses; Extended Families; and Single Point of Contact.

Double and Triple Role Nurses

5.3 There was a strong sense that the new Community Nurse Role represented a return to an older model of community nursing that had „failed“. A number of participants thought that the previous roles of triple and double duty nurses were abandoned due to concerns over the depth and range of knowledge and skills required to satisfy each.

„I had a lot of district nurses who were also midwives. The roles were separated and the reasons given at that time were that they [post holders] could not keep the expertise that was required. The disciplines become more complex and more evidence based, and we become more accountable and working at a higher level, and that they couldn't do that so they were deliberately separating those posts. And suddenly we were saying, to often the same staff, hey we've got an idea - you're not allowed to do midwifery because that's too complex but why don't you do a bit of school nursing and health visiting as well. And I think that caused quite a lot of problems because we were actually asking them to go back to a model that was not seen as being ultimately successful in the past“.

(Manager).

„I felt as if we were going back in time having had dual roles that didn't work and I think district nurses were more scared with all the child protection issues in health visiting whereas the health nurses we had all been staff nurses and with some training could probably do it.“ (Transitioned Health Visitor).

On the other hand, there were some nurses who felt comfortable with the new role but did not feel comfortable sharing this with their colleagues. This

tension is explored in depth in a later section (5.10 Structure and Organisation).

„...there was a huge outcry that nurses are going to go back to dual roles...I was one of the only ones in the team that didn't freak because before I went into being a public health nurse I had worked as a community and nurse and midwife so I had had a dual role and I didn't know if I was going to be that bothered really... but I didn't tell any of my colleagues that because there was such an outcry“. (Transitioned Health Visitor).

Extended Families

5.4 Respondents also raised concerns about the demographic information which appeared to underpin the Community Health Nurse role, or to be more precise the model of a typical family which they thought was used to promote the new role i.e., the traditional extended family.

„Gone are the days that you're actually having the family with all the extended family, the grandfathers, the baby, everybody in the same house, we don't see that no wadays so if we're going in to see a patient very seldom is there a child or a health visitor need there, it's purely district nursing. Whereas years ago you went out and all the family was in the one house so you could potentially have had the health visitor going in but also a district nurse going in but that doesn't happen.“ (District Nurse)

Single Point of Contact

5.5 There was also some dispute as to whether service users would welcome the notion of one nurse looking after their family needs, particularly if this resulted in a conflict of interest.

„Quite often if you speak to families they see their needs independently and they don't necessarily want to be represented by the same professional. So quite often in family situations like social work you'll have a parent with a social worker and a child with a separate one because the needs of family members sometimes have to be represented by different people because they conflict.“ (Manager)

„And families may worry you know. Do I tell this nurse something very personal about the child or father of the child or whatever, and will she ... whether there's any chance that granny might find out. It shouldn't under confidentiality but I can see why families would feel nervous about that situation.“ (Manager)

Changing professional boundaries

5.6 Much of the discussion in the focus groups and interviews focused on professional boundaries. These shaped nurses' professional identity and many raised questions about the impact of change on such identities. They also raised issues about the role of education in bringing about change and being able to sustain a multiple role nurse in the future.

Professional boundaries

5.7 Professional boundaries were valued and often thought difficult to change.

„I think what you're looking at is people who have made a definite choice to be a health visitor or to be a district nurse or school nurse and they chose that because of the knowledge and skills and their personality a lot of the time. (Other nurse profession)

„From a personal point of view, I thoroughly enjoy my role as a community nurse and that's where my knowledge base is, where I'm most comfortable with. I think people choose to do a health role because that's what they want to do. I think they try to merge both roles, which might not necessarily be what they've chosen to do... I think there's a bit of conflict there". (Staff Nurse).

Education

5.8 Whilst the transition education was valued by participants they thought it may be inadequate in preparing them to undertake the CHN role. Incidentally traditional nurse training was also criticized in that it was designed around specialist rather than general care.

„We couldn't possibly fulfill what they were expecting. The roles are too different. The expertise, they don't provide the training in general nurse training to get these nurses that when we all retire were going to be able to come out as Community Health Nurses. A 12, 15 week module does not equip you with the skills to look after children and adults, I'm afraid". (District Nurse).

„I think the education for nurses needs to be more flexible. And I feel, yes, what's being offered at the moment is completely inadequate to prepare you for going to look after children and to learn parenting skills. It's just completely inadequate, just reflecting on my own training and the type of conditions children have. With heart conditions they're congenital conditions. It's totally different from the type of heart conditions that we've seen in our patients and I think just to know about the two and to be practising and working with these patients everyday is just incredibly difficult." (District Nurse)

Sustaining multiple roles: Jack of all trades

5.9 The majority of respondents reported that it would be difficult to keep up to date with developments in all nursing disciplines and they were concerned about maintaining the specialist knowledge and skills needed for each area. Concerns were also raised around a potential dilution of skills and competencies which could compromise patient care.

„Our community health profile tells us the age and population within the area and the new housing that is expected may cause there to be a rise in the younger children in the area which then affects schools, which then affects work, which then affects transport, so all these public health issues are contained within that profile. But it doesn't state that one person should be able to do that, it does state that we should be able to provide for all these people but not that one person should be able to do it“. (Transitioned Public Health Nurse).

„The only impact it would have, it would reduce the quality of care because I'm having to then stretch myself over two disciplines and also I'd be seeing the district nursing patients less because I'm then also going up to the health visiting patients as well.“ (Transitioned District Nurse)

Structure and organisation

5.10 Another dominant theme concerned the structure and organisation. The main issues here were critical mass and the level of support for the proposed change, including managerial support.

Post-education

5.11 Following the transition education most nurses went back to their original teams and posts and there were few examples of significant change. There was also evidence that the new job titles appeared confusing and as a result old job titles were reinstated by those who had transitioned as illustrated in the second quote.

„...most people they went back in to the team.....the majority of people had gone back into the (original) post. (Transitioned Public Health Nurse).

„...the term community health nurse and public health nurse sound very similar yet they're very different roles. And so at one point I was a health visitor then I was a public health nurse then I was told to call myself a community health nurse but people didn't know who I was... so I didn't know what I was either, it was all of these things. So now I've gone back to the term health visitor because that's what everyone always understands“. (Transitioned Health Visitor).

Work environment

5.12 Embedding the CHN role in practice was seen as challenging due to the persistent and overwhelming opposition to it. A lack of critical mass was viewed as problematic by transitioning and non transitioning nurses. Additionally, those who had undertaken the transition education and were highly motivated to carry out this role often returned to practice and experienced much resistance.

„I was actually called a traitor which was a bit...“ (Transitioned Public Health Nurse).

„I think that more people had negative views of the transition role, maybe because it's dilution of skills, to have so many skills and be a specialist in all of these skills. The feedback that I got was very negative.“ (Transitioned District Nurse).

„I think logistically as well if you did the training and thought I could do this generic role, and if you come back and there's two separate teams and there's not a pool of you working together you end up not really fitting in to what's there, so if everybody in an area ... which is what we tried to do; if everybody had bought into it, and done it, then it would have been easier to come back to because everybody's sharing it and you're working together. But what I found was that there were individuals who were keen and wanted to change who came back into a team where half of the team were very resistant. And there was a lot of anxiety and some of the team felt quite threatened by the fact that some of these other people had done this magic training and thought there was something different. So there was quite a lot of ... locally ... quite a bit of animosity. And that didn't make it easy for those who had done things and come back and end doing something different.“ (Manager).

5.13 There was a however the suggestion that support for the new role could be more easily achieved in nursing teams that already worked across health disciplines. As the following illustrates, the dynamics of the multidisciplinary team are perhaps more suited to the adoption of a new role which is more diverse and thus more supportive of it. Nurses saw multidisciplinary working as an important way to address the issues which were raised by the Review of Nursing in the Community and this is outlined in more depth in Section 4.7.3 Changing the System.

„The teams started off with a very different point, so we were already a long established integrated team not just within nursing but within... with the allied health professions as well. So we had already recognised that the team approach in providing care to the community is really the way to go and I think for us the review of nursing really embedded that even more into our practice and just felt that we were on the right track and that within the team itself we would have the competencies across the board.“ (Manager)

Managerial support

5.14 There were some who thought their managers were supportive and tried to put things in place to support the nurses who had transitioned.

„Yes, she encouraged all her staff to go and she gave all her staff the entitled study time and was very keen to know your plans. She came and she wanted updates...“ (Transitioned Health Visitor).

5.15 Nevertheless, many spoke about the lack of managerial support and resources in some areas, which made implementing and embedding the new role extremely difficult.

„I think there was a lot asked of us and we were all happy to take on new roles and new skills but my personal opinion in our area is that there’s been a massive lack of resources and lack of time as always there is. But there has been no support from managers I would say to allow us to carry out the job holistically within the time frame. So you’re forced to pass it on (to district nurse, health visitor or school nurse colleagues) when you really don’t want to because you don’t have the time“ (Transitioned Health Visitor).

„I feel that management probably hasn’t given us the support and pushed us to embrace our transitional education. I don’t think that even my manager will know what I studied on... she’s never asked me about it. And I think she should be pushing me to implement my plan but she’s never once asked me. When I think about it that’s really bad. There’s been no encouragement to change your way of working and they’ve invested all this money and no body’s pushing from the top“ (Transitioned Health Visitor).

Staff nurses working as generalists

5.16 Many participants, nurses and managers, thought the CHN role and transition education should have been aimed at staff nurses who generally work at band 5 rather than band 6 nurses (Health Visitors, District Nurses) and band 7 (Team Leaders). The rationale for this appeared to be that band 5 Nurses would be able to offer generic care across the disciplines but still have specialist nurses to provide support and advice. One idea was that staff nurses could rotate around the nursing team.

„It was in the pilot team the community staff nurses who were working across health visiting school nursing and district nursing and probably out of every member of the team they rose to the challenge and enjoyed that. I personally felt towards the end when it focused the review on nursing community that it was really at the wrong level and should have been looking at the community staff nurse role“ (Staff Nurse)

„We’ve got Band 5s that do rotate, or there’s possibility for them to rotate within that one year but they weren’t subject of the training and you felt that if perhaps they had been it might have been more beneficial?“ (Manager)

5.17 Although supportive, the views and experiences of staff nurses and some managers gave rise to a number of concerns, some of which reflected those already given about the new community health nurse role.

„I find that there’s probably an easier transition at staff nurse band 5 level because they are not so involved with the really complex things on the assessments so there’s a bit more flexibility at band 5 – in public health not across district nursing though I do have some people who do some shifts in district, some in health and some in school. But that’s odd shifts and odd people, it’s not an amalgamated service, it’s just some people are able to move.“ (Manager)

„We had a trial in (local) area, a staff nurse have been given the opportunity to double duty as it were, she found it useful, she did find it hard to... she felt she couldn’t give either her full capacity, she was too tied up on her health visiting days and not see things through on her district nursing days so she’s back in her original post“. (Transitioned District Nurse).

Impact on knowledge, awareness and working practice

5.18 It could easily be concluded from the findings presented thus far that there was no positive impact on nurses as a result of the new role. However some of the nurses who had completed the transition education felt that it helped heighten their awareness and re-engagement in the wider aspects of health and social care. It helped them to consider these within their own role and in some instances it led to a change in practice.

Knowledge and awareness

„It’s the way that your thinking’s kind of changed a wee bit... see a broader [perspective]. You would go into [a consultation with] an anemic patient and say “Oh I’ll just take the bloods” or if a woman’s had a section.... saying “Oh I’ll just change the dressing” and support them in that way, whereas historically it would have been the district nurses “[role]“. (Transitioned Health Visitor)

5.19 One area where there was evidence of stronger influence was in public health including community health profiling and health promotion.

„The health needs analysis.....will also have an impact on patients because of everybody really understanding the population more and then services are being planned accordingly. Now that wouldn’t have been met before and so that’s a result of the project“. (Manager).

„...I think that’s really important, a really positive thing that came out of the new nursing community, that the district nurses were able to start to get back to thinking about health promotion, health improvement and also the need to identify the needs of the community is positive too, and to think about the skills that the teams would develop according to the needs of the community as opposed to what the needs were in the past“. (Staff Nurse).

Working practice

5.20 There were examples cited where the education had resulted in opportunistic changes in practice rather than a systematic change in the way in which care was organized or delivered.

„Swine flu obviously was something that was identified and we would all work together as a team whereas previously that would have just been down to district nurses so we were going out in multi-disciplinary teams immunising patients in the community. So from that point patients would probably have noticed a difference because there was someone with the district nurse who they weren't used to seeing. They asked who you were and you said „well I'm a public health nurse" or „health visitor" and they seemed a bit surprised but they were very accepting of the change as long as you were a trained nurse giving the jab.“ (Transitioned Public Health Nurse)

„... I was previously just doing health visiting and just about the time of doing the transitional education I was doing a little bit of schools, working in some schools and I've taken on a dual role now. And part of the transitional education was about improving my knowledge in schools which I didn't have previously.“ (Transitioned Public Health Nurse).

„Mine has been fairly positive change as well in respect to similar to [name of nurse] but I was public health trained but mainly in a health visiting role and now I have a day a week in schools in (local area) at the moment.“ (Transitioned Public Health Nurse).

5.21 However when asked whether these changes had an impact on patients, most transitioned nurses thought there was no discernible impact.

„When you look at the patients as a whole I don't think they really know how much difference has been made. They... at the end of the day most patients show that from patient satisfaction... as long as it gets done and whoever they see is pleasant, they're not bothering who does it. But I think given the choice and they were asked would you rather it was someone else who came and then someone else two hours later, then they would say „no I would rather have the same person“. But they're very unaware particularly the older generation... they seem to be just happy to go get someone to go in and have a look at whatever is bothering them.“ (Transitioned Health Visitor)

„Whatever way it went I don't think there would be any difference to patients at the moment.“ (Transitioned District Nurse)

„Quite honestly I don't think they'll have noticed any difference because a nurse is a nurse.“ (Transitioned Public Health Nurse)

The future

5.22 There was little doubt that the Review of Nursing in the Community in Scotland and the subsequent pilots had given rise to debate within the nursing professions and from this debate reflection on how community nursing should develop. For example some of the core elements which were advocated in the Review were viewed as extremely relevant to the future of community nursing.

„I'm not meaning it failed but we've not been able to proceed with it the way that it [the concept] was created. I think the core principles were really good and I think some of these will be kept in place, principles like self care... you know there are some really good principles that the model is based around and I think we've had a lot of eagerness because everybody has to be really eager... and in a way it's a shame that was lost..“ (Health Visitor)

Strengthen existing practices and developing new practices

5.23 There was a strong sense that community nursing should involve more public health, anticipatory planning and encourage self-care.

„That's about having a public health role focussed on the younger population and how you determine how that younger population may be could ... change. I mean that's just my thoughts but if you think in terms of the role of nursing within promotion of health there could be something you could develop there. But in terms of district nursing, what they're looking at, they're very much with the older population and yes health promotion comes into that and is all about keeping people well but isn't as closely align to the younger population.“ (Manager)

„I think it's definitely the way forward, and I would love to see it as the normal that we give more and more nursing care in the home and people only... they stayed at home for the nursing care as the normal. Whereas in the past, folk have maybe been taken into hospital for things. Maybe just extend the role even more to do more things at home maybe.“ (Transitioned Public Health Nurse)

„I think also we have to encourage nurses to be more enablers because they tend to do things for patients and this has allowed people to be more enabling and get people to look after their own health. And to start that young, I'm thinking of young diabetic children so we can carry on that self management but also encourage older people to be in charge of their own health. And also use this to look at public health and involve all the disciplines to look at public health and improve that.“ (Transitioned Public Health Nurse)

Changing the system

5.24 Most of the respondents thought that the system of care needed to change to allow better ways of providing care, including the development of interdisciplinary relationships. The responsibility of care was not seen as confined solely to the nursing professions. There were a range of health and social care partners involved. Thus there was a perceived need to introduce

system change which focused on multi-agency working and better communication including greater centralization of General Practitioners.

„There would be a key worker, it might not necessarily be a nurse depending on the situation because in that particular initiative there’s the police, there’s social work, health visiting, school nursing, you know there’s quite a number of agencies, and housing, you know a number of agencies involved. The likelihood is that it would be either social work or health who would take the lead but it would be dependent on the needs of that situation.” (Manager)

„I think the communication between services at the point of transition [in care] is something that needs to be further developed and possibly, was highlighted, with the community nurses’ role there’s possibly work ongoing there and that’s something we’d need to continue and further develop.” (Manager)

„I think [local area] having five different practices is just ridiculous..... but if it was one big practice and we worked geographically, you would probably work around your schools you’re attached to. You did the housing areas within them areas you would be far more beneficial... you as the public health nurse for that area and certainly take on some of the school work as well.” (Transitioned Health Visitor).

5.25 Inter-agency team work resulted in improved confidence among nurses both in terms of their practice and in the ability to call on others as required.

„It is a multi-agency approach. So everything is fed back to the multi-agency team because obviously this is all done with consent from parents. So all of it is discussed with the multi-agency team and if it was felt that there were conflicting interests then that would be addressed with that multi-agency team and they would then look at how best to address that.” (Manager)

„One thing that happens here at [local area] and that should happen everywhere, is that we have a weekly primary healthcare team meetings with the GP’s, when district nurses, health visitors, school nurses and other allied health professionals are in the room and then of course there will be discussions about families where for example where people, the doctor would say that the fact that this granny is going into hospital will have an impact on this family because it’s the granddaughters main carer and so on and so forth, so we’ll talk about the wider families in the primary healthcare team meetings which the girls here said they did anyway, prior to [the review], so it’s a good practice that was already existing.” (Health Visitor)

Team working and communication amongst nurses

5.26 Better team working and communication was also seen as important across the nursing disciplines including community staff nurses. It is notable that this view was often expressed in the context of preserving the existing nursing disciplines as illustrated in the third quote below.

„I think it’s probably... you really need to involve the whole team. I think the focus on the... what’s been perceived as the senior staff maybe wasn’t the best way to go about things. You know people feel alienated. Everyone needs to be involved in such a huge changed role. I think a lot of health professionals feel that it’s been a very much top down approach.“ (Staff Nurse)

„We don’t have good communication with our district nurses if I’m totally honest. We work very closely with our school nurses... as health visitors we are very closely linked with our schools and nursery. (Transitioned Health Visitor)

„My own personal opinion is that I would like to see the disciplines continue as they are. I like to see District Nursing continuing with their own specialism, treatment room as they do and maybe working more closely with DN which I think is probably evolving a little bit anyway. But I think public health nursing should continue but perhaps be more working across age bands and nought to nineteen. I know they have a very big focus on the early years at the moment and the drive that if young people, if they get it right in the very early years...for both parents and young people, then everything else comes right in the future. I’m not sure that... obviously it’s going to be 10, 15 years longer before we see any benefits of that. So still got quite a scope of the younger generation to go through. But I do think that there’s scope for public health nurses to work more closely together... and deliver more targeted interventions to look at that locality needs, looking at what other areas in the community work with and being able to profile a little bit more. I wouldn’t like to see a joined up CHN... much prefer it to be in the disciplines. (Other nurse profession)

5.27 There were some examples cited where team working was already being developed with a view to minimizing unnecessary contact with multiple care providers, improving communication and developing new posts.

„I think one of the potential impacts is around the fact that we’ve set up the single point of access so actually people should find that access to the teams is much easier now than they did previously.“ (Manager)

„I think that’s how I would want things to move forward. And I also think that if the teams have been allowed more time for their own team building and better facilitation team building and came up with local solutions because the teams here know their area, they know the patients then that would have been more successful. And I think we’re using that actually as the springboard to look at how things were working. Here we’ve had a couple of days looking at how to carry forward things like the health agenda right across the community team.“ (Transitioned Public Health Nurse)

„I think in the future what you have to look at is whether that’s the most appropriate person for that team and for that family and I think that’s something we would all invest. Just thinking of an example, I had a situation where I had a child in school who had a parent who was terminally ill. Now in that situation I contacted the district nurse and at that point they weren’t involved but were able to give me information about the family which helped me to approach them. But had that they had been involved then they would have been the best people to approach the mother... so it’s helped us look at who is the best person to deal with certain issues.“ (Transitioned Public Health Nurse)

Listening to nurses

5.28 There were a large number of comments on the way the Review had been introduced and an appeal for greater consultation with nurses before further policies are designed and implemented.

„I think we have to be really careful about any other model that comes out whatever it may look like... be or could this person look like or... we damaged our health visiting service by going down this way and we caused a lot of anxiety, a lot of pain, and a lot of cases... and the health visitors that I know... a lot of them were trying to get to what they were so many of them forgot what it was like to be a health visitor. I think we don’t want to put them down that road again so I think how the government actually plans to pilot anything that’s new has to be really carefully thought about... coz we don’t want that again.“ (Other nurse profession)

„Well, obviously we think it’s a waste of money and I think if the people who had the ideas and wanted to go ahead with this project, I think if they had really spent quite a bit of time listening to what the staff thought about what would be the benefits and advantages and disadvantages and how things were really working then I think they could have saved a lot of time and money here because this is what we all said at the beginning. We’re not against change of course, we always want to change, and all want the service to go forward and the quality to improve, but none of us saw this as being something that would benefit patients, we actually did see it as something that would potentially take nursing time away from the patients, which it did, and we couldn’t really see what the benefits were going to be and so unfortunately it’s one of those horrible moments when you think that all that money’s been spent and we’ve all been proved right.“ (Health Visitor)

5.29 A contrasting view of the Review of Nursing in the Community suggested that it actually raised the profile of community nursing however further consultation should seek the views of those who undertook the transition education.

„One of the benefits is that it has actually raised profile of nursing and community... they're still very specific disciplines... but it has got people talking about it and I think the community nursing the... I think it needs to be... it definitely raised the profile so that's going to really positive outcome so I think people that went through the module... I think they have been able to look at how to do things differently. And we're the ones that tried to do things differently, so I suppose we're the experts in that... not the people who have set the module but who went through it. So I suppose this kind of thing, this feedback is essential... as even things progress in the modernising nursing community does continue we need to be asking the right people because we're the ones who shape the future.“ (Health Visitor)

6 CONCLUSIONS

Summary of research findings

6.1 Nurses and their managers participating in the study questioned the strategic vision of the new Community Health Nurse Role or to be more precise the model of nursing upon which the role was based. For many it represented a return to a previous model which, in their view, had „failed“ i.e., double and triple duty nurses. Furthermore it was strongly associated with the extended family which was thought to be outdated and no longer fitted modern family structures. The CHN role challenged more traditional nurse boundaries which formed strong professional identities and were highly valued. Some concerns were raised regarding the effectiveness of the transition education in helping nurses change their identity and sustain their new role. Another important issue was that of critical mass. Many nurses returned to their original teams after the transition education and experienced opposition to the new role. In some instances they also lacked managerial support.

6.2 There were, however, some favourable reports. The transition education helped heighten nurses' awareness and re-engagement in the wider aspects of health and social care. This was particularly so in public health, including community health profiling and health promotion. It also helped them to reflect upon their role and led some to change their practice. Notable examples included district nurses, public health nurses and health visitors conducting immunisation programmes; health visitors taking on district nurse duties such as taking bloods and changing dressings; and health visitors and public health nurses visiting schools. However these were often viewed as opportunistic rather than systemic changes and there was little discernible impact on patient experience. There was support for the notion that the new role could be more easily accommodated in teams that already worked across health disciplines.

6.3 There was little doubt that the introduction of the CHN gave rise to extensive debate within the nursing professions in Scotland. There was broad support for the core elements such as promoting self-care, adopting a public health approach to nursing, developing community profiles, and preventing unnecessary hospital admissions. However nurses thought that, rather than focussing on changing nurse roles, more should be done to improve interagency working and foster better collaboration among the nursing disciplines. Some examples were offered including identifying a single point of access to health and social care, greater liaison with nursing colleagues to improve patient management, and multidisciplinary team meetings to improve communication. There was a strong sense that the new Community Nurse Role was introduced from the top and had not fully considered the views of nurses to which it was directed. Thus many felt the need for greater consultation before new policies are introduced.

Making sense of the findings

6.4 These findings represent an account of those closest to the proposed reforms. The report provides insight into the structural and other issues which affected the uptake and implementation of the Community Health Nurse role. These focus on the following areas:

Education

6.5 Whist nurses in the current study valued the education they received there were some concerns about its effectiveness in helping them change and sustain their new role. The main issue was around the depth and scope of education required to meet the required diversity of the role. Any gains were confined to an improvement in knowledge. Some also linked this problem to their initial nurse training which prepared them to work in specialist subjects rather than broad areas of health.

6.6 The resulting tension between specialisation and breadth is not easily reconciled, although it should be noted that education was viewed as instrumental in developing community and public health nursing in Ireland (Poulton 2009; Markham and Carney 2008) the USA (Hill et al 2010) and the Family Nurse Role in Scotland (Scottish Executive 2003).

6.7 More specifically, Markham and Carney (2008) and Hill et al (2010) indicate that improvement in knowledge and also competence was necessary to help change nursing roles in the community. The issue of competence links well to the educational programme which was designed for the Family Nurse Role in Scotland where students highly valued the skills based parts of the course specifically those which focussed on communication, assessment and health promotion (Scottish Executive 2003). The Family Health Nurse Role education was longer (delivered over one year) compared with that for the Community Nurse Role which was delivered over several weeks. However it should be noted that majority of nurses who were trained in the Family Nurse Role also struggled to incorporate their ideas into practice.

Managing change

6.8 Changing existing roles is difficult and there were three areas which we think proved extremely problematic in doing so: the level of support required to bring about change, the strategic vision of the new role and ownership of the new role.

6.9 Critical to the success of such development is the level of support from their nursing colleagues and those from other disciplines. For example resistance by other health care professionals acted to limit the role of district nurses in England (King et al 2010), practice nurses in Australia (Halcomb et al 2008; Mills and Fitzgerald 2008; Jasiak and Passmore 2009); school nurses in the USA (Krause-Parello and Samms 2009); and advanced practitioners in England, the USA, Canada and Australia (Aranda and Jones

2008; Bonsal and Cheater 2008). We also noted in the baseline study that approximately one-third of nurses supported the new community nurse role (Kennedy et al 2009). It is probably reasonable to conclude that the lack of widespread support for the new role continued after the baseline. Therefore support did not reach a level necessary for its implementation. Building critical mass was also recognised as important for the future development of the Family Health Nurse role in Scotland (Scottish Executive 2003).

6.10 There was uncertainty around the strategic vision of the new role which, as we have demonstrated, was framed in terms of an older approach to community nursing that was thought to have „failed“ i.e., double and triple duty nursing. This failure was linked to the breadth and depth of knowledge and skills required to carry it out. Critically, the diverse nature of the new model also represented a challenge to the existing professional boundaries. There are examples in the literature where the development of such diverse roles in practice has been successful but it requires great flexibility on behalf of the individual nurse (Yarwood 2008; Fagerstrom 2009) and their nursing colleagues (MacDuff 2006) to make these work. We think success depends on a shared vision of the new role and an understanding of how it fits within the health care setting. As our findings suggest there was a shared vision which was viewed as highly problematic by nurses.

6.11 We think our findings fit very well with a more macro theory of role development as described by Aranda and Jones (2008). They explain how new nursing roles are essentially socially and politically constructed. Critical to this theory of development is the mechanism by which new roles are adopted (or rejected) by nurses. Nurses are viewed as being actively involved in the process of „re-constructing boundaries, identities and social relations in healthcare“. Our findings have provided insight into the boundaries which were created by community nurses in the three pilot sites and ultimately where they positioned themselves in relation to those boundaries, particularly in terms of ownership of the new role.

Leadership and organisational support

6.12 It would be misleading to suggest that there was a total lack of support for the new role. There was clearly a strategic commitment to the policy by the Scottish Government and the health boards who volunteered to participate and pilot the new community nurse role. Some local managers and the nurses who took part in the programme were also supportive of it.

6.13 Nurses also thought they should take a stronger lead in developing their public health role, encouraging anticipatory care and self care. They envisaged adopting extremely proactive roles in working alongside services users to help them improve their health, avoid unnecessary use of more intensive healthcare and live independent lives. Community nurses are extremely capable of building these relationships with service users and it forms an important part of their professional identity (McIntosh and Runciman

2008). Indeed it is likely that nurses see this as critical part of their professional development.

6.14 Key to this development, however, is the working dynamic of the nursing team (including managers) and other health professionals. It was noted that nurses who undertook the transition education were better supported by teams with a history of multidisciplinary working across nursing professions and other health professions. This connects well with the notion of critical mass which needs to be developed before a new role can be successfully embedded into a team (Scottish Executive 2003).

Research

6.15 There are methodological limitations to the research which concern sampling and representation. First, the views outlined in this report represent nurses and their direct managers and not strategic managers and policy makers. Second, it represents the views of those who volunteered to take part in the transition education and those who did not undertake the education from the three pilot areas, which means the views of those from the remaining Health Boards in Scotland are not considered. Third, there were nurses who declined to participate in the research and it is possible that the voices of those who held contrasting views were missed.

6.16 There are also strengths of the research. Every effort was made to include nurses from a range of disciplines which were affected by the Review of Nursing in the Community in Scotland. We also, after a preliminary analysis of our data, included nurses thought to be indirectly affected by the role i.e., community staff nurses. We included nurses who had undergone the transition education, members of their immediate nursing team and those from non-transitioning teams. The data presented in this report represent the views of those most directly affected by the new policy, those who work alongside them and those who were given the opportunity to adopt the new role and declined.

Recommendations

6.17 The theoretical development of nurse roles as described by Aranda and Jones (2008) provides a useful perspective from which to view the implementation of the CHN role. The model of nursing and the related attributes were viewed as highly problematic by nurses and became important territory upon which the implementation of the new role rested. It could be argued that these constructions became major stumbling blocks for the new role and should be addressed when designing future policy. An essential part of the design process is the consultation which recognises the importance of co-constructing new roles particularly in developing critical mass which will secure support for a new policy. A crucial part of this is how the roles fit with existing teams.

6.18 We would also agree with the recommendations which appeared in the evaluation report of the Family Health Nurse in Scotland (Scottish Executive

2003) which suggested that before introducing new roles developers devise a detailed plan which facilitates and sustains such roles. Specific attention could be paid to why the particular role is needed; what work will be done; how it will fit with current practice; what resources will be available to support it (including managerial support); and how the new role will be incorporated as part of a wider review of service provision. We would add that this requires a strong strategic vision of any new role.

6.19 Nurses valued the transition education which was designed to prepare them for the new role, although any gains were confined to an improvement in knowledge. Markham and Carney (2008) and Hill et al (2010) indicate that improvement in knowledge and also competency was necessary to help change nursing roles in the community. Interestingly the educational programme which was designed for the Family Nurse Role in Scotland was valued by students for its emphasis on communication, assessment and health promotion skills (Scottish Executive 2003). It should be noted that education is one of many facilitators commonly cited in the literature. Nevertheless designers of courses could consider how both skills and knowledge are best promoted in their training programme.

6.20 As we noted in the literature review which accompanied this report (Annex C) the tension surrounding the introduction of new nursing roles tends to dominate the scientific literature, however there are studies which point to new developments within nursing which merit closer scrutiny and which may lead to more effective care. The first is the co-construction of therapeutic nurse patient relationships. The second is the co-construction of nursing roles. The third is partnership working with other nurses and other health professions. If taken together and implemented well then these may make for more effective forms of practice and ultimately improved health of service users. This takes us to our final recommendation that future research could focus on evaluating the impact of the new nursing practices on the end users as well as providing insight into how new roles work.

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ANNEX A NUMBER OF NURSES TRANSITIONING AND THOSE INVOLVED IN THE EVALUATION

| Professional Discipline | Participating NHS Board | | | Total |
|-------------------------|--|-------------|-------------|-----------|
| | NHS Board A | NHS Board B | NHS Board C | |
| | Total Number Nurses Completing Transition Education by end of 2009 | | | |
| Health Visitor | - | 8 | 2 | 10 |
| District Nurse | 9 | 11 | 6 | 26 |
| Public Health Nurse | 7 | - | 5 | 12 |
| TOTAL | 16 | 19 | 13 | 48 |
| | Number who participated in focus groups and/or interviews | | | |
| Transitioned Nurses | 4 | 9 | 7 | 20 |
| Non-Transitioned Nurses | 3 | 14 | 18 | 35 |
| Managers | 6 | 5 | 9 | 20 |
| | | | | |
| TOTAL | 13 | 28 | 34 | 75 |

ANNEX B GLOSSARY OF TERMS

Community Staff Nurse: A registered nurse who works in the community as part of the district nursing and/or health visiting team. The role does not require them to hold a specific specialist community qualification but involves caring for those on the district nursing or health visiting caseload. They may be based at a health centre or general practitioner premises.

District Nurse (DN): A registered nurse who holds a specific community specialist practitioner qualification and provides nursing care to people in their own homes and in other settings in the community. They may be based at a health centre or general practitioner premises and work in teams with other professionals and agencies

Health Visitor (HV): A registered nurse or midwife who holds a specialist community public health nursing qualification and is also registered as a “Specialist Community Public Health Nurse”. They promote the health and wellbeing of communities and aim to prevent ill health. They also work with individuals and have an important role in supporting children in the early years of life and their families. They may be based at a health centre or general practitioner premises and work in teams with other professionals and agencies.

General Practice Nurse (GPN): A registered nurse who may have a specific community specialist qualification and is employed by a GP practice to provide a range of services usually within the surgery for the practice population. Services may include, managing long term conditions, treating minor injuries and illness and delivering health screening programmes.

Public Health Nurse (PHN): A registered nurse or midwife who is registered as a “Specialist Community Public Health Nurse” on the third part of the Nursing and Midwifery Council’s Register”. Introduced in 2001, in this model of practice there is no discernible difference between the role of a health visitor and that of a school nurse. Both have a public health focus, but work with children and young people at different stages of their development and in different community settings. Public Health Nurses share a common education programme and work together to address the needs of communities, co-ordinated at Community Health Partnership level.

School Nurse: A registered nurse who provides a variety of services to children and young people within schools. Services include health and sex education, developmental screening, immunisation programmes and health interviews. They may have a specific community specialist qualification and are **usually** registered as a “Specialist Community Public Health Nursing” (school nurse) on the third part of the Nursing and Midwifery Council’s Register”.

Team Leader: It is a requirement in Scotland that team leaders in public health nursing (schools) hold a specialist practitioner qualification and are graded at the same level as other public health nurses (existing health visitors).

Multiple Role Nurse: Multiple Role Nurses comprise Family health Nurses and, those who hold more than one role .

ANNEX C LITERATURE REVIEW

Literature Review

Aim

To inform the evaluation of the new Community Health Nurse Role, in particular the design and methods.

Methods

The search for literature

A combination of free text and thesaurus terms were entered into the following online bibliographic databases: British Nursing Index, Cinahl Plus, Medline and Psychinfo. The search strings were tailored according to each database. Details of the online search strategy appear at the end of this report.

The searches were carried out on 29 and 30 June 2010 on full versions of each database. Results were restricted to material published between Jan 2008 and June 2010. The 2008 cut off was chosen because it marked the end of our last literature review which was published in the final report of the community nurse baseline study (Kennedy et al 2009).

We acknowledge that practice nurses were not included in the Scottish Government's policy. However we included them in this review because of the Australian government's policy to expand their role and the possibility of gaining relevant insights to this process via recently published research.

Papers retrieved and number included

Table 1 illustrates the initial results of the search strategy from each of the bibliographic databases. A total of 683 articles were identified. After examining the abstracts 88 (13%) were thought to be relevant. The main reasons for exclusions at this stage were: not relevant to community nursing and not a research based study. All 88 studies were retrieved as full papers and, after further assessment, 33 were included in the review. The main reasons for exclusion at this stage were: a review of research based on narrow selection of the literature (e.g., convenience search), purely theoretical papers or commentaries.

Table 1 number of publications retrieved and included

| Database | Total Retrieved by Search Strategy |
|-----------------------|------------------------------------|
| CINAHL | 326 |
| British Nursing Index | 87 |
| Medline | 79 |
| ASSIA | 30 |
| PsycInfo | 136 |
| Cochrane Library | 25 |
| Total | 683 |

Summarising the findings

Data were extracted from each of the 33 papers and summarised using the following framework. A summary of each paper appears in tabular form in the section titled **Summary of Each Study**. These are listed by nursing group and country of origin.

Author
Title and source
Nursing group
Country
Aim
Method
Key findings

These summaries were used to form a **narrative summary** which synthesised the findings arising from the review.

Narrative Summary

Five themes were apparent in the literature:

- a) The range of community nurse activities
- b) Role expansion and the consequences of that expansion
- c) The impact of community nursing on the health of patients
- d) Theoretical development of community nursing
- e) Research methods

a) The range of community nurse activities

Community nurses engage in activities which reflect the population they serve. For example district nurses who work with the elderly form professional relationships that are founded on key values around longevity, therapy, and family (McGarry 2008). Health visitors respect family routine and have empathy for children and parents (McIntosh and Runciman 2008). School nurses collaborate with teachers, parents, guidance counsellors, and school administrators (Krause-Parello and Samms 2009). Public health nurses engaged in surveillance which involves screening (Megher-Stewart et al 2009). As such community nurses develop experience in working with

certain client groups and become relatively skilled in doing so. Indeed the special relationship between nurses and service users is highly valued by service users (McGarry 2008; McIntosh and Runciman 2008; Kennedy et al 2008) sometimes more so compared with other primary care professionals, such as general practitioners (Bonsall and Cheater 2008; Kelcher et al 2009).

Not all nursing activities are so well defined, particularly if the nurse is engaged with complex health problems which are socially determined. An example is public health nurses who provide „holistic care“ (Markham and Carney 2008). These nurses often deal with chronic health conditions which required more complex methods of prevention. Thus in many studies there are references to complexity of health or health care, working across services, and across teams.

b) Role expansion and the consequences of that expansion

Role expansion can happen in two ways a) focussed expansion, or b) diverse expansion. The first was typified by practice nurses in Australia where the government encouraged them to expand their role by taking on more clinical tasks from general practitioners (Jasiak and Passmore 2009). They also helped to co-ordinate services for patients and developed administrative roles (Joyce and Piterman 2009). The second type of expansion was typified by Public Health Nurses in Ireland, Norway, USA and Canada (Philbin et al 2009; Clancy and Svensson 2009; Kaiser and Farris 2009; Meagher-Stewart et al 2009) where roles were more „holistic“ and directed towards families or groups rather than individuals.

There were consequences which were common to both types of expansion. First, was the reaction by their colleagues including doctors and other nurses. This reaction was critical to the success or failure of a new role. For example resistance by other health care professionals acted to limit the role of district nurses in England (King et al 2010), practice nurses in Australia (Halcomb et al 2008; Mills and Fitzgerald 2008; Jasiak and Passmore 2009); school nurses in the USA (Krause-Parello and Samms 2009); and advanced practitioners in England, the USA, Canada and Australia (Aranda and Jones 2008; Bonsal and Cheater 2008). There was however evidence of support for these roles. For example a recent study conducted in England concluded that nurses, doctors and patients support nurses in taking on more work from the general practitioner (Branson and Badger 2008). Support leads to more embedded roles.

The research literature reflects the debate which appears in the wider nursing journals about expanding the role of community nurses. Some commentators argue that 70% of the work of general practitioners could be done by nurses and therefore their role might expand in this direction (Sweeney 2009). However, there are others who see such a move as one which potentially threatens more traditional practices of community nursing which are based on the social aspects of care. They are therefore hesitant to recommend a more individualistic approach to health care which is based on a medical model of intervention (Greenway et al 2008).

One of the more immediate issues facing nurses who take a more comprehensive approach to health care is pinning down the core elements of their work. The role of public health nurses has been difficult to define and is sometimes viewed by other professions as a „jack of all trades“ (Philibin et al 2009; Clancey and Stevansson 2009). The nature of these roles was often shaped by the nature of the given condition. For example nurses often dealt with chronic health conditions which required more complex methods of prevention. Thus there was a clear need for greater flexibility when dealing for instance with families with a diverse range of needs (Yarwood 2008; Fagerstrom 2009).

Training was also seen as either a barrier or facilitator to the expansion of a nurses“ role. Post-graduate education was instrumental in helping community nurses in New Zealand to develop constructive relationships with families (Yarwood 2008). Education was also instrumental in developing community and public health nursing in Ireland (Poulton 2009; Markham and Carney 2008), public health nursing in the USA (Hill et al 2010), and practice nursing in Australia (Halcomb et al 2008).

c) The impact of community nurses on the health of patients

Perhaps the greatest test is whether community nurses have a beneficial impact on patients. The most robust evidence for this comes from the published reviews of evidence. Bonsall and Cheater (2008) assessed the impact of community based advanced nurse practitioners and concluded that nurses could provide safe and effective care which was comparable to doctors, however there was little available evidence on their economic benefit and no evidence on whether role maturation lead to greater patient benefit or detriment. Kennedy et al (2008) reviewed the evidence on community nurses which included a wider range of nursing roles and concluded there was little evidence to support the different models of nursing. This was reflected in another review of community nursing conducted by Kelcher (2009) which suggested that patients“ knowledge of health improved, but no evidence the community nurses had a greater impact on mortality, health, hospitalisation or readmission when compared with doctors. Fagerstrom et al (2009) reviewed the evidence on home visiting for elderly people. Studies included nurses and other professionals and the authors concluded that these visits **could** reduce mortality, improve function and reduce admissions to long term care among the very frail, however the evidence was equivocal.

d) Theoretical development of nursing

There were a few papers which tested the theoretical basis of nursing practice. This resulted in a move beyond the description of nursing practice which was apparent in many academic papers to an empirical and more robust assessment of the evidence. Notable examples include McGarry 2008, McIntosh and Runciman 2008; and Aranda and Jones 2008. McGarry (2008) highlighted the importance of the micro environment in shaping nurse

patient relationships and the values which underpinned the therapeutic value of these relationships. They examined the more immediate practice setting i.e., the patient's home. McIntosh and Runciman (2008) assessed partnership working among community paediatric nurses using Bidmead and Cowley's (2005) partnership framework. The authors included the immediate practice setting but also examined partnership working between nurses and other health and social care professionals. Aranda and Jones (2008) used social theories to explain how new nursing roles were socially and politically constructed. They examined how these new roles developed when health care systems changed and thus adopted a more macro view of nursing practice development.

e) Research methods

Nineteen (58%) of the studies used a qualitative methods, nine (27%) used quantitative methods (mainly surveys), and five (15%) were systematic reviews of the literature. Focus groups and interviews formed the basis of most qualitative studies. The findings from most qualitative and quantitative studies were reported using descriptive techniques. However as noted above there were some studies which were theoretically based and this helped them move towards a more sophisticated level of analysis. Some studies also used innovative methods to help provide richer insights either by using novel data gathering techniques or providing the opportunity for comparison within their study design.

For example, King et al (2010) used the Pictor method to elicit in depth data about community nurses practice in palliative care. Pictor is based on a family therapy technique developed by Ross et al (2005) and was used by King et al (2010) to identify and understand the relationships between the patient, their family, friends and professionals. It involves the participant drawing a diagram of the people involved in their case, including themselves and their family. They draw arrows and lines to depict the relationship between each member. The interviewer then asked them to describe these relationships and their impact on their care. Other researchers designed their study to increase the potential of comparison and thus a more insightful analysis. Appleton and Cowley (2008) used a case study which involved a comparison of nurse and patient's views. Mulcahy et al (2008) used nurse patient dyads i.e., a nurse and a patient chosen from their case load. Clancy and Svensson (2009) used purposive sampling to elicit the views of a wide range of professionals. The aim of purposive sampling is to increase the comparative potential of a study. Preset criteria are used to recruit different groups of people who may offer a different perspective on the research topic for example men and women. Arbon et al (2008) interviewed nurses, other professionals, and patients.

Identified knowledge gaps and how the review informed the current evaluation.

Our previous review (Kennedy et al 2009) highlighted the lack of consensus over the role of community nurses and considerable overlap between nursing disciplines. Much of the literature focused on diversity within nursing roles particularly those adopting a more public health approach, although some community nurse roles were more focussed e.g., advanced practitioners. New roles, such as the family health nurse in Scotland co-existed alongside existing roles. However, some research suggested these roles may be become more embedded into community services and more acceptable to other professionals over a longer period.

These findings were supported by more recent research. The tension caused by introducing new roles, or expanding existing roles, remained a dominant theme in the research literature. Many papers illustrated how the new roles were shaped by the reaction of other professionals including medical and nursing colleagues. Education and training were viewed as crucial in helping to define these roles. Some commentators question whether the new roles were desirable and argued these represented a threat to more traditional community nurse practices.

New systematic reviews have appeared in the academic literature which addresses the question of effectiveness including comparisons with other professionals such as doctors. While there is some evidence that community nurses have a beneficial impact on patients health, the evidence for the impact on patients health is either equivocal or patchy.

The aim of the current evaluation is to assess the impact of the new community health nurse in Scotland. Given the comparatively low uptake of the new role across Scotland it was not appropriate to use quantitative methods. Recently researchers have used qualitative techniques to define the core elements of community nurse practice and to assess the impact of these roles on patients. They have employed comparative designs which involve a range of key stakeholders in one study e.g., patients, nurses and other members of the care team. Some have used data gathering and analytical techniques which move beyond description. Others have used theory to help to interrogate their data.

Our study will contribute to this body of research. It uses a case study design which involves patients, nurses and other health professionals and compares nurses who have adopted the new role with those who have not. This will include observations of nurse patient interactions, interviews with nurses and patients, and focus groups with other nurses, doctors and professionals from other services. We will also use emotional touch points to help gather in depth data about the nurse patient experience (Dewar et al 2010). Finally we will use three prominent theories to help inform the interpretation of our data:

- a) The co-construction of therapeutic nurse patient relationships
- b) Partnership working.
- c) The social construction of nursing roles.

Summary of Each Study

District Nurses

1

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|---|
| Author: Wilhelmsson S and Lindberg M (2009) |
| Title and Source: Health Promotion: Facilitators and barriers perceived by district nurses. International Journal of Nursing Practice 15, 156-163 |
| Nursing Group: District Nurses |
| Country: Sweden |
| Aim: Examine the barriers and facilitators to health promotion |
| Method: Qualitative interviews with purposive sampling n=54 |
| Key findings: District nurses think they should be encouraging health promotion but they feel stuck in chronic disease management (medical oriented tasks) and focus less on health promotion. They also lacked support from management (who were medics) for health promotion e.g., organisational priorities set by the health centre were wrong. The medical rather than the social model of care dominated. Heavy case loads may contribute to this. Nevertheless secondary prevention may prove a pragmatic answer to the dilemma. |

2

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| Author: McGarry J (2008) |
| Title and Source: Defining roles, relationships, boundaries and participation between elderly people and nurses within the home: an ethnographic study. Health and Social Care in the Community, 17,1,83-91 |
| Nursing Group: Community nurses (District Nurses) |
| Country: UK (England) |
| Aim: Examine the impact of the relationship between nurse and patient on care. |
| Method: Participant Observation of nurse patient interactions and follow-up interviews. Nurses =16 patients= 13. |
| Key findings: The relationship between nurse and patient is co-constructed and that location, the nature of relationships and the meaning of health an illness are particularly important. These relationships are founded on key values around issues of longevity, therapy, and family and as such these were personal rather than professionally shaped. Nurses also work across health and social care boundaries. The methods used were designed to „explain and capture the inherent complexity and or qualities of nursing in the home“ rather than describe or quantify. |

3

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| Author: King et al (2010) |
| Title and Source: Community Palliative Care: Role Perception |
| Nursing Group: District Nurses and Community Matrons |
| Country: UK (England) |
| Aim: Examine the relationship between community nursing and palliative care. |
| Method: Qualitative interviews based on the Pictor method n=15 nurses and n=7 key stakeholders (managers). Pictor is based on family therapy and highlights the people and relationships involved in a recent „case“. |
| Key findings: All thought nurses had valuable role to play in palliative care, principally around the coordination of care, providing information and emotional support and providing physical care. There were some doubts around their ability to manage cases due to the volume and complexity and that the role was around specific tasks. New expanded roles may trigger defensive responses from existing professionals. The Pictor method was useful in aiding reflection on the ways nurses worked with patients. |

Health Visitors

4

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| Author: Appleton V and Cowley S (2008) |
| Title and Source: Health visiting assessment – unpacking critical attributes in health visitor needs assessment practice: A case study. International Journal of Nursing Studies 45, 232-245 |
| Nursing Group: Health Visitors |
| Country: UK (England) |
| Aim: Describe the core attributes of health visiting assessment |
| Method: Case study of 15 health visitors. Each study involved HV and families and comprised of observations, and qualitative interviews. |
| Key findings: The core attributes are: holistic assessment; multi-factorial and complex assessment; prioritisation; all clients can have unmet needs; influence of personal values and life experience; ongoing nature of assessment; difficult to articulate how they conducted an assessment. Combining observations and interviews were viewed as important in „unpacking the various elements of health visiting assessment“. However no comparison groups in this study. |

5

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| Author: Hogg R and Hanley J (2008) |
| Title and Source: Community Development in Primary Care: opportunities and challenges. <i>Community Practitioner</i> 8,1,22-25 |
| Nursing Group: Health Visitors |
| Country: UK (Scotland) |
| Aim: Explore HVs views on community development and barriers against and facilitators for. |
| Method: Semi-structured interviews with 16 nurses |
| Key findings: Community development is about helping people mobilise their resources to collectively address problems. Most nurses thought they possessed the skills to help people do this. The course they completed did not help them to do this. Some other barriers included target driven systems, low organisational priority, and lack of systems thinking as core in health visiting practice. |

6

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| Author: McIntosh J and Runciman P (2008) |
| Title and Source: Exploring the role of partnership in the home care of children with special health needs: Qualitative findings from two service evaluations. <i>International Journal of Nursing Studies</i> , 45,714-726. |
| Nursing Group: Community Paediatric Nurses. |
| Country: UK (Scotland) |
| Aim: Empirically conceptualise partnership |
| Method: In-depth interviews with 17 parents and 20 professionals including medical, nursing, social services, education and the voluntary sector. |
| Key findings: Two types of partnership were explored. One between nurses and service users (parents) and the second between nurses and other agencies. Bidmead and Cowley (2005) model of partnership was used to analyse the data. Evidence for each existed: Nurses and professionals respected family routine and empathy for the child and parents. Nurses also demonstrated a deep understanding for different styles of adult learning, how to alleviate stress and parental vulnerability to their child's health condition. There was also evidence of extensive partnership across social care boundaries. Partnership is multi-faceted and is knowledge, skill and resource intensive. |

Practice Nurses

7

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| Author: Halcomb et al (2008) |
| Title and Source: Cardiovascular disease management: time to advance the practice nurse role. Australian Health Review, 32, 1, 44-55 |
| Nursing Group: Practice Nurses |
| Country: Australia |
| Aim: Examine the barriers and facilitators to role development |
| Method: postal self-completion survey n= 284 and qualitative interviews n=10 |
| Key findings: Barriers included legal implications (fear of litigation), lack of space, belief there is no need to change and negative attitudes from GP. Facilitators include collaboration with GP, training, opportunity to deliver care, high job satisfaction and positive consumer feedback. Interdisciplinary collaboration (un this instance between the GP and Practice Nurse was viewed as critical to the success of an expanded role. |

8

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| Author: Senior E (2008) |
| Title and Source: How general practice nurses view their expanding role. Australian Journal of Advanced Nursing 26,1, 8-15 |
| Nursing Group: Practice Nurses |
| Country: Australia |
| Aim: Explore the barriers and enablers to the expanded role of practice nurses |
| Method: In depth interviews with 22 registered and enrolled practice nurses |
| Key findings: 86% were happy with the new role. GPs were seen as supportive and this was a crucial enabler. Nurses thought the new role improved care and enhanced job satisfaction. |

9

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| Author: Mills J and Fitzgerald M (2008) |
| Title and Source: The changing role of practice nurses in Australia: an action research study |
| Nursing Group: Practice nurses |
| Country: Australia |
| Aim: Report on methods used to expand the role (e.g. well women clinics) and barriers and facilitators |
| Method: Action research |
| Key findings: GPs were not supportive and this mattered particularly around cervical screening. Team work was also seen as important. |

10

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| Author: Jasiak S and Passmore E (2009) |
| Title and Source: Enhancing the roles of practice nurses: outcomes of cervical screening education and training in NSW. Australian Journal of Advanced Nursing 27, 2, 40-45. |
| Nursing Group: Practice nurses |
| Country: Australia |
| Aim: Report their role and barriers to that role |
| Method: Self completed postal survey n=149 |
| Key findings: Most (76%) had expanded their role in providing more clinical services, information and education of women's health. The main barrier to role expansion was lack of support from GPs. 69% wanted more training and education. There is a lack of data on the impact on patients. |

11

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| Author: Joyce C and Piterman (2009) |
| Title and Source: Farewell to the handmaiden? Profile of nurses in Australian general practice in 2007. Australian Journal of Advanced Nursing 27, 1, 48-58. |
| Nursing Group: Mixed group of nurses working in general practice (registered and enrolled practice nurses). |
| Country: Australia |
| Aim: Describe the working practices of practice nurses. |
| Method: Self completion cross-sectional survey n=104. |
| Key findings: All nurses undertook duties related to direct patient care, coordination of care and management of the clinical environment (e.g., 90% undertook practice management or admin tasks). 77% liaised with other health professionals: 66% liaised with social work or community services, 73% coordinated patient services. Thus indications of advanced roles. However not clear how much of a health promotion/prevention role they have. Therefore support required to develop their careers. |

12

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| Author: O'Donnell A et al (2010) |
| Title and Source: Practice nurses' workload, career intentions and impact of professional isolation: a cross-sectional survey. BMC Nursing, 9, 2. |
| Nursing Group: Practice nurses. |
| Country: UK (Scotland) |
| Aim: Describe practice nurses' role and support for it. |
| Method: Cross sectional survey n=329 |
| Key findings: Common activities were coronary heart disease management, cervical cytology, diabetes, chronic obstructive pulmonary disease. Most 52% felt isolated in their role, particularly if not part of a larger team e.g., small practices. |

Public Health Nurses

13

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| Author: Meagher-Stewart D et al (2009) |
| Title and Source: Population Health Surveillance Practice of Public Health Nurses. Public Health Nursing, 26, 6,553-560. |
| Nursing Group: Public Health Nurses |
| Country: Canada |
| Aim: Examine the facilitators and barriers to public health surveillance |
| Method: Qualitative telephone interviews n=55. |
| Key findings: Public health surveillance is defined as identifying changing risk profiles and health status patterns and forecasting future disease trends. Part of this is reporting suspicious cases. Most nurses were involved in screening and awareness of the social determinants of health. This made heightened awareness of gaps on service use or health inequalities. Surveillance networks played a key role in surveillance e.g. sharing information and expertise with other professionals, identifying gaps in services, helping inform the local community. This in turn may have helped towards a systems approach and ultimately better health outcomes. Thus more than using epidemiological data called „ecosocial epidemiology“ and less individually based approach to practice. |

14

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| Author: Markham T and Carney (2008) |
| Title and Source: Public Health Nurses and the delivery of quality nursing care in the community. Journal of Clinical Nursing 17, 1342-1350 |
| Nursing Group: Public Health Nurses |
| Country: Ireland |
| Aim: Explore the factors which affect the quality of care |
| Method: Qualitative interviews with eight public health nurses |
| Key findings: Nurses provided „holistic care“ i.e., meeting the needs of a diverse population. Effective communication was required to help plan and deliver care and thus poor communication was a barrier to good quality care. Large case loads affected the quality of care and added stress. Education and training were seen as important in helping nurses work more effectively. Resources such as technology and basic infrastructure were lacking. |

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| Author: Mulcahy H et al (2008) |
| Title and Source: Participatory nurse/client relationships: perceptions of public health nurses and mothers of vulnerable families. Applied Nursing Research 21, 169-172. |
| Nursing Group: Public Health Nurses |
| Country: Ireland |
| Aim: To assess the level of mutual participation between public health nurses and vulnerable mothers (where there was cause for concern of harm to the child but no evidence of harm). |
| Method: Standard and open assessments in the form of an interview with 44 dyads to assess concordance on key aspects of care: needs, satisfaction and response. |
| Key findings: Findings indicate close levels of participation. They met regularly, and agreed on the required support, information and technology, and decisions. However the clients did not fully agree that the nurse met their needs. |

16

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| Author: Philibin et al (2009) |
| Title and Source: The role of the public health nurse in a changing society. Journal of Advanced Nursing, 66, 4,743-752. |
| Nursing Group: Public Health Nurses |
| Country: Ireland |
| Aim: To clarify the role of the public health nurse. |
| Method: Qualitative interviews with 25 nurses |
| Key findings: Four key findings emerged: the „jack of all trades“ whereby they are seen as a catch all service. Their remit appears very wide in terms of the population they serve, and that nurses are also expected to be very specialist. Prevention takes second place to cure and this represents a tension in the role. In essence the role needs to be limited and better defined. If not overload may result. This comment was made in relation to the new Scottish Role (see discussion). Nevertheless Job satisfaction was high and team work may be a solution. |

17

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|---|
| Author: Clancy A and Svensson T (2009) |
| Title and Source: Perceptions of Public Health Nursing Practice by Municipal health Officials in Norway. Public Health Nursing 26, 5, 412-420. |
| Nursing Group: Public Health Nurses |
| Country: Norway |
| Aim: Assess views on public health nursing |
| Method: Qualitative interviews with 5 local politicians and 6 senior local authority administrators. |
| Key findings: All were aware of public health nurses, but thought the focus of their work was to general. They thought PHNs should concentrate on working with families. There was also a lack of collaboration between PHNs and the local authority. |

18

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| Author: Kaiser K and Farris N (2009) |
| Title and Source: Public and Community Health Nursing Interventions with Vulnerable Primary Care Clients: A Pilot Study. Journal of Community Health Nursing. 26, 87-97. |
| Nursing Group: Public Community Health Nurses |
| Country: USA |
| Aim: Assess the effects of public community health nurse visits on vulnerable patients |
| Method: Quasi-experimental design on 80 patients (19-93 years) with unmet needs. The 80 were assigned randomly to the intervention or control Intervention = mutual goal setting. Vulnerable defined as: frail elderly, those with poor health literacy, those with unstable chronic conditions, and poor. |
| Key findings: No significant effects on health behaviour of the 10 week intervention programme but less need identified among participants of that programme over time. |

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| Author: Hill et al 2010 |
| Title and Source: Barriers and Facilitators to the Incorporation of Environmental Health into Public Health Nursing Practice. Public Health Nursing 27, 2, 121-130. |
| Nursing Group: Public Health Nurses |
| Country: USA |
| Aim: describe the barriers and facilitators to environmental health among public health nurses. |
| Method: Cross-sectional self administered survey n=141. training |
| Key findings: Public health nurses are often asked about environmental health issues e.g. household exposure to risks. However many report lack of time (21%) or interest shown by patients (15%) as barriers to engagement on environmental health. Facilitators are education or resources. |

School Nurses

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| Author: Smith F (2009) |
| Title and Source: School nursing in the UK: Where are we now? British Journal of School Nursing 4, 7. |
| Nursing Group: School Nurses |
| Country: UK (whole of the UK) |
| Aim: Comparison of the 2005 and 2009 survey of school nurses conducted across the UK. |
| Method: Comparative cross-sectional time series survey conducted by the RCN. |
| Key findings: Ratio of nurses to schools in 2005 = 1 nurse to 14 schools. 71% felt this was insufficient; 50% said their workload was too heavy; 90% were too busy to provide the service required; 75% wanted to change the balance of their role to include health promotion, pupil counselling and sexual health. Child protection conferences rose to 70% from 50% in 2005. In 2009 nurses were engaged in health promotion and sexual health, obesity and mental health. Lack of time still figures as a barrier to delivering nursing care (64%). Nurse school ratios remain the same although there are variations. There was a 14% decrease in access to training. 82% reported being valued by the school. 54% were satisfied with their job. |

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| Author: Krause-Parello C and Samms K (2009) |
| Title and Source: The US model: The role of school nurses in New Jersey. British Journal of School Nursing. 4, 6, 287-292. |
| Nursing Group: School Nurses |
| Country: USA |
| Aim: Explore the roles and responsibilities of school nurses. |
| Method: Interviews with 27 nurses |
| Key findings: Roles are expanding because of the increase of children with chronic conditions e.g. asthma (most common), diabetes, seizures, hepatitis. Duties include administering medications (most common bronchodilators), nursing (first aid, urinary catheterisation, tube feeds, nebuliser), glucose testing) screening, and referrals. Nurse pupil ratio = 1:1300 thus not always possible to administer medications which is the school nurse's responsibility (Policy). Health promotion consisted of counselling, information giving and workshops. School nurses collaborated with teachers, parents, guidance counsellors, and administrators. Few said they were valued by the school. |

Specialist Role Nurses including Advanced Practitioners

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| Author: Aranda J and Jones A (2008) |
| Title and Source: Exploring new advanced practice roles in community nursing: a critique. <i>Nursing Inquiry</i> 15, 1, 3-10. |
| Nursing Group: Community nurses |
| Country: International |
| Aim: A critique of new community nursing roles based on existing evidence. |
| Method: literature review of 112 papers. |
| Key findings: The new advanced practitioner roles reflect the changing nature of health care work and actively challenge and reshape boundaries, identities and social relations in health care. Thus practitioners develop a sense of self and agency. In a sense to nurses take or make these roles. How practitioners do this requires further exploration. Why do some adopt these roles whilst others do not? How nurses view themselves is important e.g., subject to oppression or spearheading change. The tension between caring and curing could be used to examine the change in nursing over time and different ways. Where do the new divisions of labour occur (between medics and nurses)? |

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| Author: Bonsall K and Cheater F (2008) |
| Title and Source: What is the impact of advanced primary care nursing roles on patients, nurses and their colleagues? A literature review. <i>International Journal of Nursing Studies</i> 45, 1090-1102 |
| Nursing Group: Advanced Primary Care Nursing (any nurse with an advanced nursing practice role in primary care – nurse clinician, nurse practitioner or advanced nurse practitioner) |
| Country: International |
| Aim: Assess the impact of advanced primary care nursing roles on nurses and patients. |
| Method: Systematic review. Papers = 88. |
| Key findings: Many nurses provide safe and effective care and patient satisfaction is high. These nurses deliver care which is comparable to doctors in terms of health status morbidity and mortality and patients' adherence is greater. There is little available evidence on cost effectiveness, efficiency or utility. The introduction of these roles has caused tension between nurses and also other health professionals. Maturation into the role is thought to improve effectiveness, but more studies are required to test this assumption. |

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| Author: Murray J et al (2008) |
| Title and Source: Survey to investigate the role of the community stroke care coordinator. British Journal of Community Nursing. 13,1,31-36 |
| Nursing Group: Community Stroke Co-ordinators (many of whom are nurses) |
| Country: UK |
| Aim: Describe how the Community Stroke Co-ordinator posts are implemented. |
| Method: Survey of 39 post holders |
| Key findings: The roles and training are poorly defined. There was a wide variation in practice: receiving referrals from a wide range of sources, (community, other hospital wards, A&E, self -referrals). Various assessments were used. Workload was heavy and knowledge of the evidence base was low. Most common source of information was National Clinical Guidelines. There was limited access to key referral services such as transport, psychology and physical therapies. A more robust evidence base may help develop the post. |

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| Author: Pontin D and Lewis M (2008) |
| Title and Source: Maintaining the continuity of care in community children's nursing caseloads in a service for children with life-limiting, life-threatening or chronic health conditions: a qualitative analysis. |
| Nursing Group: Community Children's Nurse |
| Country: UK (England) |
| Aim: Explore factors which influence nurses' case loads |
| Method: Qualitative interviews with six nurses |
| Key findings: Nurses display values that are consistent with human centred nursing. Case loads were managed to ensure continuity of care. Care is socially constructed e.g., between the service user and nurse and between the health care system and the nurse. Support from colleagues was important in helping them to function. |

More than one community nurse group

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| Author: Kennedy et al (2008) |
| Title and Source: 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 |
| Nursing Group: Multiple community nursing groups (Review) |
| Country: International |
| Aim: Explore the evidence base for community nursing |
| Method: Systematic review. Papers included = 73 |
| Key findings: Little evidence which supports the effectiveness of different models of community nursing and in particular little evidence that these reduce health inequalities. The effectiveness of nursing depends on trusting relationships between nurses and patients. Nurses are ideally placed to conduct assessments and anticipate and prevent health problems. |

27

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| Author: Fagerstrom L et al (2009) |
| Title and Source: An integrative research review of preventive home visits among older people – is an individual health resource perspective a vision or a reality? Scandinavian Journal of Caring Sciences, 23, 558-568. |
| Nursing Group: Multi-professionals but includes district nurses and „other“ nurses. |
| Country: International |
| Aim: To assess the practice and effects of home visits |
| Method: <i>Systematic Review 18 papers.</i> |
| Key findings: The aim of home visits is to help older people live independent and health lives. Visits usually involve screening, assessment, support and referrals to other services. These visits can reduce mortality, improve function and admissions to long-term care among very frail older people although the evidence is equivocal. The main focus of visits appears to be on narrow health outcomes rather than more social dimensions of health e.g., social isolation. |

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| Author: Kelcher et al (2009) |
| Title and Source: Systematic Review of the effectiveness of primary care nursing. International Journal of Nursing Practice 15, 16-24. |
| Nursing Group: Various working in general practice including nurse practitioner, practice nurse, health visitor, and community nurses. |
| Country: International |
| Aim: What is the impact of primary and community care nurses on patient health outcomes compared with primary care doctors? |
| Method: Systematic review 31 studies |
| Key findings: Nurses provide a diverse range of care such as chronic disease management, illness prevention, and health promotion. Satisfaction with nurse care is better than that given by doctors and a greater impact on quality of life was also evident. The impact on patients' knowledge was also greater. However there is no evidence that nurses have a better impact on mortality, health, hospitalization or readmission. |

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| Author: Arbon P et al (2008) |
| Title and Source: Reporting a research project on the potential of aged care nurse practitioners in the Australian Capital Territory. Journal of Clinical Nursing, 18,255-262. |
| Nursing Group: Nurse practitioners in the community |
| Country: Australia |
| Aim: Investigate the impact of the nurse practitioners on hospital admissions, timely interventions and strengthen multi-disciplinary working. |
| Method: Mixed methods including routine visit data, interviews with nurses, survey (n=43) and focus groups of professionals in the clinical support teams, survey of clients (n=32). |
| Key findings: The research did not answer the key questions directly. Instead it assessed the „potential“ impacts of the posts and concluded that the nurse practitioners can play a role in assessment with view to early intervention. Can foster collaboration and access to timely care and brokering within the health service. The impact on patient health and hospital admissions was not assessed. |

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| Author: O'Neill M and Cowman S (2008) |
| Title and Source: Partners in care: investigating community nurses' understanding of an interdisciplinary team-based approach to primary care. Journal of Clinical Nursing 17, 3004-3011. |
| Nursing Group: Public health nurses, general nurses and practice nurses. |
| Country: Ireland |
| Aim: Investigate community nurses' understanding of interdisciplinary team-based approach to primary care |
| Method: Focus groups with three groups: public health nurses (n=10), general nurses (n=10) and practice nurses (n=7). |
| Key findings: Nurses thought they contributed to team work and that this in turn lead to enhanced patient care and improved access to services but recognised there were challenges such as: the local availability of a full range of services and team members to suit the local population; resources to help people live at home; the need for supportive team work; poor educational preparation. |

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| Author: Poulton B (2009) |
| Title and Source: Barriers and facilitators to the achievement of community-focused public health nursing practice: a UK perspective. Journal of Nursing Management 17, 74-83 |
| Nursing Group: Community Health Nurses (District Nursing, community staff nurses, school nurses, health visitors, community mental health nurse, practice nurses, community learning disability nurse, midwives, occupational health nurses) |
| Country: UK (N. Ireland) |
| Aim: Examine the barriers and facilitators to public health practice |
| Method: Survey of a random sample of community health nurses n=409 |
| Key findings: Most spent time with families but only 18% spent time on community activity and 9% had conducted a community assessment. Public health nurses (school, health visiting and occupational health) did more community based work. Main facilitator was education and the main barriers lack of managerial support and the need for elaborate routine data recording. |

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| Author: Yarwood J. (2008) |
| Title and Source: Nurses' views of Family Nursing in Community Contexts. Nursing Praxis in New Zealand, 24,2,41-51 |
| Nursing Group: Mixed group of registered nurses working in the community (Public Health Nurses, Practice Nurses, District Nurses, Well Child Nurses, and Rural Health Nurses). |
| Country: New Zealand |
| Aim: Explore how community nurses interacted with families |
| Method: Four focus groups n=18 nurses. |
| Key findings: Nurses experienced a great deal of satisfaction in working with families. The valued building relationships with families and other professionals. Family nurses saw themselves as good networkers which was necessary to address complex health problems such as violence, building family resilience and fostering collegiate support. Post registration was also valued in helping them develop relationships with the family. They tended to work beyond individuals and more with the family. |

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| Author: Branson C and Badger (2008) |
| Title and Source: Skill mix in general practice: patients', professionals' and managers' perspectives. Primary Care, 18,1, 35-39 |
| Nursing Group: Multi-professionals including GP employed nurses, practice nurses, district nurses and health visitors. |
| Country: UK (England) |
| Aim: Contribute to an understanding of skill mix in primary care, but particularly the role of nurses. |
| Method: Survey of one area in England (n=278 professionals n=241 patients) |
| Key findings: 68% of patients and 84% of professionals thought nurses could take on more work from GPs. Practice nurses were viewed as important in developing the skill mix. District nurses and health visitors were less visible in the skill mix as viewed by GPs and patients. Over 50% of patients thought routine/repeat prescriptions could be carried out by nurses, but not complex drugs. GPs were less willing to delegate these tasks and others such as demand for immediate care, anti-coagulants, skin complaints, musculo-skeletal problems, mental health or respiratory problems. Over 75% of GPs had already delegated monitoring tasks for chronic conditions such as asthma, diabetes and heart disease. Patients are less willing to see nurses for „same day issues" or „heart problems" (which they viewed as life threatening). Continuity of care was seen as important to patients i.e., seeing the same doctor or nurse. |

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Search Strategies

CINAHL (EBSCO)

- 1 Community Health Nursing (MH)
- 2 community health nurs*
- 3 community nurs*
- 4 health visit*
- 5 district nurs*
- 6 public health nur*
- 7 family health nurs*
- 8 Schools, Nursing (MH)
- 9 school nurs*
- 10 practice nurs*
- 11 S1 orS 2 orS 3 orS 4 orS 5 orS 6 or S7 orS 8 or S9 or S10
- 12 Nursing Practice (MH)
- 13 Nursing Role (MH)
- 14 Professional Practice (MH)
- 15 practice development*
- 16 generic N3 role*
- 17 Nursing Intervention (MH)
- 18 (Decision Making or Decision Making, Clinical) (MH)
- 19 Patient Discharge (MH)
- 20 "Patient Admission (MH)
- 21 S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20
- 22 S11 and S21
- 23 S11 and S21 - Limiter - Published Date from: 20080101-20100631
- 24 S11 and S21 - Published Date from: 20080101-20100631; Research Article
- 25 (MH "cluster sample+") or TX life experiences or TX human science or TX discourse* analysis or TX narrative analysis or TX lived experience* or TX field research or TX field studies or TX field study or TX giorgi* or TX husserl* or TX merleau ponty* or TX van kaam* or TX van manen* or TX spiegelberg* or TX colaizzi* or TX heidegger* or TX participant observ* or TX data saturat* or TX semiotics or TX heuristic or TX hermeneutic* or TX etic or TX emic or TX focus group* or TX purpos* sampl* or TX constant comparison or TX constant comparative or TX grounded research or TX grounded studies or TX grounded study or TX grounded theor* or TX phenomenol* or TX ethnon* or TX qualitative or (MH "ethnological research") or (MH "ethnography") or (MH "phenomenology") or (MH "focus groups") or (MH "discourse analysis") or (MH "theoretical sample") or (MH "field studies") or (MH "constant comparative method") or (MH "thematic analysis") or (MH "content analysis") or (MH "observational method+") or (MH "purposive sample") or (MH "qualitative validity+") or (MH "grounded theory") or (MH "ethnonursing research") or (MH "phenomenological research") or (MH "ethnographic research") or (MH "qualitative studies")
- 26 S23 and S25
- 27 S24 or S26

Medline (EBSCO)

- 1 Community Health Nursing (MH)
- 2 community health nurs*
- 3 community nurs*
- 4 Public Health Nursing (MH)
- 5 public health nurs*
- 6 health visit*
- 7 district nurs*
- 8 family health nurs*
- 9 Schools, Nursing (MH)
- 10 school nurs*
- 11 practice nurs*
- 12 S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11
- 13 Professional Practice (MH)
- 14 nursing practice
- 15 practice development*
- 16 generic N3 role*
- 17 Nurse's Role (MH)
- 18 S13 or S14 or S15 or S16 or S17
- 19 S12 and S18
- 20 S12 and S18
- 21 S12 and S18 – Limiter - Date of Publication from: 20080101-20100631;
Clinical Queries: Qualitative - High Specificity

ASSIA (CSA)

1. Community nursing (DE)
2. Health visiting" or "health visitor client relationships" or "health (DE)
3. Public health nursing" or "public health nurses (DE)
4. #1 or #2 or #3
5. Limit 4 to publication year = 2008-2010

PsycInfo (EBSCO)

- 1 Nurses or Nursing (DE)
- 2 community health nurs*
- 3 Community Services (DE)
- 4 Primary Health Care (DE)
- 5 Public Health Service Nurse (DE)
- 6 public health nurs* (KW)
- 7 health visit* (KW)
- 8 district nurs* (KW)
- 9 school nurs* (KW)
- 10 practice nurs* (KW)
- 11 S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10
- 12 professional practice* (KW)
- 13 nursing practice* (KW)
- 14 practice development* (KW)
- 15 generic N3 role*
- 16 nurse* role* (KW)
- 17 S12 or S13 or S14 or S15 or S16
- 18 S11 and S17
- 19 S11 and S17 - Limiters - Publication Year from: 2008-2010
- 20 S11 and S17 - Limiters - Publication Year from: 2008-2010; Methodology
empirical study, field study, interview, -focus Group, literature review, -
Systematic Review, -Qualitative Study, -Quantitative Study

ANNEX D TOPIC GUIDE FOR FOCUS GROUPS AND INTERVIEWS



Indicative Topic Guide for Focus Groups and Individual Interviews

Community Health Nurse role in Scotland

The aim of the focus groups and interviews is to allow participants to express their views and experiences of the Community Health Nurse Role by allowing a space in which they can feel comfortable in raising issues which are of importance to them. The following areas, therefore, should be viewed as indicative and not exhaustive.

Areas to be explored:

- General perceptions of the CHN role including its introduction at policy and local level
- Effect on those undertaking the transition education including knowledge, skills, professional development and professional relationships
- Effect on the nursing team including team structure and professional relationships
- Impact on inter professional working
- Effect on patients and carers experiences and outcomes
- Perception and experience of structural support
- View on the future – how things might to go.

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