A Study of the **Role and Workload** of the **Public Health Nurse** in the **Galway Community Care Area**

**THE UNIVERSITY OF DUBLIN**
Trinity College

School of Nursing and Midwifery Studies
A Study of the Role and Workload of the Public Health Nurse in the Galway Community Care Area

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Prepared for the Public Health Nurses of the Galway Community Care Area, and commissioned by the Nursing and Midwifery Planning and Development Unit, Western Health Board.

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Executive Summary

This study examined the role and workload of the Public Health Nurse (PHN) in the Galway community care area. A key purpose of the study was the development of an appropriate caseload/workload measurement tool for use by the Public Health Nursing Service.

The changing sociological and demographic nature of society in Ireland, reductions in length of hospital stays, technological advances in care delivery, and increased demand for health promotion activities has impacted on the workload of the Public Health Nursing Service (Department of Health & Children, 2001a, 2001b). Issues raised during the consultation process for the Commission in Nursing (1998), in relation to public health nurses, included an increasing workload and an increasingly complex range of social and health issues.

The range of activities and responsibilities is broad and can lead to difficulty in articulating the boundaries of the PHN role. Chavasse describes the aim of public health nursing as “to contribute to health care in the community and for the community” (Chavasse 1995: 5). The PHN interfaces with a multitude of client groups in the community. “The key to the provision of the public health nursing service is to understand the need of the service at the point of delivery” (Hanafin et al, 2002:69).

Workload assessment is an attempt to predict the nursing time and skills required to provide nursing care. The number and acuity of clients is an indication of nursing workload. The attempt to capture the nature of the work in any measurement tool is complicated by the range of services that may be delivered in any one patient interaction. Designing a system that would provide objective evidence of patient need was a difficult task, as the care that the PHN delivers is so complex and this led to a dedicated effort to capture both the direct and indirect elements in community care.

A partnership approach between Trinity College Dublin, School of Nursing & Midwifery Studies research team and the project steering group (PHNs, Director PHN, and representatives from the Nursing and Midwifery Planning and Development Unit, Western Health Board,) was crucial to the success of this study. Semi-structured interviews were conducted with 21 PHNs, 2 RGNs, 1 Assistant Director PHN and 1 school nurse PHN. Visits to 9 health centres also provided an opportunity to observe and document facilities, records and working practices, to increase understanding of the context within which the PHNs were working.

The revised Easley Storfjell Patient Classification Index (ESPCI) (Allen et al 1986; Anderson and Rokosky 2001) caseload/workload measurement tool was selected for use in the study and extra categories were added to capture the unique aspects of the role of the Public Health Nurse in Ireland. These categories arose directly from the analysis of the semi-structured interviews and took cognisance of the contextual and contemporary issues in public health nursing. Steps were taken to ensure the content validity and inter-rater reliability including a pilot
study of the re-named Community Client Need Classification System with 8 Public Health Nurses in the Dublin area.

Caseload/workload analysis was carried out in agreed locations with the assistance of 29 PHNs, over a period of 2 weeks. Over the course of the two weeks, 1,349 clients were assessed using the Community Client Need Classification System. All PHNs were asked to record the time spent on the various aspects of their work during the two weeks of the study as well the total time spent travelling and the non-caseload activity. Participants were asked to record the time they spent on both direct and indirect care, in addition to the unmet needs for each client during the two-week period. The numbers admitted and discharged from the caseload were recorded by the PHNs. The PHNs’ views regarding the usefulness of the tool in practice were also evaluated during the course of the study.

The strategic placement of the PHN role in the community (Chavasse 1995; Department of Health 1997; Hallett and Pateman, 2000) was a recurrent feature in this study and the opportunities to develop the role further in the area of case management were also highlighted.

The largest groups of participants in the study were aged between the 46-55 with a mean experience level as a PHN of 15 years, reflecting the national statistics on age profile of PHNs (Department of Health and Children, Nursing Policy Division 2002c). The PHNs in the Galway study are a seasoned and mature workforce but the demographics do highlight the potential problem of an aging workforce.

The study supports the notion that the PHN role transcends the human lifespan on a continuum of care from cradle to grave and within every facet of the community. Open referrals are a distinguishing feature in the PHN service and this is very much in contrast to the practice of other community care providers where the numbers of patients on a caseload is monitored and indeed limited.

The tool captures the multidimensional aspects of the PHN role and affords insight into the complex nature of their work. The study did discriminate between lengths of time spent with clients of different need level and does indicate a positive linear relationship between PHN time and client need. The tool was used to assess clients from all care groups. The child health and older persons care groups generated the largest number of assessments. The PHNs spent the majority of the time caring for the elderly (44%) and children (22%). The significant care commitment to the elderly is one area where further augmentation of the PHN service with more RGNs may free up some PHN time to concentrate on other aspects of the role.

Over the course of the study, PHNs spent 64% of work time on patient activity with the remaining time on travel and non-caseload activity. Of the time spent on patient activity approximately 74% of the time was engaged with direct patient care with the remaining time spent on indirect patient care activities. The study uncovered a range of unmet needs, which resulted in extra workload in terms of direct time expended per client.
The majority of PHNs see their future as being part of the primary care team in line with the Department of Health’s proposals (Department of Health and Children 2001a). The provision of material resources for the use of the public health nurse was quite variable in this study although a general pattern existed where insufficient resources were devoted to capital investment.

The study indicates that there are areas where the PHNs may be inappropriately utilised and are frequently engaged in activities that substitute for the work of other members of the community care team. A key difficulty in the provision of the PHN service is in the selection of priorities and the study would suggest that the approach to care and indeed the care priorities indicates that the PHN's focus is on the curative aspects.

The themes that emerged in this study describe the broad, all-encompassing role of the PHN that involves 'hands-on' clinical care for diverse client groups, in addition to a heavy administrative role that includes taking on tasks more suited to other health professionals or assistants. The challenges that face the PHNs include an increasing role in the primary care team, changes in the culture and demographics of their client population, and a need to acknowledge and change hierarchical systems of management in order to develop a shared vision for the future. There was a realisation that the health service is changing and that the role will need to change concurrently with developments in community and primary care nationally.
Recommendations

7.1. Public Health Nurses

7.1.1. Case management

- Develop a case management system, which includes a referral system for effective and efficient workload and caseload management.
- Define criteria for referral to the PHN service.
- Monitor admissions and discharges to caseloads.
- Establish criteria for admission and discharge from caseloads.
- Establish criteria for active and inactive case loads.
- Monitor the number of cases on the active list- (this needs to be defined, e.g. number of clients seen at least monthly by either a PHN or RGN).
- Decide on criteria for the numbers of clients on an active case list.
- Define the client as being either the person recorded on the returns or the family.
- Administer the Community Client Need Classification System to each client on admission to a caseload.
- Review existing clients at a predetermined time as agreed by all members of the Public Health Nursing Service in Galway Community Care Area, using the Community Client Need Classification System.
- Develop a framework of case management that incorporates regular planned case discussions between members of the Primary Health Care Team and all other relevant stakeholders.

7.1.2. Role

- Define and clarify the role of the PHN within the proposed Primary Care Teams before such structures are implemented.

7.2. Management

7.2.1. Human resource management

- Provide access for all PHNs to IT and training.
- Develop a fully responsive health information management system for the Public Health Nursing Services, which is capable of integration with existing health information management systems in the Galway Community Care Area and Western Health Board.
- Provide secretarial and administrative support for all PHNs in the region.
- Develop a model of supportive supervision.
- Encourage the utilisation of the individual personal development plans, which are presently available in the Western Health Board.
- Develop an organisational climate that promotes team building, peer support, openness and transparency with regard to intra-professional and interprofessional relationships.
- Work to develop flattened organisational and managerial structures within the Public Health Nursing Service.
- Petition for and encourage the move towards one-site venues for Primary Care Teams.
- Audit the quality and review the health and safety issues of the work environments (health centres) of Public Health Nurses.
- Health Board investment in the buildings from which the public health nursing services are delivered should be increased as a matter of urgency.

**7.2.2. Strategic planning**

- Develop a five-year plan as a means by which to implement the above recommendations of this report in line with current and emerging local, national and international policies.
- The strategic plan needs to address a number of issues:
  - to recognise the curative and preventative aspects of the role of PHNs.
  - to recognise the needs of the public health nursing services and the clients it serves within the overall primary care team.
  - to recognise the skills of PHNs with particular client care groups.
  - to recognise the need for the PHN to become more involved in researching and developing community health services.
  - To recognise the need for PHNs to develop a Community Profile in partnership with members of the multi-disciplinary team.

**7.3. Western Health Board Nursing and Midwifery Planning and Development Unit**

**7.3.1. Management**

- Review the use of ratios of PHNs to population as a means to resource the PHN nursing service as previously recommended by the Department of Health (1997) and Hanafin et al (2002) in the context of emerging policies.
- Develop and implement Primary Health Care networks as recommended by the Primary Health Care Strategy (Department of Health and Children 2001a).
- Implement a total quality system of delivering primary health care and public health nursing service in line with the recommendations of the Quality and Fairness: A Health System For You (Department of Health and Children 2001b).
- Provide an adequate skill mix within the envisaged Primary Health Team.
- Increase the involvement of PHNs in developing and co-ordinating services at a macro level, utilising the unique knowledge that PHNs have of community health needs.
- Develop a Public Health Nursing Service which is person/client led as opposed to a service led system of care delivery.

### 7.3.2. Education and training

- Develop a package of in-service training courses in a wide variety of areas of Public Health Nursing practice.

### 7.4. Further Research/Trinity College Dublin

- Modify the Community Client Need Classification System in line with the suggested changes and conduct further research to examine and test the tool regarding its utility and reliability in practice settings.
- Provide ongoing consultation and advice to the research site in order to ensure consistency in the application of the tool in practice settings.
- Conduct further research with a larger sample of PHNs in other areas to examine the potential reliability and generalisability of the tool in other health care settings.
- Conduct further research with other Health Care disciplines with regard to the utility of the tool as an inter-professional measure to classify client need.
- Encourage further studies into areas of PHN work that were identified in this study to be problematic:
  - Ineffective calls to clients, resulting in a sizeable proportion of unproductive time for PHNs.
  - Current working practices that have changed due to the changing sociological profile of the population, e.g.:
    - Timing of clinics
    - Working hours
    - Non attenders to clinics
    - Unmet needs within the public health nursing service - e.g. patients awaiting referrals, equipment, translator, etc.
A STUDY OF THE ROLE AND WORKLOAD OF THE PUBLIC HEALTH NURSE IN THE GALWAY COMMUNITY CARE AREA
School of Nursing and Midwifery Studies, Trinity College Dublin

Introduction

Public Health Nursing was first included on the An Bord Altranais register in 1960 (Commission on Nursing 1998) and resulted from the amalgamation of the midwifery, voluntary district nursing services and nurses employed by the local authorities (Leahy- Warren 1998). There are 1,878 Public Health Nurses (PHNs) on the live register of An Bord Altranais (An Bord Altranais 2001). Population size is the basis for public health service provision, so each population of 2,500 is served by a PHN. PHNs are generalists with a wide range of responsibilities for all age groups, encompassing primary, secondary, and tertiary care (Hanafin et al 2002) and involving activities relating to the health needs of individuals, families and communities (Department of Health 1997). Chavasse describes the aim of public health nursing as “to contribute to health care in the community and for the community” (Chavasse 1995: 5). The PHN interfaces with a multitude of client groups in the community. The range of activities and responsibilities is broad and can lead to difficulty in articulating the boundaries of the PHN role. The literature would suggest a lack of clarity in the Public Health Nurse role in Ireland (Chavasse 1995; Hanafin 1997).

The purpose of this study is to examine the role and responsibilities of Public Health Nurses in Ireland. Chapter 1 presents an overview of the public health nursing service, its nature and scope, and identifies the community groups to which it responds. It reports on the statutory obligations and specialist aspects of the role that influence the practice of Public Health Nursing in Ireland. Chapter 2 examines the contemporary issues that affect the workload of the PHN in the context of community care services in the Irish Republic, and includes an overview of the literature that informed the selection and design of the workload measurement tool employed in the study.

The complexity of defining nursing workload and productivity is discussed. The strengths and weaknesses of the varied approaches to measuring the work of nurses are considered in the light of contemporary issues. Chapter 3 describes the methodology, and the findings of the study are presented in chapters 4 and 5. The discussion and recommendations for the future that arise from this study of the role and workload of the PHN in the Galway Community Care Area are outlined in the final chapters of this report.
Chapter One - The Role of the Public Health Nurse

1.1. Educational Preparation

The education and training of PHNs takes at least six years in addition to a minimum of 2 years clinical practice (Hanafin 1997). The educational preparation includes registration as a general nurse, registration as a midwife and a higher diploma in Public Health Nursing. One of the key themes to emerge in the literature was the capacity of the PHN to see the larger picture, due to broad education base and specialist knowledge of community resources (Reutter and Ford 1996; Hanafin 1997). The PHN has extensive knowledge of the statutory and voluntary organisations in the community, enabling them to coordinate primary health care in the geographical area to which they are attached (Hallet and Pateman 2000). Hanafin (1997) explains that PHNs are ideally placed in the community to impart information and advice to clients that is specific and sensitive to their individual situation, thus fulfilling their role in health promotion and education. The broad remit of the role of the PHN has enormous implications for the continuing educational needs of PHNs.

Debate abounds regarding the retention of the midwifery qualification as a prerequisite for entry to public health nursing courses. The Department of Health (1975) recommended that PHNs retain the midwifery qualification as they envisaged the increased role of the PHN in antenatal and post-natal care. They argued that the midwifery qualification enhances the “patient’s confidence” in the Public Health Nursing service and public confidence would be reduced considerably if the nurse were not a fully trained midwife. The unpublished review of Public Health Nursing (Department of Health and Children 1997) recommends dropping the requirement for a midwifery qualification as a pre-requisite for entry to the Higher Diploma in Public Health Nursing. However, the report contains a note stating than five of the eighteen listed members of the review committee wished to be disassociated from the recommendation. This was preceded by the recommendation in the “Future of Nursing Education and Training in Ireland” that the midwifery requirement should be replaced by a midwifery and childcare module (An Bord Altranais 1994). The Commission on Nursing (1998) reiterated the Bord’s recommendations and further recommended that a working party be established, composed of nurse educators and PHNs to determine the content of the maternal and childcare module. This working party was established in March 2002, but entry requirements are as yet unchanged in practice. Such a change would require an alteration to the rules for registration to remove the requirement for a midwifery qualification. The debate continues. Advocates of abandonment cite the need to encourage nurses with skills other than general nursing and midwifery into the specialisation (Department of Health 1997). It is anticipated that the National Strategy for Nursing and Midwifery in the Community currently under development will produce some resolution on this subject (Department of Health and Children Nursing Policy Division 2002).
1.2. Job Description

The Department of Health’s Circular (27/66) in 1966, “is perceived by many as the core strategy statement in relation to the role of public health nursing in the community” (Commission of Nursing 1998: 153). “The object should be to provide such domiciliary midwifery services as may be necessary, general domiciliary nursing particularly to the elderly and at least equally important to attend to the healthcare of children” (Department of Health 1966:ii). The actual job description outlined in the Department of Health Circular (The Department of Health’s Circular (27/66) in 1966 greatly underestimated the diversity and range of activities in this multifaceted role.

Developments in primary care suggest the role of the PHN may be at a macro level in contrast to the statutory instrument, which appears to confine nursing to a series of tasks. The Commission on Nursing (1998) recommended that the Department of Health and Children reviewed this strategy, as the role of the PHN had evolved immensely in the previous 30 years and the circular predates the formation of the health boards. The Department of Health and Children (2000a: 41/2000) in the most recent PHN job description makes effort to capture the diversity of the role. It states that the role of the Public Health Nurse is to focus on “a district or area meeting the curative and preventative nursing needs of the population within the area.” The Public Health Nurse will be expected to provide a broad based integrated prevention, education and health promotion service and to act as a coordinator in the delivery of a range of services in the community” (Department of Health and Children 2000a). The document lists a total of 29 main duties and responsibilities, requiring the PHN to be involved at all levels of community care.

The inherent strength of public health nursing may lie in its broad perspectives and in its ability to meet the changing requirements of healthcare consumers. This may render it at odds with the prescriptive nature of a job description. The PHN client group is identified in the DOH 1966 circular and has not been superseded. These client groups include anyone who requires a domiciliary clinical nursing service, infants and children, people with mental and physical disabilities, the elderly, and acute or chronically ill people (Hanafin 1997).

1.3. Research on the PHN Role in Ireland

There are few studies available on the role and work of the PHN in Ireland. There is some difficulty in comparing the work of the Irish PHNs with similar roles internationally. Community nursing roles have many titles and incorporate activities undertaken by a variety of health professionals internationally. Community nurses have distinct roles and titles, for example in the United Kingdom, the terms district nurses, health visitors, practice nurses and community midwives are used. Denyer et al (1999: 21) describe the Irish Public Health Nurses as “generic community nurses” whereas O’Sullivan (1995: 18) uses phrases such as “all-purpose nurse” and that the PHN cares for people of all ages, “from cradle to the grave”. O’Sullivan (1995) undertook a qualitative analysis of Public Health Nursing in 1994 titled “A Service Without Walls”. In the course of this study she interviewed 37 people (17 PHNs, 6 Superintendent/senior PHNs and 16 from management and other
professions), to ascertain their views of the role of the PHN. The conclusion reached was that the PHN has a dual role, preventive and curative. However the preventive role is often overlooked as PHNs struggle to meet the increasing demands of the curative role. The need for clarification of the role was a frequent theme in this study.

There have been two major surveys of the workload of the PHN, one conducted in 1975 by the Department of Health and the other in 1986 by the Institute of Community Nursing (Burke 1986). The methodologies employed and the consequent data generated were not similar, making comparisons between the two difficult. In 1975 the work of PHN (n=700) was categorised around the patients visited, infants, mentally handicapped children, psychiatric patients, terminal care patients, aged, other adults, and unclassified. The work attempted to calculate the percentage of time that PHNs spent on each category. The average caseload of the PHN was 28 patients and travelling time accounted for 25% of the PHN’s time. The largest proportion of work time was spent on visits to the elderly. Burke (1986) in the second national study examined the workload of 732 PHNs. This study attempted to quantify the time spent on various activities. To this end, a record of daily activities was made over a period of four weeks. Travel time and patient numbers were not recorded in this study. Staff just described their activities in a workload diary with some general guidelines. Fifteen categories of nursing duties with several subcategories attached to each were isolated (35 in total). Some of the main categories were home nursing, child welfare visits, ineffective calls, clinics, school inspection, health education, team consolation, and supportive care. Simple descriptive statistics were used to analyse the data. The quantitative approach does offer some insight into the tasks undertaken by the PHN in the course of her work but does not capture those aspects of the role that do not lend themselves so readily to measurement. In both studies the data collection was largely one-dimensional and failed to capture the complexity of the role. On the face of it they tend to echo the extremely brief job description outlined in the Department of Health Circular (1966), which was the official blueprint for this community role until the job description was revised in 2000.

1.4. Nature of Work and Statutory Obligations

1.4.1. Role as care manager

The Department of Health and Children (2000a) states that the job description of the PHN includes “the management of nursing care and the patient’s environment”. PHNs are required to participate actively in planning care and to establish care priorities based on nursing and medical need (Department of Health and Children 2000a). PHNs are responsible for assessment of need for support services such as home help and home care attendants. The need for coordination in the community is an opportunity for development of the PHN’s role (O’Sullivan 1995). The PHN is viewed as ideally suited for this co-coordinator role due to “her universal access to the population, her skill in assessing people and needs and her awareness of the role of other professionals” (O’Sullivan 1995: 40). Hanafin (1997) outlines the managerial functions of
the PHNs that include identifying and prioritising population needs, quality assurance, audit, liaison and interaction between the voluntary organisations and evaluation of the health services.

Case management is another feature of the role as PHNs have a caseload of clients in their care. The National Council on Ageing and Older People define case management as “the development of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a case manager or a team” (Delaney et al. 2001:7). PHNs are the contact point between the hospital or institutions and the community and are charged with liaising with relevant stakeholders on discharge planning and to perform home assessments prior to discharge. Nurses are ideally suited for the case management role (Chan et al 2000), which includes client advocacy, co-ordination and promotion of independence, elements that are reflected in nursing theories and philosophies (Chan et al 2000).

1.4.2. Role in antenatal/postnatal care
PHNs are educated as midwives and this enables them to provide antenatal, intranatal and postnatal care although in practice they do not provide a domiciliary midwifery service (Hanafin 1997). Denyer et al (1999) recommend that the PHNs have a role in antenatal care. The largest role with regard to midwifery care is focused on post-natal care and they are responsible for on-going child, maternal and family health monitoring. PHNs are also required “to liaise with and advise parents and guardians with particular emphasis on breast feeding” (Department of Health and Children 2000a). In 1994, the Department of Health, in its strategy for health stated “every baby will have a visit from the Public Health Nurse as soon as possible after discharge from the maternity hospital/unit, ideally during the first 24 hours” (Department of Health 1994a: 57). Due to the delay in the notification of birth being forwarded to a PHN, this goal was not being achieved (Department of Health and Children 1997). As a result hospitals are now asked to send early notification of birth via fax or email to a PHN to facilitate this early post natal visit (Denyer et al 1999). The Western Health Board monitors the percentage of newborn children contacted by a PHN within 48 hours of hospital discharge, as one of the performance indicators, and their target range for 2002 is 80- 90% (Western Health Board 2002b).

1.4.3. Role in child health
Child health is a fundamental role of the PHN (Department of Health and Children 2000a). The duties of public health nurses include “health education, and propaganda among families in her district with a view to encouraging them to avail of immunisation, maternity and child welfare services, school health examination, etc” (Department of Health 1966). Child health remains a central focus of the role in the current job description where 6 out of the 29 duties are attributed to it (Department of Health and Children 2000a) (see Appendix 8.01 & 8.02). Denyer et al (1999) undertook a review of screening and surveillance services for all children under 12 years of age. The “Best Health for Children” report Denyer et al (1999) proposes that child health surveillance is synonymous with secondary prevention and thus constitutes one component of child health promotion. They recommend in their report that “community
nursing services for infants and preschool children be delivered by community child health nurses and for school children by school nurses...PHNs by virtue of their training would be suitable for such positions.” (Denyer et al 1999: 42). The role of School Nurse is envisaged to incorporate the planning and delivery of the school based screening programme (Appendix 8.03). The third review of child health services in the UK (Hall 1996) states that the role should also include the multidisciplinary management of children with complex needs, including child abuse, visiting children, who have not been immunised and to provide additional support to new parents.

### 1.4.4. Role in child protection

The enactment of the Child Care Act (Government of Ireland 1991:3:1) gives explicit direction to each Health Board and its employees “to promote the welfare of children in its area who are not receiving adequate care and protection”. The role of the PHN in child protection was first documented in the Department of Health Circular (1966) where it states that the PHN should follow-up “at risk” children in association with the general practitioner. This circular defined children “at risk” as the “identification as one needing special supervision and perhaps treatment over a number of years” (Department of Health 1966:ii). The Public Health Nurse is the only professional among all the service providers in the community who has a mandate to visit all families with babies and children (Hanafin 1998). The investigators of the Kilkenny incest case (South Eastern Health Board 1993:41) state that “in the case of “at risk” families, the PHN will be aware of the factors affecting a child’s development and her visits will be more frequent.” The PHN’s role is perceived as supportive, supervisory and educative. If the PHN is aware of risks regarding the welfare of children, she is required to take appropriate steps to report her concerns to the appropriate personnel. “When there is an involvement of other health care professionals, the PHN will continue with the already established pattern of visiting to the family and will work closely with the other professionals to support the family and look after the child’s interest” (South Eastern Health Board 1993: 21). In some cases the PHN will be the “key worker” dealing with children at risk”. Hanafin (1998) concurs with the South Eastern Health Board’s (1993) view of the role of the PHN in primary and secondary child protection. However Hanafin (1998) argues that the PHN has a limited role in tertiary prevention with children who have been identified as “at risk”, due to their lack of education and resources. This limited role, she proposes, involves the PHN working within the multidisciplinary, multi-agency team, in ongoing monitoring of children and their families.

The role of the PHN, like other health professionals in contact with children, as outlined by the Department of Health and Children (1999b), in the National Guidelines for the Protection and Welfare of Children, is secondary prevention, in other words, to report child abuse and “to be alert to the possibility that children with whom they are in contact may be being abused” (Department of Health and Children 1999b: 37). The Western Health Board’s Child and Family Care Services Strategy (Western Health Board 2001d: 17) state that the role of the PHN includes “early identification of child care concerns and subsequent follow-up of family support and team working with other disciplines.” The national guidelines
(Department of Health and Children 1999b) state that the PHN may have a role in assessing reported concerns about child protection.

Finally, the Department of Health and Children (1999b: 118) view the PHN as one of the “professionals who are key front line staff in child protection work” and thus require continuing professional education on childcare protection.

1.4.5. Role in family support services

There are many family support services presently being provided by the Department of Health and Children. Two home-based services include the public health nursing service and the Community Mothers Programme (McKeown 2000). The Community Mothers Programme has been rigorously evaluated and proven effective (McKeown 2000), however “there has been no systematic evaluation of the effectiveness of home visitations” by the public health nursing service (McKeown 2000: 23). This issue may gain prominence in the light of recent demographic changes. There has been an increase in the proportion of all dependent children living with one parent, from approximately 5% to 12%, between 1983 and 1998 in Ireland (McKeown and Sweeney 2001). The percentage of total births to mothers, aged less than 20, has increased slightly from 4.5% to 6.2% between 1988 and 1999 (McKeown and Sweeney 2001).

The National Children’s Strategy (Department of Health and Children 2000b: 74) stated that “quality parenting programmes are to be made available to all parents, with a special emphasis on the needs of fathers, lone parents, ethnic minority groups, including Travellers and marginalised groups”. Expansion of such programmes such as the Teenage Parenting Initiative and the Community Mothers programme to all health boards is another recommendation of the National Children’s Strategy (Department of Health and Children 2000b).

1.4.6. Role in home nursing

The PHN is required in the new job description to “provide home nursing” (Department of Health and Children 2000a). The 1966 Circular on District Nursing states that the duties of the PHN include “domiciliary nursing in co-operation with the appropriate medical practitioner, including nursing of the aged and chronic sick” (Department of Health 1966: ii). Home Nursing was categorised in the 1975s workload study (Department of Health 1975) as technical, basic or preventive, and educational nursing. The Burke study (1986) indicated that the PHN spent approximately 44% of time on activities related to home nursing. The recent job description of the PHN (Department of Health and Children 2000a) describes the duties as “to provide home nursing” and “to effectively manage requests for home nursing following discharge from hospital or institutions”. Hanafin (1997) argues that the home based and direct contact with clients places public health nurses in a unique position to give information and advice to clients that is both specific and sensitive to their individual situations.
The increasing elderly population, coupled with the shorter length of hospital stay has greatly increased the demand for home nursing. Changes in technology and medical advances have enabled many more patients to be cared for in their homes but have also resulted in greater complexity in the nursing care to be delivered.

There is a view that some of the home nursing role could be carried out by others working in the community (Hanafin et al 2002), although Hanafin (1997) points out that the development of skill mix is fraught with difficulties and tensions. Hallett and Pateman (2000) in their United Kingdom based qualitative study investigated the role of the staff nurse in the community. One of the key findings of the study was the potential for skill suppression and limitation of professional development for those staff without specialist nursing qualification. There is evidence of greater deployment of RGNs in some areas (National Economic and Social Council 1987; Commission on Nursing 1998). Hanafin et al (2002) suggest that RGNs are not generally employed in response to population need and are often only engaged on a part-time or temporary basis.

1.4.7. Role in care of the elderly
The Department of Health (1966:ii) in its circular on district nursing outlined the role of the PHN in the care of the elderly as follows: “Compilation of a register of elderly persons resident in their district; regular visitations of elderly persons advising and assisting them, through liaison with the appropriate officers in the health authority, to avail of such health and/ or Social Welfare benefits or services as they may be entitled to or require” The recent job description of the PHN states that the role of the PHN is “to provide regular preventive services for older people with a view to maintaining older people in dignity and independence at home in accordance with the wishes of the older person” (Department of Health and Children 2000a).

Burke’s survey of Irish Public Health Nurses highlighted the amount of time PHNs spent with the elderly (Burke 1986). The increasing age profile of the population will, according to the Health Strategy (Department of Health and Children 2001b) and the Western Health Board Care of the Elderly Strategy (2001a), increase demand for community nursing service. The participants in O’Sullivan’s research (1995), cited services for the elderly as one of the weaknesses of the care provision, and the problems identified included a lack of an accurate geriatric register and “unclear lines of demarcation between the Coordinator of Services for the Elderly and the Superintendent PHN” (O’Sullivan 1995: 39). Another respondent highlighted the following as special needs of the elderly, “night sitting or night nursing services, for screening or anticipatory care, or for assessment”. Anticipatory care is defined by the Western Health Board (2001a: 33) as care “concerned with anticipating the health problems of older people before they arise or at an early stage”.

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There is enormous potential for health promotion among the elderly as illustrated by a recent survey, which showed that less than 50% of the elderly reported receiving the influenza vaccine (Garavan et al 2001). The Western Health Board (2001a) states that this increasing demand coupled with insufficient home nursing service are some of the weaknesses of the present service for the elderly (Western Health Board 2001a).

Secondary prevention, which includes screening, is also an important role of the PHN in the care of the elderly and the result of this surveillance is the maintenance of a register of older people at risk. Hanafin (1997: 296) states that the PHN is “legally required to maintain an at-risk register”. This is in contrast to the Western Health Board (2001a), which states that this was a traditional role of the PHNs. The Western Health Board Care of the Elderly Strategy states that there is “no legislation which specifically provides for services for older people” unlike the childcare services (2000a:26).

The National Council on Ageing and Older People, in partnership with the Western Health Board and the ERHA recently conducted a survey to ascertain the views of older people, aged 65 years and older (n=937), living in the community, regarding health and social service provision (Garavan et al 2001). There was a high satisfaction (98%) with the Public Health Nursing Service and 15% of the respondents in Garavan et al’s (2001) study reported receiving a visit from the PHN in the past year, and 14% of these requested more visits. 3% of the elderly, who had reported receiving no PHN service, stated that they would like to receive the service. Garavan et al (2001) also interviewed the elderly living on the Aran Islands. They report that PHNs have “many key roles, including those outside the conventional role of nursing. Indeed, they are required to carry out extended duties of care, which may include being on call twenty-four hours per day; arranging for other health services to visit the islands, recruiting home helpers and carers for older people; organising social gatherings for older people; completing applications for mobility aids and home adaptations; providing first aid, physiotherapy, chiropody, occupational therapy, social work and transport for older people and picking up healthcare supplies etc.” (Garavan et al 2001: 225). The elderly respondents did recommend that Inis Oírr PHN service be increased during the summer months due to the influx of students and tourists. “Generally older people were very satisfied with the care they received from the public health nurse. Satisfaction was particularly expressed on Clare Island, where they reported that the nurse provided an excellent service for them, was truly caring and professional and there were no complaints at all. However, some felt she needed an ambulance to carry out her job more effectively” (Garavan et al 2001: 226).

The Department of Health and Children (2001b) and the Western Health Board (2001a) recommend the development of care management approaches for the elderly. The Health Strategy also advocates the appointment of key workers to plan care for the dependent older person. Suggestions from both parties include the development of criteria for assessing the elderly people at risk and of those aged 75 years and over.
The unpublished review of Public Health Nursing (Department of Health 1997) reiterates the importance of care planning in collaboration with carers and the PHN’s supportive role of carers.

1.4.8. Role with disadvantaged groups

The second of the Health 21 targets require Ireland to reduce the Health inequalities “by substantially improving the level of health of disadvantaged groups” (World Health Organisation 1998). Disadvantaged groups targeted in the 2001 Health Strategy (Department of Health and Children 2001b) include travellers, the homeless, asylum seekers/refugees, prisoners and drug misusers. The PHN has long being recognised as one of the key health professionals involved in “delivering primary health care” for the travelling community (Department of Health 1994a; Government of Ireland 1995). The Travellers Health Strategy (Department of Health and Children 2002a: 74) states “in the front line of health services, public health nurses provide a critical point of contact with Travellers”. Many health boards have designated PHNs for travellers and the Department of Health and Children recommend that this be “developed more widely”. The role of the designated PHN for Travellers should include the following:

- Direct service provision to Travellers of all ages and both sexes including Primary Health Care interventions such as advice, nursing diagnosis and referral.

- Ensuring that individuals understand and are properly utilising medications and special diets prescribed by their GP or by hospital doctors.

- Monitoring the health and social needs of Travellers under their care including gathering data for health surveillance.

- Delivery of health promotion/ preventive services, in partnership with Community Health Worker.

- Co-ordinating/ organising appointments with specialist services and follow up.

- Liaison with other relevant personnel including Health Board and local authority social workers, home helps, teachers etc.” (Department of Health and Children 2002a: 75)

Many travellers have difficulties in accessing postal services and the Department of Health and Children (2002a) recommend that the travellers may nominate their designated PHN to receive copies of correspondence from secondary care and specialist services, relating to appointments.

The number of applications for asylum in Ireland has increased dramatically from 91 in 1993 to 7,724 in 1999 (Public Health Department North Western Health Board 2001). This dramatic increase in caseloads, coupled with the complexity of care and time consuming consultations due to the language barrier has dramatically increased the workload of PHNs (Northern Area Health Board 2002). The homeless have
been identified as needing enhanced health promotion programmes and greater health care services (Homeless Agency 2001). Multidisciplinary care teams, which include PHNs have been formed to help meet the needs of the homeless in the community. The Travellers Health Strategy (Department of Health and Children 2002a) and the Northern Area Health Board (2002) highlight the need for further education for PHNs working with these disadvantaged groups.

1.4.9. Role in education

The Public Health nurse is required “to provide practical work experience and guidance and act as course preceptors for student public health nurses or other student nurses during community placements” (Department of Health and Children 2000a). The Department of Health and Children’s document “From Vision to Action” reports on strengthening the nursing contribution to public health (Department of Health and Children 2003) and advocates that all nurses have a public health component to their education in addition to specialist training for public health nursing practice. The future may see demand on the PHN to have input into the education and training of unlicensed personnel. The volume and variety of nursing and other students to be facilitated to achieve educational outcomes in the community has placed additional responsibility on the PHN in practice. The unpublished review of public health nursing (Department of Health and Children 1997) called for greater recognition of the workload generated in precepting student nurses in the field.

The review also made recommendations regarding the continuing education needs of PHNs. Increasing specialisation at all levels of healthcare has made it difficult for a generalist to provide care (Chavasse 1995). The breadth of the PHN role has implications for continuing education due to enormous variety of expertise that may be required of them during the working day. The review committee on Public Health Nursing recommended that the individual educational needs of PHNs be identified and study leave be allocated according to service need (O’Sullivan 1995). Chavasse (1995) proposed that continuing education for PHNs should not only focus on in-service education on specific nursing abilities but should also be geared at developing political and leadership skills necessary to fulfil the role related to promoting health in and across communities.

1.4.10. Role with other community nursing services

The job description of the Public Health Nurse, published by the Department of Health and Children in 2000, does not mandate a specific role in psychiatry or learning disability. The 1966 circular suggests that the role of PHN would include the provision of nursing services and support in the homes of people with disabilities (Department of Health 1966). This role is further explained by the more recent Department of Health and Children job description for Public Health Nurses (Department of Health and Children 2000a) suggesting a role for public health nurses in the provision of “support to persons with disabilities and their families on an ongoing basis”. Public Health Nurses have a role in palliative care and “they are supported
in this in a small way by the hospice nurses who work from, and are administered by, the hospice care institution” (Leahy Warren 1998: 15).

Palliative care is not specifically addressed in the job description but care of the terminally ill is implicit in many of the other duties. Learning disability, psychiatry, and palliative care nurses do work in the community but do so in isolation from the nurses working in the public health nursing service. In some geographical health board areas in Ireland, liaison PHNs are employed to work specifically with people with intellectual disabilities. General nurses, as already discussed, are employed in some areas. Initiatives are underway nationally to provide a community midwifery service, but this is confined to a very small number of care areas. Practice nurses are available in some areas but not uniformly and their work relationship is primarily with the general practitioner. Hanafin et al (2002:70) state that these community nursing services “operate within the structure and organization of their own institutional setting”. However when other nursing services, for example psychiatry, learning disability, palliative care or community or midwifery are absent or insufficient, responsibility for these groups falls back to the PHN. Hanafin et al (2002) point out that the public health nursing service is considerably dependent on other nursing services. They explain that inconsistency in the availability of other nursing services can cause considerable inequity in the availability of the PHN service.

1.4.11. Role in health promotion

Hanafin (1998) describes the role of the PHN as a health promoter, manager and clinician. In 1966, prior to the World Health Organisation’s definition of health promotion in 1986 (Department of Health and Children 2000c) the Department of Health (1966) outlined the duties of the PHN, which incorporated some aspects of health promotion. The PHN was noted to be a key person to promote health in the community in the 1994 Health Strategy (Department of Health 1994a). The Cardiovascular Health Strategy Report (Department of Health and Children 1999a: 51) stated, “public health nurses are involved in a range of health promotion activities in schools and with groups in the community”. The PHN is perceived to have an important role in promoting the health of the elderly (McMahon 1998) and children (Denyer et al; Department of Health and Children 2000b; National Conjoint Child Health Committee 2001; Public Health Department North Western Health Board 2001). They are also charged with promoting breast feeding (Department of Health 1994b), educating on the prevention of accidents (Eastern Health Board 1998) and reducing the risk of cardiovascular disease (Department of Health and Children 1999a) and cancer (Department of Health 1996). The new Health Promotion Strategy in the Western Health Board (Western Health Board 2002c) further illustrates the important role of the PHN in health promotion and has appointed a PHN for cardiovascular health promotion.

The Department of Health and Children (2000a) states that the Assistant Director of Public Health Nursing must “identify and develop the organisation and delivery of health promotion activities in their areas”. The job description of the PHN includes opportunistic health promotion and participation in
“formal health education and health promotion activities” (Department of Health and Children 2000a:41/2000). PHNs have a history of participation and leadership of community based health promotion projects such as the Community Mothers Scheme (Johnson et al. 2000a), promoting healthy eating among school children (Public Health Department North Western Health Board 2001), prevention of falls among the elderly (Eastern Health Board 1998) and the Teen Parents Support Initiative (Riordan and Ryan 2002). Chavasse (1995) highlights the strategic placement of the role of PHN in terms of epidemiological data collection thus contributing to the body of public health knowledge. Hanafin (1997) tells us that PHNs are regularly engaged by voluntary and statutory organisations to collect data information relevant to public health.

A serious weakness of the Public Health Nursing service is that “the curative dimension took precedence over the preventative” (O'Sullivan 1995: 38). The “sheer volume of their curative work” results in the PHNs being “dragged away” from their health promotion responsibilities were the views of one of the managers interviewed by O’Sullivan (1995). The Western Health Board (2001a: 34) also reports that the “the high demand for curative and personal care services, coupled with the limitation of resources available, results in little opportunities to develop health promotion for older people”.

The Commission on Nursing (1998:154) suggests “the PHN should be allowed focus to a greater extent on a health promotion and disease prevention role in the community”. Hanafin (1997) and Chavassee (1998) outline the important role of the PHN in developing a community health profile, thus aiding in identifying the health needs of the community. These recommendations are also endorsed in the unpublished review of Public Health Nursing (Department of Health and Children 1997).

1.5. Collaboration/integration of the PHN Role in Community Health Services

One of the key areas for improvement highlighted in the Health Strategy (Department of Health and Children 2001b) was the need for improved integration between related services. The broad educational base and inter community knowledge provided renders the PHN role as a mechanism through which local needs can be identified and they have the capacity to develop a structure and coordinate to meet those needs in the community (Hanafin et al 2002).

The introduction of skill-mix is advocated by several reports to supplement the public health nursing role National Economic and Social Council 1987; O’Sullivan 1995; Department of Health and Children 1997; Commission on Nursing 1998). Skill mix is a relatively recent phenomenon in Irish community nursing and includes using unlicensed personnel. The Department of Health (1997) also suggests the permanent employment of the general nurses to work in the Public Health Nursing team and that the PHN should retain the responsibility
for managing the caseload. However, Hanafin et al (2002: 20) report that “it remains unusual for the service to be delivered through delegation or formal collaboration with other team members”. Hanafin et al (2002) report that in reality, there is little evidence of employment of general nurses in the community with most general nursing services being provided by public health nurses while Home care attendants tend to be focused on household duties rather than care giving. The Western Health Board (2001a: 34) report “there is an inadequate structure for the provision of nursing services in community with currently no approved general nursing posts in the Western Health Board region, although there a number of general nurses employed on a part-time basis”. O’Sullivan (1995), in a qualitative study of public health nursing, found that general nurses were perceived as both a threat and a resource. Hanafin et al (2002) suggest that inconsistency in availability of other personnel in the community result in unpredictable demands on PHNs.

The link role of the PHN and knowledge of the roles of other healthcare professionals was perceived by some study participants as a “strength” (O’Sullivan 1995:38). However, others reported there were “no structures for collaboration with GPs, and social workers”. The Commission on Nursing (1998) also commented on the poor liaison between GPs and PHNs. The public health nurse often works in isolation from other health care colleagues rendering communication pathways as essential to effective practice. Lack of communication between healthcare professionals and between one sector to another, has been highlighted as one of the major weaknesses of the overall Irish health service (Department of Health and Children 2001a).

The literature indicates a desire for closer working relationships with general practitioners (GPs). Some pilot studies are underway nationally to test out methods of organising care to primary care team approaches. Hayes et al (1992) surveyed 35 GPs from one community care area on their views of public health nursing service in Ireland. The study set out to elicit views on home visiting. 88% reported satisfaction with service but 37% were dissatisfied with access and 48% were dissatisfied with “out of hours” service. This study is limited due to the confinement of sample selection to one community care area but does offer some insight into the concerns of some health care colleagues in receipt of service from public health nurses. It has been said that attention should be focused on research and development of services which reflect the consumer agenda” (Plews and Bryer 2002:1). In a small study of the role of health visitors in the child health clinics in the United Kingdom, the researchers were inspired by the concern that community nursing is largely invisible and there is a requirement for increased knowledge about nursing interventions. Plews and Bryer (2002) stress the importance of basic descriptions in searching for evidence of effectiveness, as without adequate description, roles may appear non-existent or ineffectual.

1.6. Specialist Versus Generalist Role

O’Sullivan’s (1995) research reported strengths and weaknesses in the generalist role of the PHN. Some respondents believed that the generalist role provided the PHN with “access to every home and family” as they cared for all population groups, which allowed the PHN to have a “holistic view of needs” of the individual, family and community (O’Sullivan 1995: 35). However, some respondents believed the PHN is a “jack-of-all-trades and master of none” (O’Sullivan 1995: 37) and there were no “parameters to role”. One respondent
perceived the role of the PHN as “doing the work of others or work that others wouldn’t do” (O’Sullivan 1995: 37). The role has traditionally been a generalist one with a broad range of services offered to the population at large by the same professional. In fact, the range of services is so broad that the public and other health care providers may not even be aware of those services to which they are not exposed. A generalist role may decrease role clarity and may result in PHNs filling gaps in the service that could be better provided by others (Reutter and Ford 1996). However, over specialisation of the role could result in fragmentation of the nursing service.

The unpublished Review of Public Health Nursing (Department of Health 1997: 35) states that the PHN is responsible for the “holistic care of individuals in their homes”. The Commission on Nursing (1998:154) vision of the PHN is as “the core of nursing services being delivered in the community”. The Commission also recommends that the PHN continue, “to be responsible for people of all ages and of every condition” and “remain focused on a district or area meeting the curative and preventive nursing needs of the population within the area”. Hanafin et al (2002) observe that the former recommendations on the role are contrary to those recommended by Denyer et al (1999) and the Commission on the Family (1998) which advocated the development of some specialist roles for example in child health. The Department of Health and Children (2002a) does advocate a specialist role in some instances. The Traveller Health Strategy advocated the role of the Designated Public Health Nurse with specialist knowledge of this particular group. The Nursing and Midwifery Community Nursing Strategy currently under development may illuminate this debate further.

1.7. Conclusion

“The PHNs of the future will have less clearly defined roles, will need to be more flexible in meeting the needs of clients, will need to have greater skills of co-ordination and delegation and more independence of thought and mind in decision-making” (Department of Health 1997: 23). This unpublished review of public health nursing (1997) made several recommendations regarding the future development of the role of public health nursing. Many of these recommendations have yet to be acted on while others have been implemented to varying degrees. The review of the service suggested the increase of PHN involvement in pre and post-natal care. The report did stress that child health assessment and interventions should only be carried out by PHNs. Other recommendations included a register of elderly people “at risk” and of those over 75 to be kept at community care headquarters for access and updating by PHNs. The main theme was that care of the ill and dependent in the home should remain central to the role of the PHN (Department of Health 1997).

There is a need to create an integrated health care service that is responsive to the needs of the people it serves (World Health Organisation 1999; Department of Health and Children 2001a; Western Health Board 2002a). The World Health Organisation has compelled governments to place primary care at the centre of the health care system as reflected in the Irish Primary Health Care strategy (Department of Health and Children 2001a). The Department of Health and Children have emphasised the need for re-orientation of the health services from hospital to community based care (Department of Health and Children 1994, 2001a). Health policy in Ireland is placing increasing emphasis on care in the community, which has implications for service providers like public
health nurses. People requiring care in the community are not a homogenous group and have a variety of acute and chronic medical conditions requiring short or long-term care in the community (Kirk and Glendinning 1998). The changing sociological and demographic nature of society in Ireland has impacted on a community nursing service that has largely remained unchanged since 1966 (Hanafin 2002).
Chapter Two

Assessment of Workload among Community Nurses

2.1. Issues that Impact on the Workload of a PHN

2.1.1 Work load

Current developments in health care are increasing the curative demands of the PHN role. Hanafin (1997) expresses concern that the clinical work may erode other functions of the PHN such as manager and promoter of health. The issues facing Irish community nursing have been mirrored in other countries and some of the major issues highlighted in the Audit Commission (1999) on district nursing in the UK concerned the difficulties of workload control. There is little clarity about service priorities and objectives (Audit Commission 1999). The commission highlights the concern in the United Kingdom that few Health Authority trusts consider the strategic purpose of services and how they should fit in with social services and other community services. Inadequate strategic planning is a feature in the Irish Community Services also. Thomas (1999) reports that the audit commission found significant variations in the type and level of care received by patients.

Workload is also a concern in Ireland. Chavasse (1998: 174) criticises the large caseloads of PHNs as it hampers their ability to “provide primary as well as secondary nursing care”. The large caseload of the PHN is deemed excessive and incompatible with the role expectation of PHNs in O’Sullivan’s report, “A Service Without Walls” (O’Sullivan 1995). There are two essential components to public health nursing, curative and preventive. In any one interaction with a client, the public health nurse may deliver multiple services. Initial referral may originate from the curative aspect of the role but the preventive role while not as obvious may be equally employed. Unfortunately, the preventive one is most likely to suffer from pressure on the service.

McDonald et al (1997) report that the University of East Anglia and Community Performance Review group were commissioned to study 24 trusts to examine management structures and working practices as part of a series of comparative studies between community NHS trusts. They specifically examined the workload of district nurses. Three questionnaires with qualitative and quantitative questions were distributed and completed by a variety of personnel, including managers, directors, district nurses etc. These were followed by a discussion/theme day when the results of the questionnaires were produced. Much greater caseloads for district nurses due to changes in the discharge and length of stay policies was the significant finding.
Reutter and Ford (1996) in a qualitative study of the perception of public health nursing in Canada concluded that while the work of PHNs is perceived as valuable and rewarding, it is not always understood by others. One of the key difficulties in work expressed by participants in this study was insufficient time to do what they need to do. The researchers concluded that the stressful aspect of public health nursing may relate to work overload rather than to the nature of the work itself. Issues relating to public health curricula, raised during the consultation process for the Commission in Nursing (1998), included an increasing workload and greater complexity in the range of social and health issues. Increasing specialisation across all disciplines of nursing does render it difficult for a generalist to provide care.

In a descriptive study, using a triangulation of methods, Evans (2002) explored the district nurse experiences of work stress (n=50). Forty-two per cent of respondents reported understaffing as a stressor of the highest intensity. Qualitative data provides further illumination of the issues associated with understaffing where a participant reports that the system is kept “ticking over” because staff “keep going, staying behind after work and taking paperwork home” (Evans 2002: 580). Jansen et al investigated the effect of job characteristics and individual character on job satisfaction and burnout in community nursing (n=441). The most significant finding of this qualitative study was that job satisfaction is positively affected by task, clarity, skill variety and possibilities for development and feedback at work (Jansen et al 1996). Houston and Clifton (2000) propose the work of corporate or teamwork models in community nursing services can contribute to practice development, stress reduction, and improve accountability outcomes.

2.1.2. Resource issues
PHNs in the Western Health Board, spent 16% of their time on clerical duties in the 1975 study (Department of Health 1975) and lack of secretarial support was a reported concern in O’Sullivan’s (1995) study of public health nursing. The Commission on Nursing (1998) recommended the provision of clerical support and new technology to support the PHNs in their role. Access to information technology, to facilitate the sharing of information with other community health care professionals, and to bridge the gap between the hospital and community sector is another suggestion by the Department of Health (1997) in its unpublished review of Public Health Nursing. The review committee (Department of Health 1997) recommended that mobile telephone and pagers and personal alarms would enhance the communication and effectiveness and to improve the security of PHNs. Anecdotal evidence would suggest that this type of practical support is not widely available to the PHN on the ground. Suggestions for improvement in communication include utilisation of information technology systems and shared care protocols, among healthcare professionals.
A Swedish study employed a triangulation of methods to explore the nursing service provided by district nurses and the dilemmas that occurred in the course of practice (Timpka et al 1996). The significant findings in this study were those dilemmas that occurred in the coordination of care. Community nurses expressed dissatisfaction with time spent following up on shortfalls in service provided by other practitioners. Care decisions taken with insufficient knowledge of home situation and without consultation with community staff was one example of shortfalls. One of the key recommendations made by nurses in this study was the need for smaller geographical areas for each nurse. The study also recommended closer cooperation with other health care providers as the type of change most urgently needed in community nursing services.

2.1.3. PHN staff/client ratios

The organisation of patient care may be practice or patch based. Tinsley (1998) explains that basing determines the client population for whom care is provided. Community nurses may be allocated to a geographical patch or may be allocated to a particular practice. Largely, the model that exists in Ireland is patch based with community nurses for the most part allocated to a specific geographical location. The public health nurse may be required to collaborate with a number of general practitioners and other health care providers as determined by the geographical area. There are some pilots of practice or specific group allocation for example, the travelling community. In other countries such as the United Kingdom, recent decades have seen a revolution in the organisation of community nursing with the development of team and corporate caseloads.

Tinsley (1998) studied various methods of organising community nurse services in the United Kingdom where practice based allocation is commonplace. This study reviewed six pilot projects specifically to evaluate the effectiveness of various methods of organisation. They concluded that no system is perfect and that a successful management system can be achieved using a practice or geographical area approach. Significantly the researchers did uncover evidence of increased teamwork and morale through practice allocation. The Cumberlege report as cited by the Audit Commission (1999) states that there are a number of disadvantages to community nurses being attached to GP practices. These include the possibility that some healthcare needs may be unrecognised and the lack of integration between the voluntary and healthcare services. The Commission on Nursing (1998) and the Department of Health (1997) advocate that PHNs remain focused on a geographical area. The Primary Care Strategy (Department of Health and Children 2000a) recommends that in the future the arrangement of primary care teams will be determined by geographical spread in addition to needs assessment of the population.

Traditionally, nurses were allocated according to the number of beds in a hospital or in the case of PHNs, the number living in a particular community. The ratio of PHN to population varies from 1:2,500 to 1:5,099 (Department of Health and Children Nursing Policy Division 2002c). The population of the Galway Community area is 209,077 (Government of Ireland 2002). There are currently 63 full-time
equivalent PHN positions, plus 9 school nurses. This translates to one PHN per 2,903 persons in the region. In urban locations the client ratios may be significantly higher than in rural regions with less dense populations. However, despite lower numbers travel times are increased in visiting clients in more isolated locations.

This literature review found that public health nursing service is largely demand led with nurses making efforts to juggle the frequency and duration of visits depending on caseload and levels of patient dependency (Burke 1986; O. Sullivan 1995; Department of Health 1997). This method of determining the number of public health nurses underlies the assumption that everyone has equal need of this service (Hanafin et al 2002). The Review of Public Health Nursing (Department of Health 1997: 26) recommends that the system of assessing the number of posts of PHNs should be determined by specific needs criteria and population ratios. The needs criteria should take account of local demography, population density, socio-economic conditions, the terrain to be covered, and community and social supports available locally. Specific population needs are beginning to be addressed. The recent Traveller Health Strategy (Department of Health and Children 2002a: 75) stipulates that “each full time designated PHN should have a caseload of no more than 150 Traveller families” and that cognisance of levels of dependency, living environment and geographical dispersal should be considered when deciding the PHN: Traveller family ratio. Hanafin et al (2002) provide compelling argument that the composition and provision of the Public Health Nursing service must be determined by the need of the community so that the service is equitable for all.

2.1.4. Referral systems

Public Health Nurses, like the District Nurses in the UK (Audit Commission 1999) have an open referral system. The Audit Commission (1999: 21) describes an open referral system whereby “anyone can be referred to it and patients are seldom turned away”. District Nurses in the UK receive 40% of their referrals from the General Practitioner and 24% from Hospital Staff. A further 13% of referrals were either self-referral or from the carer (Audit Commission 1999). In Ireland, 80% of referrals to PHNs were from General Practitioners in the 1975 study (Department of Health 1975). Hayes et al (1992) suggest that there continues to be a high referral rate from GPs to PHNs, and data from the Director of Public Health Nursing in the Galway Community Care area indicates that GP referrals have increased from 4,943 in 2000 to 6,554 in 2002 (Malee 2003).

O’Sullivan (1995) reported that the lack of written referrals impacted on the PHNs’ ability to manage their workload. Referrals received often lack essential information about the patient’s condition (O’Sullivan 1995; Audit Commission 1999) contributing to community nurses’ difficulty in managing their caseload. O’Sullivan (1995) suggests some practical solutions to improve the referral process including written referrals and standard discharge paperwork for those under 5 or over 75 years. The unpublished review of Public Health Nursing (Department of Health 1997) recommends the notification
to PHNs, of all children under 5 years of age, discharged from hospital. Progress has been made in the area of notification of newborn discharges with hospitals mandated to notify PHNs within a defined period (Department of Health 1994a). The Commission on Nursing (1998) suggests the facilitation of direct referrals by PHNs to other professionals such as speech therapists.

2.1.5. Future developments

The Department of Health Strategy (2001b) reflects the consumer demand for a seamless service, with improved integration between hospital and community services. Reductions in length of hospital stays, technological advances in care delivery, and increased population demands has placed further pressure on community nursing workload (Department of Health and Children 2001b). Furthermore, changes in immunisation guidelines, in addition to demand for increased health promotion activities, are just some of the variables impacting on workload issues for this group of health care workers (Department of Health and Children 1999b; 2000b). Recent Department of Health reports such as the National Children Strategy (Department of Health and Children 2000b); Primary Care-A new direction (Department of Health and Children 2001a); the Traveller Health Strategy (Department of Health and Children 2002a) and the Report of the Working Group on Elder Abuse (Department of Health and Children 2002b) will further impact on the role and responsibilities of public health nurses.

Public health nursing is a complex service with an extensive remit, which may be incompatible with the size of caseloads (Chavasse 1995). Future years may see shortages of PHNs. The Nursing and Midwifery Resource Final Report (Department of Health and Children Nursing Policy Division 2002) cautions that there is potential for shortages in the number of PHNs due to ageing, unless numbers recruited to and retained in the profession increase. The Health Strategy (Department of Health and Children 2001b) advocates a re-orientation of services towards primary care. The Department of Health in the “Primary Care: A New Direction” report, indicates the potential requirement for an extra 2,000 community based nurses and midwives to provide the desired 24 hour nursing service in locally based teams. The National Economic and Social Council, in their review of community services, recommended a re-assessment of the nurse/population ratios, re-organising work patterns to provide a 24 hour service and lastly to increase clerical support to the PHN service (National Economic and Social Council 1987). The report also recommended that RGNs and nurse’s aides should be involved in home nursing services. Recent years have seen the introduction of other nursing disciplines in the community. General nurses are employed in some areas. Community midwives in a very limited number of care areas are engaged in the provision of a home midwifery service.

2.2. Assessment of Workload/Productivity

The purpose of this study is to examine the role of the public health nurse and the workload that dictates the parameters of that role. In the literature regarding workload, productivity and workload are used interchangeably.
“Productivity is defined as the contribution toward an organisational end result in relation to resources consumed” (Bain 1982 as cited by McNeese-Smith 2001: 7).

McNeese-Smith (2001) interviewed thirty American hospital based nurses to ascertain their views of productivity. Nurses described their productivity in terms of quantity; (working hard, doing extra work, teamwork) and quality (process and outcome). Benefiel (1996b) ascertained the opinions of 360 American home healthcare managers, on the knowledge and skills of productive community nurses. The nurse managers identified 35 areas of knowledge and abilities, which are categorised as practice management, communication, client/family management, knowledge/skills maintenance, written documentation, home healthcare knowledge and nursing process. Health promotion is not independently categorised and this limits its utility as a suitable tool for Irish community nursing.

Workload assessment is “an attempt to predict the nursing time and skills required to provide nursing care” (Hughes 1999: 317). There are many difficulties inherent in measuring nursing workload. Nurses do many tasks simultaneously, and multitasking can be difficult to measure (Endacott and Chellel 1996). The physical aspects of nursing are relatively easy to observe and measure. Many workload measurement tools document direct nursing care (patient centred nursing care activities) but fail to document the indirect nursing care (activities carried out away from patients and can include activities done in preparation for patient care, communication with other healthcare staff, organising services etc). Fundamental but less tangible aspects of the role, like caring and health promotion are even more problematic. Research in the USA (Schuster and Cloonan 1989 as cited by Marek 1996) demonstrates that home care nurses spent 70% of their time on indirect nursing care, as compared to 30% on direct nursing care. Jakonen et al (2002), in their documentary analysis of Finnish Public Health Nurses’ workload diaries, provide insight into the complexity of this indirect-care. They described actions such as acting as an intermediary between patients and other healthcare professionals, negotiating and consulting with the multidisciplinary team. Methods of assessing nursing workload may be categorised as activity based or dependency based (Hughes 1999).

2.3. Activity Based Workload Measurement Systems

A number of activity-based systems have been developed worldwide to measure workload.

2.3.1. Number of visits

The easiest, least complicated method is simply to record the number of PHN visits. Traditionally, assessment of community nurses’ productivity focused on the number of productive visits per day (Churness et al 1991; Benefield 1996a-b). Granfield (1992: 38) described a productive home visit as “one in which the client was at home and public health nursing service was rendered”. The information yielded from such a measure is limited. Critical information on aspects of care concerning the acuity level of the client, the complexity of nursing care given or the quality of the care (Benefied 1996a-b), is not captured.
Evaluation of community nurses’ productivity should focus on the effectiveness and organisation of the care activities as well as efficiency (Benefield 1996a).

### 2.3.2. Workload diaries

Many researchers used work diaries, either structured or unstructured, to analyse the activity of community nurses (Burke 1986; Jenkins-Clarke et al. 1997; Chan et al. 2000; Jakonen et al 2002). Workload diaries may also be used to ascertain with whom the community nurse liaises, as illustrated by Chan et al (2000). Some researchers (Jakonen et al 2002) used content analysis to analyse diaries, while others used quantitative methodology. Variations in approach and differences in data collected can render some approaches unreliable. Lynn (2002) designed a simple, easy to use, time-based information system to record how long nurses spent with patients in an outpatients and day therapy unit. The tool comprised 5 time bands for patient treatment/ nursing intervention, varying in length from 20 minutes to 2 hours. This traditional patient classification tool was criticised for reducing nursing to a series of tasks.

### 2.3.3. Work sampling

Work sampling involves an observer recording at regular intervals the time spent by nurses on various activities. These activities may be recorded in minutes and categorised as direct care or indirect care related activity (Flynn et al 1999). Self-reporting, such as is used in workload diaries, is less accurate and less expensive than work sampling (Urden and Roode 1997). Work sampling requires direct observation by a third party and can be time consuming. It can be seen to be the most accurate method of collecting information on what people do at work. It can, however produce a Hawthorn effect in sample participants and bias the quality of the data collected.

The strength of activity based systems lie in their ability to measure the tasks that nurses actually do in the course of their work. The major limitation of activity based systems is that they focus on care given and ignore the unmet needs of the patient/ community.

### 2.4. Dependency-based Workload Management Systems

Dependency is often referred to as ‘classification’. Patient classification systems are defined by Giovannetti (1979: 4) as “the categorization of patients according to some assessment of nursing care requirements over a specified period of time”. Endacott and Chellel (1996: 39) differentiate between patient and nursing dependency and define patient dependency as the “assessment of a patient’s ability to care for him or herself, for instance with regard to feeding, personal hygiene and mobility” (Endacott and Chellel 1996: 39). In contrast, nursing dependency is defined as “the patient’s total need for nursing care including education, rehabilitation and psychological care”. The number and acuity of patients/ clients is the principal determinant of nursing workload (Walts and Kapadia 1996). Patient dependency tools usually focus on tasks- e.g. need for hygiene, and physical
care such as injections etc. They can overlook the psychological care or the support needs of carers, which are important considerations in community nursing. Patient dependency systems in the community focus on the need for care and are sometimes known as caseload-weighting tools. There are thousands of patient classification systems, particularly hospital focused and they may be categorised as prototype or factor systems (Huber 2000).

### 2.4.1. Prototype patient classification systems

Patients are categorised according to the average care they require and these categories are hierarchical in the prototype classification system. The characteristics of the patients in each category are described. Walts and Kapadia (1996) categorise patients on the number of nursing hours required. Freeman et al (1999) developed a district nursing dependency tool in which patients are categorised in terms of care need. i.e. Long-term/ palliative care, rehabilitation care, administration of prescribed/ requested treatments only and treatment of technical procedures only and educative/supportive/ advice. Each patient was reviewed to ascertain the frequency of visits required on a monthly basis and the length of visit required. Scores were allocated to the frequency and the length of time, and patient dependency was calculated by multiplying the two scores. This tool has not been tested for validity and reliability. The Dutch Patient Classification System (Algera-Osinga et al. 1994) categorises patients according to the type of care needed, the expected number of visits per week and the total length of the service provided. This tool is undergoing further development, as there was a lack of homogeneity between the duration of home visits and the different care type.

One of the limitations of the prototype classification system is that the categories may be so broad that different patients within the same category may require different amounts of community nursing service. This can limit the ability of the Prototype system to predict the number of visits or the duration of visits. Algera-Osinga et al (1994) suggest that a factor classification system might provide a better insight into the nursing workload and can be integrated with a complexity of nursing scale to determine the nursing skills required.

### 2.4.2. Factor patient classification systems

The factor system utilises critical indicators of nursing care, to represent the direct care requirements. Time and motion studies are utilised to measure the time required for these critical indicators. Huber (2000) states that adjustments for indirect nursing care are included in the factor patient classification system. One major criticism of the factor system is that of reductionism and that it is task focused and does not represent the holistic role of the nurse.

Churness et al (1991) developed the VNA-LA/USC Home Health Patient Classification System, a factor patient classification system for community nursing in the USA. The time calculated for each activity was recorded during observation of home visits during the development of the tool. Churness et al (1991:20)
acknowledge that “a weakness in the system is that at best only 46-64% of the variation in length among home visits has been accounted for.”

Peters (1988) as cited by Hays et al (1999) first developed The Community Health Intensity Rating Scale (CHIRS) which has since been refined (Hayes et al, 1999). CHIRS aims to determine the intensity of a client’s holistic need for care and is developed around four domains; physiological, environmental, psychosocial and health behaviours. These domains are the same used in the Omhaha Classification system for community nurses (Martin and Scheet 1992; Hays 1995). Each parameter is rated individually and an overall rating is also given to the client.

This American tool has been tested for content validity and concurrent validity among a variety of different client groups (Peters 1988). Interrater reliability has been reported by Peters (1988) as 78%, and Hays (1992) also reports good interrater reliability with kappa values ranging from 0.43 to 0.86. Hays (1995) undertook a retrospective study of 44 randomly selected high-risk prenatal clients and 42 high-risk infants, applying the CHIRS to the discharged clients’ records. The aim of the study was to ascertain if the intensity scale aids in predicting the amount of community nursing required. Data were collected on the number of nursing visits and nursing effort. The amount of variance in the number of Public Health nurse visits was statistically significant with the CHIRS for the high-risk infants ($R^2 = 0.073$ $p = .013$). Regression between the CHIRS score and nursing effort was statistically significant for both the high-risk infants and the prenatal clients. The limitations of this study include the small sample size and the retrospective nature of the study. No evidence has been found to show that this tool was ever used in Ireland or the UK.

2.4.3. Caseload versus workload

The role of the nurse in the community involves more than the management of a caseload. Caseload is the total number of cases for a healthcare worker while the workload is the caseload plus a number of other activities, which would include the indirect nursing care (Orme 1995). One of the limitations of this method of analysing workload is that it focuses solely on the direct nursing care and not on the necessary indirect care, which may include case conferences, record-keeping, travelling time etc (Orme 1995). District Nurses and Health Visitors in the UK are being asked to do caseload profiling. However, a recent review of the district nursing service in England and Wales demonstrated that district nurses rarely do this (Audit Commission 1999). Caseload profiling, as described by the Audit Commission (1999), is a systematic review of a district nurse’s caseload and profiling the age, gender, frequency of visits, patient dependency and care packages. Caseload profiling facilitates workload measurement and better management of caseloads (Audit Commission 1999). Caseload profiling is used to prioritise needs of a total caseload and to monitor trends in behaviour.
2.5. Measuring Case/Workload in the Irish PHN role:

the Easley-Storfjell Instrument

The role of the PHN in Ireland is a generalist role, combining home health nursing, care of the elderly and childcare issues as well as health promotion for the community. The approaches to workload measurement in the Irish PHN service to date have been focused around the collection of quantitative data on the activities of the working day. The role of the PHN is very broad and complex and any tool that aims to assess patient dependency, will require a multitude of factors, from child health to care of the elderly. If a tool contains too many factors, then it is cumbersome and not user friendly. In contrast, if crucial factors are not included, then the tool will fail to predict the amount of public health nursing service required. The ideal workload measurement tool for PHNs needs to be easy to use, yet measure the direct and indirect nursing care. As the role is so broad and complex, qualitative data are required, drawing together the main concerns, knowledge, values, and interventions as well as the activities of the day.

The Easley-Storfjell Instrument for Caseload/Workload Analysis (CL/WLA) is a very comprehensive tool combining assessment of direct and indirect nursing care, i.e. caseload analysis as well as workload analysis (Albrecht 1991). This tool has been used in the USA and Canada since 1997. The CL/WLA facilitates a nurse to describe her caseload according to time, type of intervention and complexity of care. The amount of time is rated from one visit or less a month to three to five visits per week. Complexity of care is categorised from minimal, moderate, great or very great. This complexity rating is used across the six variables in the patient classification system:

- Clinical judgment required or assessment needs
- Teaching needs
- Physical care needs (technical procedures)
- Psychosocial support needs
- Co-ordination and care management needs
- Number and severity of problems

This tool has been tested for validity and reliability in the USA (Albrecht 1991) and has been revised by Anderson and Rokosky (2001). The level of complexity was increased from four to five points and criteria have been developed for each level within each category. The Easley-Storfjell instrument provides a framework that will need modification for Irish public health nursing, but one that is capable of capturing both direct and indirect components of the work.
2.6. Conclusion

“The key to the provision of the public health nursing service is to understand the need of the service at the point of delivery” (Hanafin et al 2002:69). This review of the literature did not yield extensive information about the role of the Irish PHN, making research that would expand specific knowledge even more relevant. Chavasse (1995) proposes that the role of the PHN in the community should be at a macro level rather than the micro and task-orientated one described in the DOH (1966) Circular (27/66). The Audit Commission (1999) does recommend that caseload profiling in the UK would assist National Health Service trusts to make estimate regarding workload generated and resource allocation. Irish community work practices are in a period of development, and debate on the actual workload of PHNs is timely. Increased understanding of the nature of the work of PHNs will assist in future planning. Hanafin et al (2002:72), in their insightful paper on the issues of equity in the service, state “There remains a need to find a solution to the overwhelming demands on PHNs, stemming from the increasing level of technical knowledge required to meet all the needs that they may encounter in the working week.” The need to determine exactly what PHNs in the Western Health Board are actually required to do, and what they wish to do, provides a sound rationale for this study.
Chapter Three

Methodology

3.1. Introduction

This chapter sets out the aims of the study and describes the setting within which the research was carried out and the methods used to gather data. The development of the research instruments is described and the methods of data management and analysis used are explicated. The care that was taken to address ethical issues and to ensure the validity and reliability of the findings is presented and discussed.

3.2. Aims of Study

- To undertake a study of the community nursing services in Galway Community Care area with a view to clarifying the role of PHNs.
- To identify, modify and develop a caseload workload measurement tool for nursing professionals working in the community.

3.3. Objectives

- Identify the significant issues relating to team working within the nursing community.
- Identify the significant issues relating to communication within the nursing community.
- Clarify the roles of nurses working in the community.
- Explore and describe the role of the Public Health Nurse in Galway Community Care area.
- Generate data that would contribute to the development of a workload measurement tool for Public Health Nurses.
- Develop and test a tool to measure caseload/workload among community nurses.
3.4. Research Methodology

A number of research methods were used in this study, employing a triangulation approach (Begley 1996; Morse and Field 1996) to ensure confirmation and completeness of data. Both quantitative and qualitative methods were used; person and space triangulation was also utilised to enhance the generalisability of the study’s findings. Investigator triangulation was guaranteed as the research team included representatives from general nursing, community child psychiatric nursing, mental handicap nursing and midwifery, which should improve the study’s credibility. Two members of the team also had relevant specialist knowledge at Master’s degree level, one holding a MSc in Public Health and another an MA in Community and Primary Health Care.

3.5. Methods

3.5.1. Qualitative methods

3.5.1.1. Group interviews
A meeting with key stakeholders, mainly PHNs, Senior PHNs, a Director of Public Health Nursing and representatives from the Nursing and Midwifery Planning and Development Unit, Western Health Board, was held at the commencement of the study to explain and agree on the methodology and expectations, to identify key people from each area to be interviewed and to arrange a schedule of visits. A partnership approach between the research team and the project steering group was crucial to the success of this study. Regular meetings took place between key stakeholders and the research team to update and amend research methods and approaches as the study progressed. Some of the information gleaned from these meetings was also documented, with permission, and used as data to inform the study findings.

3.5.1.2. Observation
Visits to 9 health centres provided opportunity to observe and document facilities, records and working practices, which contributed to an understanding of the context within which PHNs were working.

3.5.1.3. Individual interviews
Semi-structured interviews were conducted with 21 PHNs, 2 RGNs, 1 Senior PHN and 1 school nurse PHN, based on issues identified from the literature. Results from the initial analysis were used to develop the selected caseload measurement tool and to adapt it for use in this specific population. Further analysis led to the development of the qualitative findings, which enlarged upon and illuminated the quantitative results.

3.5.2. Quantitative methods
Caseload analysis was carried out in agreed locations, on agreed personnel, using the previously identified, developed and pre-tested workload/caseload measurement tool. A major part of this study was concerned with the thorough testing of the tool to ensure its validity and reliability, in order that it may be
used with confidence throughout the area in future. To this end, a number of evaluation questionnaires were also included for the PHNs to complete, in order to generate quantitative data on the usefulness and acceptability or otherwise of the tool.

### 3.5.3. Setting
The community care area in the county of Galway comprises of an urban area (Galway city) and two types of rural area; east Galway, which is well populated and, by contrast, the under populated western region of Connemara. The Aran islands are also included in this community care area, and pose their own special challenges.

### 3.5.4. Population
There are 63 full-time equivalent PHN positions in this area. They are assisted in care-giving by a number of registered general nurses employed within the region.

### 3.5.5. Sample
Purposive sampling was used for the qualitative part of the study; i.e. participants who have an expert knowledge of the topic are requested to take part in the study. A target of approximately 20 respondents was regarded as being adequate in order to achieve data saturation. In the event, 21 PHNs and 4 other nurses were interviewed, following identification by the steering committee of PHNs, who were the originators of the research and who continued to play an active part in monitoring and facilitating the research process. This report relates only to the results of the interviews that are pertinent to the aims of the study, i.e. the role of the PHN.

It was intended that the respondents should be representative of the different geographical aspects of the county of Galway, thus an even spread of respondents from urban (Galway city) and rural sites (both from east Galway and Connemara) were chosen. Also, one respondent from the Aran islands was interviewed. All interviewees were volunteers in that they were asked to participate by the steering committee, but were free to refuse. All participants were reminded again at the start of the interview that they were free to withdraw at any time, to ensure that they were willing participants. For the quantitative part of the study, 29 PHNs were involved in using the Community Client Need Classification System over a period of two weeks.

### 3.5.6. Qualitative instrument - interview schedule
The interview schedule (Appendix 8.4) was constructed in order to reflect the aims of the study and the related literature (O’Sullivan 1995; Department of Health 1997; Boarder 2002), and included areas such as barriers and enablers to good communication, team working and opinions on community nursing service delivery. The guide contained both specific questions and prompts that were designed to elicit
more detailed information. Although the guide was used as the framework for the interviews it was a loose structure that was flexible enough to allow respondents to lead the interview in directions that were not always accounted for by the guide; thus richer, more varied data were obtained. Furthermore, the sequencing of the questions was often led by the interviewee as is the nature of semi-structured interviews (Hollway and Wheeler 2002).

### 3.5.7. Quantitative instrument

#### 3.5.7.1. Identifying research tools

Following an extensive review of the literature, a number of potential caseload/workload analysis tools were isolated. Many tended to be uni-client group focused; school nursing, home health nursing, care of the elderly (Burt et al, 1996; Hayes et al 1997; Anderson and Rokosky 2001), which did not suit the unique role of the Irish PHN. Other tools used to classify patients/clients in community settings have included systems that explore the issues highlighted in Table 3.1.

The revised Easley Storfjell Patient Classification Index (ESPCI) (Allen et al 1986; Anderson and Rokosky 2001) was identified as the tool with the greatest potential utility for this study. This instrument clearly attempts to capture the issue of the intensity of nursing interventions required by clients in receipt or in need of nursing interventions within a community context. Both the direct and indirect aspects of care are well addressed by the tool and the issues of travel time, liaison with other professionals, educational activities and community development are also considered. Permission was sought from the tool’s developers for its use in research and education with acknowledgements.

### Table 3.1 Caseload Workload Measurement Systems

<table>
<thead>
<tr>
<th>Caseload Workload Measurement Systems</th>
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<tr>
<td>Rehabilitation Potential (Daubert, 1979)</td>
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<tr>
<td>Health Status (Ballard and McNamara, 1983)</td>
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<tr>
<td>Nursing Diagnosis (Hays, 1992, 1995 and Peters, 1988)</td>
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<tr>
<td>Nursing Interventions (Algera – Osinga, Halfens, Hasman and Wiersma, 1994; Churness, Kleefel, Onodera,</td>
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<td>and Jacobson, 1988, Saba et al., 1991, Saba and Zuckerman, 1992)</td>
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<tr>
<td>Patient Problems with related outcomes and Nursing Interventions (The Omaha system; Martin and Scheet,</td>
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<tr>
<td>1988)</td>
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<tr>
<td>Broad Based Patient Needs (Allen et al., 1986; Stafford, Scemons and Jones, 1997)</td>
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</table>

(Anderson and Rokosky 2001: 57)
3.5.7.2. Consultation with experts

A visit was undertaken to Banbridge and Craigavon Health and Social Services Trust for discussion with personnel who used a similar tool. The key issue that emerged from this visit was recognition of the complexity of the PHN's role in the Republic of Ireland which, in comparison with their UK colleagues, incorporates the two roles of health visitor and district nurse. It was very apparent that it would be necessary to make a number of modifications to the Easley Storfjell Patient Classification Index to ensure its appropriateness for use by PHNs in an Irish context.

3.5.7.3. Construction/modification of the caseload/workload classification tool

Throughout the study, re-reading of the literature and constant liaison between the members of the research team and the steering group influenced the construction of the tool. The process was similar to using constant comparison, which added robustness to the qualitative findings while adding validity to the construction of the tool (Strauss and Corbin 1998). Feedback from the initial findings from the semi-structured interviews also contributed to the development of the workload management tool.

The first modification made to the tool by the research team was that of contextualisation, as much of the language used in the revised ESPCI (Anderson and Rokosky 2001) was American in focus. Two of the researchers modified the language used in the tool to ensure its utility in an Irish context. The tool was also renamed the Community Client Need Classification System – the rationale for this name change was based on the reality that PHNs work with and manage the care of clients from a variety of client care groups, not all of whom are "patients".

The original Easley-Storfjell instrument for Caseload / Workload Analysis (Anderson and Rokosky 2001) covers six criteria which include the use of clinical judgement, teaching needs, psycho-social needs, case management, physical care needs and the number and severity of nursing problems presented by a client. Three extra categories were added as a result of the semi structured interviews carried out by researchers exploring practice issues with PHNs and RGNs in the Galway Community Care Area.

3.5.7.4. Addition of new categories

The new categories, 'child and family support', 'health promotion' and 'environment', were designed to capture the unique aspects of the role of the Public Health Nurse in Ireland, which differs from the role of home health nurses in USA and Canada, or the roles of the district nurse and health visitor in the UK. The 'child and family support' section was designed to capture those aspects of the PHN role that include the monitoring and surveillance of children at risk and the provision of education with regard to parenting skills, as well as family support for children who have behavioural difficulties. The literature and the qualitative data both suggest that health promotion (including parent-craft, neonatal care, child health screening, breast-feeding support, promotion of immunisation, metabolic screening and accident prevention) is a central focus of the role of the PHN, which required its inclusion as a distinct category.
The assessment of clients’ housing conditions as well as the making of representations to environmental health officers and to housing departments on behalf of clients, was an element of the PHN role that was not described in the Easley-Storfjell. (Appendix 8.16).

3.5.7.5. Assessing content and face validity
Following the adaptation and modification of the tool, the content validity of the tool was examined during a workshop on the tool conducted with members of the Steering Committee in Galway. Subtle modifications were made by the PHN experts at the workshop. For example, hospice visits were removed from the original tool and bereavement visits were added. Changes regarding the weighting of certain nursing activities within the classification system were made in an attempt to put a context on the public health nurse’s work as applied to the tool.

3.5.7.6. Assessing reliability
The research team then requested that members of the steering group submit scenarios regarding clients for whom they care, from a variety of client care groups. Members of the research team and members of the steering committee, through a process of telephone conference, discussed the use of the tool in these scenarios, to ensure that the tool could be used for all client groups, to clarify any further gaps in the tool and to enhance validity. To assess reliability, each PHN taking part in the education workshop (section 3.5.9.2.) was given the same scenario to score independently, using the tool. The named pre-test scores was placed in an envelope and sealed. Each PHN that was involved in using the tool in practice for 2 weeks was then asked to score the same scenario using the tool at the end of the 2-week period (See pre and post test scenarios, Appendix 8.17). Unfortunately, only 11 research participants took part in both the pre and post-test exercise, and the 2-week study period. A kappa score of .17 was recorded indicating a low level of agreement; this would need to be tested again using a larger sample of PHNs who are familiar with using the tool.

Inter-rater reliability was measured by assessing the percentage agreement between raters for the acuity levels and overall clients’ scores. Seven of the 11 research participants (54%) were in agreement as to the needs level of the client on the pre-test measure. It was also significant that 10 (76.9%) of the 13 research participants rated the client within two needs levels, banding 3 and 4.

In the post test exercise agreement levels between raters was slightly lower at 46.2%, or 6 raters, agreeing on a needs level of 3, and 38.5%, or 5 raters, agreeing on a needs level of 4. Again, 11 of the research participants (84.6%) rated the client within two needs levels, banding 3 and 4. One potential limitation as to the levels of percentage agreement between raters could be explained by a month delay between the time of running the educational workshops and the actual study.

Different researchers measure inter-rater reliability differently. Churness et al (1988) determined consistency of measurement by calculating the percentage of agreement between two groups of nurses.
Percentage of agreement ranged from 33% to 100% for the different variables within the tool and only 33% of the variables fulfilled the criterion of 65% percent agreement. Anderson & Rokosky (2001) reported both percentage agreement and Cohen’s Kappa for both staff nurses and investigators for the Revised Easley-Storfjell Patient Classification Instrument (R-ESPCI). In their study, staff nurses’ percentage agreement increased from 36% (kappa= -.15) to 52% (kappa= 0.04), similar findings to the above.

3.5.8. Pilot study

One PHN from outside the health board area was interviewed, with her permission, in order to test the semi-structured interview schedule. No changes were found to be necessary following this interview.

A pilot study of the Community Client Need Classification System was carried out with 8 Public Health Nurses in the Dublin area, who offered valuable input into the further development of the tool. The minor modifications made at this point were structural, in terms of the presentation of the data collection tools, as opposed to content issues. As a result, some categories were broadened and a number of the questionnaires and data collection instruments were amalgamated. Other inclusions were made in an attempt to portray aspects of the PHN’s role not already captured by the tool in its raw state. The pilot study also helped the research team to improve the overall presentation of the client need classification system and the data collection instrument that would be utilised in the study.

3.5.9. Data collection

3.5.9.1 Qualitative interviews

The majority of the interviews took place in a room in the workplace of the participants, generally the local health centre or clinic. Three interviews took place in a room in the local hospital, which was convenient for interviewer and interviewee alike. Each interview lasted between 45-60 minutes. All interviews except one were recorded on a standard tape recorder that was placed in a convenient location to pick up both voices. In one instance, the interviewee was extremely uncomfortable being recorded and effectively refused to speak when the tape recorder was on. In this case, the interview was continued but not taped and notes were made by the researcher from which a brief transcript was later reconstructed. Participants were also asked to complete a demographic questionnaire, including questions on gender, professional qualifications and levels of professional education, number of years working as PHN, age profile and location of work, which was also used for participants in the caseload analysis component of this study (Appendix 8.07).

3.5.9.2. Quantitative data collection

Caseload/workload analysis was carried out in agreed locations with the assistance of 29 PHNs, over a period of 2 weeks, using the previously developed and modified Community Client Need Classification
System. Prior to the data collection period, two workshops with the PHNs in the Galway Community Care Area were arranged in order to introduce potential research participants to the Community Client Need Classification System, and to explain the use of the data collection instruments. There is little evidence from other studies as to how nurses who engaged in such projects were taught the use of the previous versions of caseload/workload measurement tools. The revised ESPCI (Anderson and Rokosky 2001) had reported a 50 to 80% agreement between raters and the Kappa coefficient agreement in the same study was low at 0.04, indicating a slight agreement only. It was felt that education regarding the use of the Community Client Need Classification System should improve the inter-rater reliability of the tool. Forty PHNs attended two workshops on two separate days. The tool was fully explained and each nurse was given the opportunity to practise using the tool, using the scenarios that had been created collaboratively between the steering group and the research team.

3.5.10. Additional data collection

Three other questionnaires were administered in order to gather data on the PHN’s extended role and to assess the utility of the tool and the PHNs’ satisfaction with using it.

3.5.10.1. Summary of client contact sheet

All PHNs were asked to record the time they spent on both direct and indirect care, for each client, during the two week period. Some PHNs were able to delegate work to RGNs so this RGN time was also recorded. Participants were also asked to document unmet needs for their clients. This questionnaire facilitated the calculation of the amount of direct and indirect time that a PHN spends with each client. To ensure consistency with the Community Client Need Classification System, the client’s details were recorded using the same client number, the client care code and the client’s total need score. Clients had the same client number for the duration of the study, which was a number known to the PHN only and not to the researchers.

3.5.10.2. Activity worksheet

Some PHNs spend time on non-caseload activity such as Health Promotion Programmes, community development and committee work. All PHNs were asked to record the time spent on such activity during the two weeks of the study as well as the number of hours worked, annual leave and overtime. The PHNs in the steering committee for this study recommended that we ask PHNs to document the total time spent travelling and the non-caseload activity such as care-taking and ordering stationery. The numbers admitted and discharged from the caseload was also recorded by the PHN. Each PHN involved in the project completed an activity worksheet which quantified their overall work activity over the period of the study (Appendix 8.18).

3.5.10.3 Satisfaction with tool

A combination of closed questions, Likert scales and open space responses were utilised in order to garner PHN views regarding the use of the tool in practice (Appendix 8.07). A summary of all the above documents is presented in Table 3.2.
Table 3.2 Research Instruments and Explanatory Documents

<table>
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<th>Research Instruments and Explanatory Documents</th>
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<tr>
<td>Semi-Structured Interview Schedule</td>
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<tr>
<td>Scenarios for Pre- and Post- Test Exercise</td>
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<tr>
<td>Briefing Letters</td>
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<tr>
<td>A Guide to using The Client Need Classification System</td>
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<td>Client Need Classification System</td>
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<td>Questionnaire to PHNs re. Client Need Classification System Tool</td>
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<tr>
<td>Activity Worksheet for PHNs</td>
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<td>Summary of Client Contact Sheet</td>
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3.6. Qualitative Data Analysis

All interview tapes were transcribed by executive officers in the School of Nursing and Midwifery Studies and imported into the NUDIST computer package for analysis. Written notes from observations and from the group interview were also documented and included as required.

Although the intention of this data analysis was not to derive a theory from the data, the approach used was consistent with the initial steps of Strauss and Corbin’s approach to grounded theory (Strauss and Corbin 1998).

All 21 of the PHN interview transcripts were scanned and segments of data (lines, sentences or paragraphs) were then analysed and given labels. This led to the identification of some 500 different initial coded labels, which were then grouped together where similarities or common characteristics existed, to form concepts. The labels were at all times compared across the data and the content or the labels of certain concepts were altered as the analysis reacted to the new data that was being generated, in the process known as constant comparison (Holloway and Wheeler 2002).

These concepts were further grouped into categories and the contents readjusted as the initial results were altered to incorporate new data. Eventually, the large number of initial codes was reduced to 19 categories, which were further grouped into four main themes. Information gleaned from the group interview and from the observations was included within these themes as appropriate. The initial findings from the semi-structured interviews and observations were used to inform the development of the selected caseload measurement tool, and to adapt it for use in the context of community nursing practice in the Galway area.

3.7. Quantitative Data Analysis

Quantitative data were analysed using The Statistical Package for the Social Sciences (SPSS) Version 11 (Pallant 2001). Data were entered into SPSS, coded and analysed using descriptive statistics. Some nonparametric inferential tests were also conducted, where appropriate (Chapter 5).
3.8. Ethical Issues

Ethical approval for this study was received from the Ethics Committee of the School of Nursing and Midwifery Studies, Trinity College. The authors adopted the International Council for Nurses' (1996) six ethical principles of beneficence, non-maleficence, justice, fidelity, veracity, and confidentiality. Letters were sent to all relevant personnel in participating centres, inviting voluntary participation. The research participants who agreed to be interviewed were given information on: the purpose, potential risks and benefits, explanation of data collection procedures, time commitment, an offer to answer any questions, voluntary participation, voluntary consent, assurance of confidentiality and researchers’ contact details, before being asked to sign a written consent form. The confidentiality of participant responses was maintained by numerically coding participant names and storing data in keeping with the Data Protection Act (1988).

Consent to participate in the quantitative component of this study was achieved implicitly as PHNs volunteered to take part in this study by the return of the completed research instrument pack to the research team, following participation in the information and education sessions. The clients who were classified using the Community Client Need Classification System were allocated numerical codes to preserve their anonymity.

3.9. Validity and Reliability

The credibility of this study was improved by triangulating data sources (Begley 1996), which led to not only an improvement in the validity of the Community Client Need Classification System, but also to the enrichment of the findings through the presentation of qualitative data.

Testing of the content and face validity of the quantitative instrument and efforts to ensure its reliability have been described (sections 3.5.7.5. and 3.5.7.6.). Further modification can now be undertaken as a result of the recommendations of this study, with a concomitant increase in the validity and reliability of the tool.

Three approaches were adopted to assure the credibility and robustness of the qualitative data for the final report. Firstly, two researchers coded the transcripts independently of each other and then discussed the resulting analysis to increase “dependability,” or “consistency” (Appleton 1995). A third researcher then acted as an auditor before the final results were written up. This dependability and “confirmability” of the data are enhanced by the provision of an audit trail (Koch 1994), which allows the process of data collection and analysis to be replicated by another researcher (Polit and Hungler 1999). The audit trail kept contains brief field notes and memos relating to the data collection and also records regarding data analysis and the emerging themes were kept. Peer debriefing was also carried out (Mariano 1995), where the two researchers conducting the qualitative section were questioned by the rest of the research team to explore their potential biases and to check the basis for the interpretations made.
Secondly, participants’ narratives have been used to illustrate themes (Jasper 1994) in the final report, which should enhance “transferability” or “applicability” (Appleton 1995) through some of the rich, ‘thick’ descriptions of the PHNs’ experiences. Thirdly, and most importantly, the credibility of the data rests on the presentation of the results of the qualitative study to the overall group of public health nurses. Presentation of the initial results was made in the spring of 2003 and there was general agreement with the results, with some particular exceptions. This feedback was incorporated into the draft report presented to the Steering group of the project in October 2003. The feedback from that meeting was included in the final report. This process of ‘member checking’ (Koch 1994) is regarded as the most important approach to establishing the credibility of qualitative data (Lincoln and Guba 1985).
Chapter Four

Qualitative Findings

4.1. Introduction

This section presents the results of the qualitative section of the study. The demographic details of all participants are described. Four themes emerged from the semi-structured interviews that sought to explore the public health nurse’s role and the issues that were of concern to public health nurses in the Galway area. The first theme ‘Jack-of-all-trades: the role of the PHN defined and described’ explicates the details of the role of the PHN and describes what the PHN did, how she did it, where the boundaries of the role lay and the intensity of the work involved.

The second theme ‘The essence of the role’ conceptualises the role in terms of its completeness, holistic elements, trust between PHN and client, and job satisfaction of the PHN. This theme is concerned not so much with what the PHN does in technical terms (which was the domain of the first theme) but with the values that drive it, and the PHNs’ conceptualisation of their archetypal role in the community. Theme three ‘Challenges to the role of the PHN’ focuses on the challenges that face the PHN in the future in the form of the supports required to enact their role and the challenges ahead to the broad role of the PHN. Theme four ‘Communication’ deals with how challenges to communication exist between team members, other disciplines and management, and communication systems required for the administration of client services.

4.1.1. Demographic details

Twenty five nurses took part, all of them female, of which 22 completed the questionnaire on demographic details. There were 20 PHNs and two RGNs. The minimum age group was 25-30 years and the maximum was 61-65 years. The largest group of participants (n=22, 88%) were aged equally between 31-35 and 41-45.

The mean experience level of working as a PHN was 12.5 years (S.D 10.82), with a minimum working time as a PHN of one year and a maximum of 30 years. On average, respondents had worked in their present community area for 7.2 years (S.D. 8.96), 13 in rural settings (59%), eight in urban settings (36.4%) and one in the island setting (4.5%).

Nineteen respondents reported that they held a Diploma (86.4%). Two respondents held a degree (9.1%) while one respondent was educated to certificate level. A total of four nurses (18.2%) were currently undertaking courses, two PHNs were undertaking courses at Master’s level while one PHN was undertaking a degree and one RGN was undertaking a computer course.
4.2. Jack of all trades: the Role of the PHN Defined and Described

4.2.1. Care groups
The first major category of data to emerge was that of the clinical role of the PHN, which was concerned with a variety of care groups, providing nursing care ‘from the cradle to the grave’. As one PHN commented:

“The Public Health Nurse is a very general family nurse as it were, covering …..the frail to the baby.” (23)

Broadly though, the PHN deals with two core groups: mothers and children, and the elderly. Direct PHN involvement with people in their middle years was generally small, but those with physical disabilities, intellectual disabilities or with mental health difficulties did require their services. The level of service provided by the PHN to these groups varied depending on the supports available from the specialist services.

4.2.2. Clinical care
This role involves direct clinical care, the importance of which was emphasised by the respondent who stated that:

“…the public health nurses are often seen as managers, but they also have a duty of a hands-on role as well.” (15)

This was elaborated as:

“dressing bedsores, giving injections, monitoring blood pressures.” (15)

The role also involved monitoring of children and adults who were at risk or potentially at risk, and assessment of clinical care or support requirements by clients, and screening children and adults.

“it could be something as simple as somebody who lives on their own, (a) home help might make the difference of keeping them at home rather than needing residential care.” (1)

Screening for child development required seeing children at 1, 2 and 3 years for developmental and speech and language assessments as well as the “heel prick test” (11) (Guthrie test) for newborn babies. This role vis-à-vis babies has increased, because of the early discharge of mothers and infants and the increased birth rate.
“(we) have to visit the babies five days post delivery, so that includes examining the mums and the babies and giving health promotion education and talking them through any problems (such as) feeding.” (11)

Despite the dichotomous nature of the job, it appeared that most PHN areas were either mainly child focused (urban and suburban) or mainly elderly focused (rural).

4.2.3. Hidden role

PHNs reported a hidden role, that is much time spent on supporting care with phone calls and clerical work; said one:

“If you had a problem family there would be a lot (of) ringing, a lot of phone calls and that would be just one case.” (10)

Another noted counselling as part her job, saying:

“I spend an awful lot of time doing invisible nursing” (2)

by which she meant counselling and spending time with people.

4.2.4. Public Health Nurse as “Jack of all trades”

The characteristic feature of this category of data was that the public health nurse has to have many and varied skills and be prepared to pick up and carry on care when other members of the team are not available, as previously found by O'Sullivan (1995). Thus, in the ordinary course of events, the PHN will refer clients who require occupational therapy or physiotherapy support, or who might need services from the mental health or intellectual disability sector, but the PHN will try to fill the gap if these services are not available. As one PHN stated:

“An awful lot of nurses allow themselves to be the pick-up person.” (2)

“I think a number of other professions have viewed us as a catch all and we have allowed that to happen” (2)

Within their scope of practice, several PHNs were prepared to take up the work of other team members in order to meet clients’ urgent unmet needs. The following was not an isolated comment:

“...the occupational therapist has such a long waiting list at the moment, that we end up ordering equipment so we can say at least that our client has got their bed or whatever, and wait for the OT to see them at a later stage.” (15)

A further comment was:
‘I think the OTs do a lot of just assessing and then leave it to the Public Health Nurse to actually order, be it cushions, ....different types of frames, raised toilet seats’ [20].

Despite engaging with others to ensure clients’ needs were met, it was emphasised that PHNs did not stray outside their scope of practice. One PHN described her interface with other professional groups in the following terms:

‘Well I do think, I can only speak for myself, and I would speak for my colleagues, we would just keep within the role we wouldn't definitely be entering into the role of the physiotherapists, we would relate to them, and refer to them and definitely wouldn't interfere in any way, and we would seek their advice, if it was that area that we would need their advice’ [17].

The concept of the PHN as a jack of all trades was crystallised by the nurse who used that phrase and complemented it by describing the PHN as a “general factotum”; she further noted that if there was a problem the management thought “the public health nurse will sort it.” (3)

4.2.5. Advocacy

Several respondents noted that this multiplicity of roles included acting as the clients’ advocate. One commented that her duties involved

“...report writing on social issues, as in housing issues, as in over crowding, as in poor housing, doing battle with environmental health officers, doing battle with the housing section, trying to get extensions for disabled people.” (3)

Another noted how she had to fight the cause for travellers to obtain services:

“No, there is a social worker that deals with the travellers but, no....in my area I deal with them and they themselves as travellers have specific needs. Many times you are fighting their cause, you are looking for maybe equipment for them, you are advising them where to get extra services, writing to the urban council to get them housing to get them housed.” [17].

Indeed, dealing with marginalised groups and advocating for them was an important aspect of the PHN work for some respondents. With regard to disabled children another said:

“Well from when they are babies until they are school going you do all the things you do for normal children, plus the added thing of you know, assessing them for easiness of appliances and incontinence wear, make sure they get to the clinics, that they are.....getting the proper services they should be getting like you know, speech therapy and
that is, that's a problem you have to keep after it, make sure they get it, we're not always successful at that either.” [24].

This approach to advocacy culminated in the respondent who saw her responsibility as empowerment; she said:

“I think that we should be empowering them, I'd prefer to be empowering them and encouraging them to do it for themselves.” (20)

### 4.2.6. Work overload

The PHN’s tendency to pick up the work of others and the open ended nature of the job, were some of the factors leading to perceived work overload. One respondent stated that

“people might stop you in the street (to consult you).” (25),

indicating that people thought you were always available. Although many participants suggested that they kept to a 39-hour week, out of hours working was a problem for some; one nurse commented:

“It has happened on numerous occasions that PHNs bring home their records and do all their paperwork in the evening.” (15)

The increased workload was attributed by some to recent demographic changes that had led to “a population burst” in some urban areas resulting in perceived deficiencies of care:

“sometimes you feel swamped, you want to give your clients time but you are conscious there are other people you have to see.” (15)

Three respondents thought that the changes in demographics required changes in the distribution of PHNs. For example, one said:

“the areas have to be looked at to see exactly what kind of clients are in the areas and do the areas need to be divided up? or should there be two Public Health Nurses in the one area, or more RGNs or more Locums in the area?” [15].

This situation led to comments such as:

“we probably don’t give (clients) as much support as we should.” (25)

The need for extra help from others such as RGNs was identified; also the ubiquitous need for secretarial help was very clear. The common nursing anthem of the need for more staff, and problems with sick and
annual leave cover being inadequate was echoed in some of these interviews. One PHN analysed the overload problem thus:

“ I think it is incredibly simple, I think we just need more PHNs.” (22)

The pressure of work overload meant that many PHNs were unable to engage in health promotion, which they saw as their primary role; this was brought in as an add on to other more pressing work such as giving direct care. Along with this there was the view from some that “our true potential is not being realised” and that sometimes this leads to burnout. To sum up the work of the PHN one noted:

“it’s a hard, hard job.” (2)

4.2.7. Health promotion

This was universally seen as being a vital, if not the vital, aspect of the work of the PHN, a view presumably also held by the Department of Health and Children as outlined in recent reports (Department of Health 1994; 1996; Department of Health and Children 1999a; 2000a; 2000b).

'Macro' health promotion was conceptualised in terms of visiting schools, setting up stop smoking classes, classes to promote breastfeeding or other health initiatives. This was a relatively rare activity that was relegated to a low priority, ostensibly as a result of an excessive workload. However, one PHN indicated there might be hidden reasons for this when she explained that she was reluctant to speak in public.

“I have to say I am not very confident about getting up and giving talks……
I would do it about once a year.” (24)

One PHN had co-operated with others in the area to establish a play school that functioned both as an assessment setting and therapeutic setting for children who were “slow” or from disadvantaged backgrounds. This project had grown and been nurtured by the PHN over the years and was clearly an example of good health promotion practice. Some other examples of good practice such as parent and toddler group, and breastfeeding support service were noted but they tended to be the exception rather than the rule. One PHN organised a ‘smear clinic day’ where women came to the clinic for a smear test, a cup of tea and health promotion was incorporated into the dialogue that followed; this seemed an imaginative approach.

'Micro’, or opportunistic, health promotion was seen as involving education of clients during ongoing interactions, which had a different primary purpose. It was a part “of every interaction” as one PHN (16) put it. It might be presented during a dressing procedure or with a family member in the home setting, with the advantage that information could be focused according to a client’s needs and background. One respondent commented:
“you could say that every single day that every house you go into you’re promoting health.” (20)

Examples of what opportunistic health promotion meant in practice were activities such as advising the elderly regarding minimising risk in their house, advising about diet or giving up smoking. This informal approach to health promotion was to some extent seen as part of the job but also conceptualised as occurring because there was no time to set up formal arrangements because of the pressures of work overload. Health promotion was seen as a more cost-effective way of deploying PHNs:

“You are actually saving money down the way really ’cos if a child is detected early ..... you don’t have the problems later on, you know even abuse and things like that, you can actually in a way prevent a lot of those things happening ..... it's really dealing with issues before they explode.” (21)

“I think we have to raise our profile in terms of something quantifiable, some sort of tool to actually show the health promotion work that we are doing.” (7)

Despite the PHNs' view of the importance of health promotion, their perceptions were that it was not valued and supported by “the powers that be,” that is “the Department of Health”. It was felt by one respondent that programmes such as

“stop smoking and healthy eating, and positive parenting have long term implications but .....the facilities aren’t there to deliver them.” (3)

4.2.8. The education of student PHNs.

This was commented upon by two respondents, both of whom were negatively disposed towards educating students on account of the extra workload, despite recent publications highlighting this aspect of their role (Department of Health and Children 1997; 2000a). One catalogued the learners thus:

“(we have) student PHNs with us, student RGNs and Gerontology students and sometimes medical students with us as well.” (15)

4.2.9. The generic versus the specialist role

There was some uncertainty regarding how the role could currently be described, one respondent said, “we are specialist generalists” (1) which was defined as “knowing what to delegate and who to delegate it to” (1). This was elaborated upon by another respondent who thought the PHN would manage the overall community nursing scene and link to the specialists; she noted:
“it'll be a more generic community nurse and that she will feed into a specialist nurse for specific needs for a client.” (16)

One telling argument for the retention of the current balance between specialist and generic forces was from an experienced PHN who explained:

“So you have the one person going in and you'll find that in (these) areas you have public health nurses who are there for 20-30 years, so they are seeing generation after generation, and they have the history of that and that is unique……….. So they almost become like a mother to the family…. a surrogate.” (16)

4.2.10. Scope of practice

This was an issue only for the data derived from the PHN who worked on the islands who described her duties thus:

“I'm at the coalface for every single problem that comes, be it a social problem, be it a medical problem, be it a nursing problem, either curative or prevention, be it physiotherapy, speech therapy, dental referrals, people coming looking for suturing, people having accidents, people having drowning incidents, people looking for transport to get onto the helicopter after they've had an accident, calling the lifeboat, escorting people to the mainland that are too sick to go on their own or go with a carer.” (4)

Because she was the only nurse/medical person on the island she had to deal with all such problems at all times of the day and night, as has been described previously (Garavan et al 2001). This nurse also carried out the screening of school children, health promotion clinics, as well as social activities that would not ordinarily be in the remit of the land based PHN.

4.3. The Essence of the Role

The second major theme to emerge from the data concerned the essence of the role. Five aspects to this theme were found, two related to care, and holism, trust and the satisfaction inherent in the job were the other three.

4.3.1. Total care

The approach to care was described by one PHN as being “curative” (4) that is restorative, related to the ancient concept of the nurse as healer. Others noted that care extends across the social divide; thus travellers, asylum seekers and refugees obtain care from the PHN. Indeed the PHN role is potentially all encompassing as one PHN noted:
“in relation to clients we see all categories, nobody is refused a service, so in relation to the clients it's difficult, there is nobody we don't see....(sigh) and we do provide a service, we do and try (to) facilitate clients, I find it difficult to see what we don't do.....” (16)

This dedicated approach to clients comes across through much of the data but is typified by the PHN working in a rural area that mainly looks after the elderly and

“elderly at risk....... would be those that would be (in) poor social circumstances, isolated conditions, living in isolated and particularly (in) bad weather you know (there is) a lot of flooding so they'd actually be cut off from maybe other households and I would go visit them on a regular basis to make sure they are okay ” (20)

The archetype identified here is the mother of the community, a local female deity. One PHN commented, “my main job is the nursing care of everyone in the area.” (24), a truly gargantuan task.

4.3.2. Care priorities

Ideally all groups received the requisite care and time was also available for health promotion and other community related activities. That state, however, did not often occur as demand for the PHNs' services often outstripped time available; therefore choices had to be made. Several examples of the type of choice that had to be made were:

“I would prioritise by our daily diary and at the moment ...I would have a number of daily calls and naturally enough they would be put into the diary for a day or so ahead and our worksheet as well - there are certain calls that could be maybe withheld for a day if the next day was going to be very busy.” [25]

“Health Promotion sometimes is left towards the bottom end of the scale.” [15]

“Well, I would look at where the greatest need is and I would work accordingly from there.” [17]

“The ideal is health promotion and health education and it's done in a very ad hoc, but it is secondary, it's of secondary importance, primary importance is home nursing, is terminally ill patients, bed bound patients, Alzheimer's and the numerous leg ulcers.” [16].

Most agreed that the acuity of need determines the priority of a client’s needs. Thus the elderly at risk, people discharged from hospital needing dressings, the terminally ill and bed bound patients received priority attention from the public health nurse. One other priority group exists and that is the neonate and his /her mother. As one PHN noted:
“mothers and babies must be seen within 24 hours of discharge from hospital and visited up to the fifth consecutive day.” (15)

Those who receive support from other agencies or who have support networks in place are classed as low priority; these would include children with learning difficulties, people with mental health difficulties and some low-need elderly. Some respondents explained that during times of crisis when demand for their service was high, routine screening would be postponed.

4.3.3. The holistic role

The concept behind this category was summed up by the respondent who noted that

“...our aim, I suppose, is to provide a holistic service to all care groups.” (25)

The overall focus of care is the client, according to the respondents in this study.

“I do think Public Health Nurses are very client focused.” (1)

stated one; another opined:

“I think we cannot lose the client focus.....it has to come back to that.” (16)

This strand of thinking seemed to be the foundation of the PHNs’ approach to their work and has been noted also in the review of public health nursing (Department of Health 1997). Whatever other duties might be required, the client was paramount. As noted above, the clients were potentially the whole community, but in actuality they were those in need at the time.

The method of care giving that the PHNs deployed was of interest. Firstly, it was mostly care given in the client’s own home. This created a different context because the setting was one where the client was comfortable and also because it meant the PHN had to establish the relationship on what was, for her, foreign ground. One commented:

“...you are a guest when you visit the home, and one has to be accepted first...it’s a process of arriving and being received and finding our way through to the family.” (23)

This concept of establishing a relationship with the family in their own home required a holistic approach if it was to work, clearly simply doing the physical nursing was not sufficient. An RGN described the process:
“they want me to have a cup of tea with them and chat, you know? And, it's amazing what you learn from them, as I said before, as regards their worries and their problems and the difficulties that they have.” (18)

4.3.4. Trust with clients

In the community, the nursing process seems to require far more in the way of relationship building, through which assessment of all the client’s problems becomes possible. The nature of the relationship between the client and the PHN leads on to the development of trust, a fundamental element of all nursing processes, but perhaps enhanced in public health nursing. This seems to be because relationships may last for long periods and also take place, as noted above, in people’s homes. In regard to this, one respondent noted that such relationships (between client and nurse) take time, they are “gradually developed and built up” (23). As noted above, each PHN has spent on average 7 years in her current position, and so would have had ample opportunity to build such relationships.

“In all these systems it is important to find the Public Health Nurse and for her to develop a trusting relationship with the family, listening very closely to what the person is saying, and trying to meet them in some way to help them to cope in a compassionate and caring way. We are there in most crisis situations in families .... whatever the problem may be, whether it is an alcoholic problem or whether a social problem of some kind, I feel that it is so important that they often find a person that they know, rather than a new person coming in that they know nothing about, I feel that the trust is developed and the Public Health Nurse has a unique role to play.” (23)

“You have to build up trust. If people don't trust you they are not going to tell you their problems, so you really want to be seen that you are listening to them and that you have their best interests at heart and that you'll do your best for them.” (15)

The nature of the relationship at its purest was articulated by two PHNs who worked in rural areas and had many years experience in practice. In the context of care of a terminally ill patient, one spoke of "journeying" with the client and his family, and spoke of the ramifications of interactions with one member of the family on the others. Another described being “a friend of the clients I look after” (22). These PHNs articulated something close to the essence of the PHN ethos of holistic care.

4.3.5. Job satisfaction

Three respondents commented positively about this aspect of the work and although many commented negatively about some elements of the job nobody offered the opposite of the comments presented below. One PHN said:

“I love my job and I love the idea that people can see me as a resource.” (4)
Another, commenting on the role of the PHN being uncertain in a time of change, said:

“I think it’s important not to throw the baby out with the bathwater, and I think we have quite a good baby.” (2)

At the end of a lengthy interview, one PHN reflected on her work and her life and stated:

“I must say I’ve been very happy in my years. I feel these years are just flying, I won’t even have time to turn around and I’ll be retired (laugh) time goes so fast, you’re so busy, but it’s a kind of very fulfilling kind of business, everything you do is of some help to somebody, you’re never interfering in a negative way it’s always a positive, that’s bound to have an effect on you, on yourself.” (24)

4.4. Challenges for the Future

The third theme conceptualised “challenges for the future.” Four main categories emerged from the data, namely:

- The PHN’s role in the primary health team
- Multi-cultural and demographic changes
- Hierarchy and management style
- Developing the vision

4.4.1. The PHN’s role in the primary health care team

There was a general consensus that the role of the PHN should be managerial in nature with the RGNs carrying out a lot of the clinical work that they (the PHNs) had formerly carried out, particularly the routine nursing care for the elderly. One PHN commented of the future:

“I would like to see more RGN help and more…..we’ll say home helps, as I say we have an excellent home help here and you can see the difference.” (10)

Another noted:

“The role, I think, just specifically the role, the professional role would be certainly the leader of the nursing team in the community with managerial delegating.” (1).

There was a desire for co-ordination of the service that was client/patient centred in its approach and a working environment that was supportive in nature. There was also a realisation that client needs were changing and that the service should therefore change:
“The future? .....I would see that clients, more clients being discharged from the hospital early. Their needs are going to be greater. We probably would need flexible hours instead of 9.30 to 5.30 and the nursing care to be 24-hour working shift, you know?”

(18)

The majority of PHNs see the future as working as part of a primary care team, which concurs with recent reports advocating development in primary care (Department of Health and Children 2001a) one PHN stated:

“I think we will change to primary care teams so I do, but where the Public Health Nurse is going to be in that I don’t know. I would hope that she would have some managerial role d’you know because I think she is a coordinator.” [20].

Such teamwork was welcomed by participants in this study, but also created anxiety as to the exact role of the PHN in the primary care team and the perceived lack of support to enact this role in the future.

“I would like to think that the role of the Public Health Nurse should be seen as a managerial role in that there should be someone to manage it, you can’t have all these people working and no-body co-ordinating it and I think the Public Health Nurse should be co-ordinating it.” (20)

It was suggested that further preparation and training for the role of co-ordinator would be required as one way of supporting the PHN in the future, and that this would involve further educational input especially in the area of team working. In addition, more modern communication systems would be required. There were no computers or access to the Internet in any of the clinic sites that were visited by the team, and no access to databases relating to patient’s needs or their assessment of needs. Indeed many of the clinics were inadequate for the intended purposes, as one researcher observed when coming upon a clinic:

“The building was small; it contained maybe five or six small rooms [no apparent waiting room]. It was sixties built with a corrugated iron roof, it looked as if it was barely habitable”

(analytic memo 6).

There were also very little or no secretarial services, which presents further challenges for developing team-work.

“There would need to be structures in place that would allow for this communication ..... again back to my baby about computers, if people were better able to communicate with each other, the telephone, fine, (it) is okay but it does have its limitations.” (1)
“We do an awful lot of administrative work that’s not ours, but what can you do, here there is no clerical back up…..we do an awful lot of writing, an awful lot, a third of our time at least is spent writing, no secretarial support…..you’re meant to be out of here at half ten, you don’t get out, and if you come back in the evening you know it’s all writing or whatever.” (10)

Sharing of cases between allied health care disciplines with the possibility of having more case conferences and case discussion regarding the management of care was suggested. There was also the issue of realising that other disciplines are now working in the community, in terms of mental health and learning disability services, and that a reassessment of the PHNs’ care groups needs to occur in order to avoid overlap in roles of community nurses.

“...we do some work with mental health disabilities and learning difficulties that we say are under our umbrella, but they’re not really under our umbrella, so we should actually say ‘these are our care groups and this is what we’re actually targeting’, do you know, and ‘this is our key work’.” (3)

Given that the most recent job description of the PHN (Department of Health and Children 2000a) does not mandate a specific role in psychiatry or learning disability, some clarification is required to ensure that the most suitable health professional cares for each client group.

4.4.2. Management style

There was a perception that nursing had a history as a hierarchical discipline, which, through insisting on conformity rather than creativity, has hindered the further development of the profession and has resulted in a lack of vision on behalf of its members. The communication difficulties with management that are part of this phenomenon were emphasised by the respondent who explained that “when you sit around a table with management [for a meeting] you know you get their back up and then you know you’ve blackened your name” [6]. Another respondent indicated that ‘they [management] don’t take on board a lot of the things [that are said to them]’ [2].

Respondents described an authoritarian approach on the part of their managers:

“It's very old fashioned, it's very authoritarian, it's, I think it's way behind and I don't think they actually take.....when you go out into the community, certainly your qualities aren't taken into account......Our group meetings are very authoritarian, just to mention. It's very much: They are at the top, we are at the bottom.” (12)
This type of approach has been found in other studies of nursing, but is not as evident in studies of other health professions (West et al 1999; Cott 2000). There was a desire on the part of these participants to see nursing move on from having an authoritarian approach, to a management style that was more facilitative and collaborative in nature. An aspiration was also expressed to have total quality management for both staff and client care where everyone was supportive of creating a vision for the future. However, there was also recognition that not all experiences from the past should be discounted and that some reflection on the positive aspects is required.

“...a lot is that low self esteem, the kind of thing tied in with a lot of nurses. I actually think what we are doing is very good and I know when I came to Galway, I was really impressed at how hard people worked, I’d say they did the work of a health visitor and a district nurse sister in the one day and would keep going, and I don’t think we want to lose that.” (1)

There was a desire for a system that was flat rather than hierarchical, as this would improve working relationships both at local and national level, where each PHN had a voice in the decision making process relating to the provision of care in the community.

“I’ve come up with working in you know, a more hierarchical structure, so to shed that, and to become you know, a more level playing field, that you have all the people on the same level.” (16)

“…you’d find yourself, you are nearly going back to Florence Nightingale, dead and buried for years, right.....it mightn’t suit, what you’re saying, but it needs to be said and the whole thing of the authoritarian approach, going back to my student nurse days and I was always in trouble. I have reared a family, I am saying 'Mother of God what is this about?' Even when they hold meetings, you know, sitting up at the top, surely we should have moved on from that.” (13)

There was a perceived ‘lack of support [for the PHNs] from management’ [12] as well as a misapprehension on the managers’ part of the reality of the workload. Another respondent stated:

“They don’t understand on the floor actually how busy it is, because maybe they worked on the floor before but things have changed a lot.” [11]

Also of note was the lack of formal mentoring/supervision for staff. For example, one PHN said:

“Ther's no appraisal about your work and how..... you as a person, what your good qualities are and develop them, there's none of that.” (12)
Additionally, there was a perceived lack of strategic planning with regard to PHN personal and professional development.

“I think, number one, if our management saw themselves as actually our support, I suppose it’s a whole retraining. You do see team leaders with the social workers and the support system they’re getting...” (13).

There was a desire for supportive and creative systems to be put in place and for more integration and collegial support between colleagues through team building and the introduction of clinical supervision; however, there was also recognition that individuals have a role to play in their own education as well.

“Support also, educational support. I feel that there is constant changes out there, ..... there’s very, very little time to actually sit down and read up on research, follow up on things and I think the support from .....an education department within the Public Health Nursing system. Also support, I think this is where we actually ourselves have to come in, support from each other as in, say, the likes of a literature group or journal club.” (6)

“We’ve no clinical supervision other than us handing in more and more statistics. If we have clinical supervision, it’s not of a great standard because they’re actually...it’s nannying, you know.” (2)

In the light of the negative comments made by two respondents re teaching student nurses in the community, and the lack of response from the other participants (4.2.8. The education of student PHNs), it is not surprising that that expressed lack of interest in teaching continues throughout a PHN’s career and is reflected in poor clinical supervision of more junior staff.

4.4.3. Multi-cultural and demographic changes

The PHNs had anxieties relating to the demographic and sociological changes within a multicultural society over which they had no control, in particular the large increase in the number of people seeking asylum.

“Well I suppose it’s through no fault of anybody, it’s the system that has just lent itself to all of this, I couldn’t blame the health board for all of this, those people came in, they had to be housed, they had to be put somewhere, and they happened to be in a particular area, but.....it’s just, we people on the ground, we do what we can, but it’s often extremely stressful, .....there could be more hands on, there could be more services put into place.... it’s coping with all of this, it’s a change for us and it’s traumatic and it’s also stressful.” (7)
There was a sense that change was imposed through legislation and policy and that the PHNs are far removed from the decision-making processes regarding their role. It is as if, due to being politically inactive, they felt a sense of powerlessness. The impact of technology and advances in the assessment and treatment of medical conditions has led to early discharge of clients back to the community as well as to the discharge of terminally ill clients who require multi-agency input. These changes have occurred without any cognisance being taken regarding the impact that they might have on community services, and the extra numbers of PHNs required. Hanafin et al (2002) report that the public health nursing service has largely remained unchanged since 1966. One respondent commented:

“Well, in order to restructure you have to look at your whole community profile, you have to start from scratch and .....you actually have to look at the whole service, what do we do and how do we go about it and what our day involves and what is the staff complement you need in relation to your population.” (6)

It is apparent that the PHN works in a multicultural society where the needs of vulnerable groups such as travelling communities and asylum seekers require consideration. The World Health Organisation (1999) is committed to ensuring access for all vulnerable groups. The implementation of this vision requires a needs analysis of the population so that workforce planning can occur simultaneously.

4.4.4. Developing the vision

There is an anxiety that the management system does not share the same vision as the PHNs in practice.

“I think I feel what we’re lacking is management structure with a vision, you have to be terribly aggressive to get what you want in terms of budgeting and all the rest of it .....we are so task led that actually we never stand back and say, what actually are we doing and why are we doing it?” (2)

The challenge for the future role of the PHN is the enactment of this vision where some PHNs feel empowered to create this vision while others feel overwhelmed with the pressure of daily work.

“I think that we ourselves are in the place to create the vision, because I feel that we are the ones on the ground and we would know what we would like, not maybe where management are because, to be honest, they see us in a different light and it’s very hard to plan for somebody else.” (8)

“I would say with great conviction, an increase in the public health nursing service, an increase of the nurses, I think they have a lot to offer, we’re in a wonderful position
to deliver a quality of service, a quality of care, that I do know, first hand, that people appreciate very much.... generally (we need) just more help and guidance and liaison with a team in the community, it would help the public health nursing service, a lot.” (7)

4.5. Communication

The fourth theme conceptualised the whole area of “communication”. Four main categories emerged from the data, namely: the interactions of the PHN between nursing team members, between other disciplines, with nursing management, and the referral system.

4.5.1. Interactions between nursing team members

The changing role of the PHN makes for extra demands on her to have the necessary facilitation skills when delegating to other nurses in the team as well as having the interpersonal skills required for team working and co-ordination.

“We have nine basic care groups, you know, we sometimes say eleven because we can divide some of the care groups into subgroups; so I think her role is very much a facilitation role with a hands on component to it, which I think is very difficult.” (16)

The slightly uneasy relationship between the PHNs and the relatively newly appointed RGNs in the community characterised discussions of their interface, a challenge that has been noted previously also (O’Sullivan 1995). One observation of the relationship between one PHN and one RGN in a rural health centre indicated that the PHN considered that the RGN was essentially a subordinate in the traditional nursing sense. Upon the researcher’s arrival in the mid morning a cup of coffee was offered by the PHN; however there was some difficulty finding the wherewithal and the RGN was instructed to fetch the component parts by the PHN. At no point did either question the power differentials inherent in the interactions, a common problem identified by Hugman, who maintains that the power structure in nursing is secure, because it is accepted by those in the lower ranks without question (Hugman 1991). This interrelationship was further classified by an RGN who noted of the PHNs:

“I think they felt that we were going to be a threat to them, you know? That RGNs would take over. So much like, care of the elderly, at risk, dressings and what were they going to do, you know? But maybe they are so long doing reactive work, that they probably will find it hard to change their role, and maybe the fact that they’re not used to delegating work, you know?” [18]

A PHN’s view was as follows:
“I personally don’t feel it [RGN’s role] threatening, I would see it being for some maybe, in some cases as in taking over a group because the RGN in our area is for elderly, and for elderly care and you could see if you wanted to look at it down that way that maybe she was coming in and taking elderly away from you and because her role is not very well defined role, that we do a bit of everything, it could be threatening in that way.” [20]

4.5.2. Interactions with other disciplines

There is a desire for effective case management between professionals involved in client assessment and treatment especially in complex cases where multiprofessionals are involved; for example, in the area of child protection.

“I suppose if you did have a client that you were particularly worried about, it would be ideal if all members that were involved in the primary health care team could have a meeting about this client to decide what to do.” (15)

There is a belief overall that for the communication system to improve requires coordination and case prioritisation relating to needs of clients, as there is a lack of seamless care between acute services and community care.

“I might have three or four waiting for her (the OT) and they’ll prioritise them.....there might be one down the road that she wouldn’t consider priority and she wouldn’t come to her that day, she’d come another day you know.” (24)

There is a desire for a team approach to client care that involves effective management of clients based on their needs. This would create a service that is less driven by reaction and care and would be strategically planned and proactive rather than reactive.

“.....I suppose everything, almost falls on the Public Health Nurse to decide the needs .... there isn’t really a coming together of all the team.” (19)

There is a belief that, as a result of ineffective communication regarding progress of clients and the needs of clients/patients, and due to lack of liaison, a great deal of time is spent on written communication. This is due to a dearth of computers and e-mail facilities as well as poor data sets.

“Well, the client’s notes, filling in those would certainly be over half an hour a day. Writing referral letters to people, there’s so many things, basically we’re here for an hour and half office work every morning and often a lot more than that but the minimum we would spend would be about eight hours a week, minimum.” (1)
The issue of stress and working in isolation impedes communication and effective team working.

“I think it’s a very hard job…..if you are working in isolation and carrying a caseload in isolation that in itself is very hard and you’re dealing with people who generally speaking have problems and stresses in their lives and maybe your heads could be rolled off and they wouldn’t notice.” (2)

“Stress and over stress and extra work load really, just too much of a heavy work hinders it (communication).” (7)

There were examples of both effective and ineffective communication between PHNs and other health professionals, similar to findings in other studies (O’Sullivan 1995; Commission on Nursing 1998; Department of Health and Children 2001a). The issue of having case discussions regarding clients on various professionals’ caseloads was considered to be an effective means of communication between different disciplines. There was also a strong argument for having the primary health care team on one site as a means of improving communication and effective team working and providing a quality service.

“A lot of our time is spent wondering should we do this, should we do that, ringing up or whatever, whereas if we were all in the one area we could have a conversation.” (14)

4.5.3. Interactions with nursing managers

Discussions around the respondents’ interactions with nurse managers brought up the issue of disempowerment and a culture of control, which were linked to a lack of job satisfaction and disillusionment with the system.

“…the problem with management. It’s very much, eh, there’s a certain bullying aspect still in it. There’s a certain kind of, eh, checking up attitude. This idea, if you finish half an hour early, if you leave early, you’ve to ring in, but yet, if you’re working on till about 6.30pm, you’re certainly not ringing in. Things like, eh, a lot of the work we do, like ordering equipment, that goes through management. They, I mean, we’re managers in the area, it’s a waste of paperwork, a waste of time and they’re not creative enough to see it – some of them are, but they’re in a system of, nobody’s able to take responsibility.” (12)

Over-control and bullying is present in most areas of nursing and midwifery in Ireland (Wynne et al 1993, Condell 1995, Commission on Nursing 1998, Frawley 1999, Begley 2002) so that it would not be unexpected or unusual to encounter the phenomenon in this population also. Nevertheless, the example above does not actually indicate true bullying, rather a culture of authoritarianism and lack of trust. It was notable, however, that five respondents requested that the tape-recorder be turned off while they were
discussing their interactions with nurse managers, for fear of repercussions. As these requests were honoured, there are fewer excerpts available on this issue.

A number of PHNs expressed that they did not feel empowered by management. The area involving child protection is particularly contentious, for example, when the PHN writes a report and the manager rewrites the report and presents it at the case conference.

“...they’ll rewrite a report for you, but when we do out a report then, very often it’s reorganised and there’s nothing drives me as mad as someone re-writing my English when I was quite right in the first place.....instead of actually a supportive environment it’s actually 'that sentence doesn’t work there, it works there’ and you know it worked perfectly well.” (2)

The role of the PHN on the islands presents a unique situation of isolation, which requires effective communication between the PHNs and their managers. There was evidence that managers are very accessible; however, the area regarding accountability and the PHN’s scope of practice at times left the PHN feeling vulnerable:

“I suppose, one thing that helps, although we are isolated geographically and you know miles and by sea, but at the end of the call .....one thing I can say .....over the years that they have been totally, totally accessible.....So they are totally behind us in one way and I mean, ok, they won’t cover us in the case of an accident if I gave out the wrong drug or something, but I do feel that they are very accessible.” (4)

4.5.4. Referral systems

This issue arose with regard to other professionals having referral systems in place and how this can be both positive and negative.

“.....most of the team do have proper referral forms, we don’t have a referral form.” (11)

This lack of a referral system in Irish public health nursing has been highlighted previously as an issue also (O’Sullivan 1995).

A referral system can potentially act as a means of recruiting more personnel due to a long waiting list; however, the concept of having patients /clients on waiting lists sits uncomfortably with most clinicians as the risks are increased. In terms of quality of care for patients, it is reminiscent of the double edged sword of being strategic in planning of services versus the human suffering that may occur; this causes ethical dilemmas for staff.
“In saying that if you make an application to a physio or particularly an OT they put it on the computer. They send you a letter saying they have accepted this patient and they will see them in due course. They may phone you up eighteen months later saying ‘is that person still looking for a service?’ So, I mean, while it protects their professionalism it might be professionalism that we wouldn't want to have as well, but I would like to think that we are a bit more accessible.” (2)

“We have no waiting list, there is no system ..... it's the nature of our work, that we can't put Mrs. Joe Bloggs down for a dressing next week when she really has to be dressed on a daily basis now she's after coming home from hospital.” (7)

The implications of the open referral system were described by one PHN, who noted that from the ‘public point of view it's great for them, but from our point of view....you never have enough time to say, well, I'll get to……. the end of the [client] list, kind of thing, so it can change your day an awful lot’ [11]. This example emphasises one of the difficulties associated with open referral, that it is difficult to plan care delivery because unexpected clients may simply arrive out of the blue. Furthermore the implication of an open referral system is that PHNs’ client lists may grow continuously. Communication systems are further hampered when PHNs are dealing with complex needs of vulnerable populations who have complex social and cultural problems.

“I have non-nationals at the moment and they had a baby that died. The non-nationals is a big issue at the moment and it’s a big problem. I had a couple in yesterday who had no English and eh, fine, we can use a translation service and they recommend it, but actually, she had a cousin there and he was very good.” (12)

The two tiered system where private patients are not referred to the PHN also creates for potential complications for patients, as postoperative complications may occur and the PHN can not plan ahead if a patient is then referred later on by their GP for follow up care.

“Well, eh, the referrals you get from the hospitals and that, the documentation we get is very limited, very brief, you know? They just tell you, eh, they don't actually explain to you how the patient is, you know. I keep the documentation itself, it's not enough to be able to make a full assessment.” (18)

More detailed, written referrals were suggested, similar to recommendations made in previous work (O'Sullivan 1995).
4.6. Summary

It is evident that PHNs in the Western Health Board strive to provide a holistic service based on a model of total quality care that is constantly hampered by outside constraints. The four themes explicated above describe the broad, all-encompassing role of the PHN that involves 'hands-on' clinical care for diverse client groups, in addition to a heavy administrative role that includes taking on tasks more suited to other health professionals or assistants. The challenges that face the PHNs in this area include an increasing role in the primary care team, changes in the culture and demographics of their client population, and a need to acknowledge and change hierarchical systems of management in order to develop a shared vision for the future. Communication systems and interactions between the nurses themselves and with all other members of the multi-disciplinary team require improvement in order to fulfil the aim of providing total quality care in the community.
Chapter Five

Quantitative Findings

5.1. Introduction

This section presents the results of the quantitative section of the study. The demographic details of all participants are described and the numbers and care groups of clients included in the testing of the tool outlined. An analysis of the assessment of needs, their classification and the unmet needs of clients that were documented was performed. Results include the hours worked by the PHNs, the distribution of their time and the figures for admission and discharges. The views of the participants as to how well the tool worked for them and its usefulness to the public health nursing service are also presented.

5.2. Demographic Details

Twenty-nine PHNs took part in this study, all of them female, with a minimum age group of 25-30 years and maximum of 61-65 years. The largest group of participants (n=14, 48%) were aged between 46 and 55 (Fig.5.1).

The mean experience level of working as a PHN was 15 years (S.D. 9.98), with a minimum working time as a PHN of 1 year and a maximum of 37 years. On average, respondents had worked in their present community care area for 9.6 years (S.D. 10.22), 18 in a rural setting (62 %), 6 in an urban setting (21%) and 2 (7 %) in both urban and rural.

All respondents were registered Public Health Nurses, 27 of whom (93%) held a PHN qualification, 1 held a Health Visitor qualification and 1 was a District Nurse. Six respondents (21%) stated that they had undertaken a Diploma course, although, as the PHN qualification has been at Diploma level since 1987, it is likely that more respondents hold Diploma level qualifications. One respondent (3%) held a degree and 1 other (3%) was undertaking a degree course. A total of 6 other PHNs (21%) were undertaking further study at the time of response in areas such as management, leadership, computers and Reiki.
5.3. Testing the Tool

5.3.1. Frequency of use

Each study participant was asked to complete the Client Need Classification Tool for all existing clients and for each new admission to the service. They were asked to repeat the assessment only if there was a change in client need over the course of the study. Twenty-nine PHNs tested the tool on a total of 1036 clients in their care, 144 of whom were new and 892 were existing clients. Each PHN that took part used the tool on between 1 and 21 new clients and on between 4 and 84 existing clients. Overall the Client Need Classification Tool was completed 1349 times. The overall frequency of Client Need Classification Tools completed per PHN ranged from 3 (lowest) to 167 (highest) and the mean usage per PHN was 5.8 on new clients (S.D. 4.88) and 38.8 on existing clients (S.D. 23.28).

5.3.2. The usefulness of the tool

All the PHNs used the tool with new clients and 18 (62%) found that it was useful in predicting the amount of input required, while 8 (28%) did not (Fig. 5.2). Twenty-eight participants (97%) used the tool with existing clients and 24 (83%) found it useful in predicting the needs of these clients, whereas 2 (7%) did not (Fig. 5.3). Twenty-one PHNs (72 %) found the tool useful in measuring workload and 6 (21%) did not.
Figure 5.2 The tool was useful in predicting the amount of input required for new clients

![Bar chart showing the distribution of responses to the tool's usefulness in predicting input for new clients.]

Figure 5.3. The tool was useful in predicting the needs of existing clients

![Bar chart showing the distribution of responses to the tool's usefulness in predicting needs for existing clients.]

5.4. Client Care Groups

Although all PHNs completed Client Need Classification Tools, the submissions of two participants had to be excluded for all following sections due to errors in their documentation.
The Client Need Classification Tool was used to assess 1349 clients from nine care groups (Fig. 5.4). Older persons (42.6%) and child health (29.4%) were the most frequently assessed care groups, accounting for 72% of all assessments of client need carried out across all care groups. Other care groups (10.7%) were the next most frequently assessed clients. Postnatal care (6.2%) and physical disabilities (5.9%) generated similar numbers of client assessments. The child protection care group accounted for the smallest number of assessments with a total of 7 (0.5%) over the two weeks of the study. Sensory disabilities (2.25%), mental health (1.1%), and intellectual disability (1.3%) groups also generated a very small number of client need assessments in the course of the study (Fig. 5.4).

5.5. Assessment of Needs

5.5.1. Criteria for assessment of level of needs
The tool has 10 assessment criteria to facilitate individual computation of total needs score and individual needs level score. The descriptor guide to using the Client Need Classification Tool (Appendix 10) was given to each participant to facilitate interpretation of the various needs levels in each criterion. Participants used the criteria to assess each client and omitted those criteria that were not applicable. Overall, the analysis indicates that level 2 was the most commonly selected needs level for each individual criterion.
The users did assess across all levels for each criterion, with apparently good discrimination between clients. The lower levels of need 1 and 2 were selected with the greatest frequency and the level selected least frequently was level 5.

5.5.2. Assessment levels used

Nursing judgment (n=1353) was the first criterion on the tool and was most frequently assessed at level 2 (30%). Some of the descriptive indicators used to explain a needs score of 2 in nursing judgments were 'routine nursing assessment' and 'routine developmental checks'.

The nursing problems (n=1243) were also most commonly assessed at level 2 (28.6%), indicating that many of the clinical interventions required were relatively uncomplicated. A need score of 1 (25.2%) and a need score of 3 (24.0%) was recorded by the PHNs in relation to the nursing problem criteria. Nursing problems as interpreted at level 1 required minimal nursing intervention, while score 3 indicates the client group were in need of more complex care. The clients who scored higher levels of need in the nursing problems category were the elderly (n=575), with level 3 recorded 139 times (24.2%), level 4, 110 times (19.1%) and level 5, 40 times (7%).

The physical care criteria (n=1186) were most commonly selected at level 2 (42.8%) across all groups. The descriptors for these criteria indicate that family may already provide a significant amount of physical care for clients. Alternatively, the physical care as described for level 2 may be episodic and feature activities such as simple dressings or injections. Level 2 was, once more, most commonly selected in the teaching need criteria (n=1174) at 42.2% and the psychosocial needs (n=1192) were also most frequently selected at level 2. Again the descriptor indicators for these criteria suggest that only a moderate amount of client support was needed in these areas.

Case management (n=1295) was one area where level 3 was most commonly selected at 34.4%. Descriptors for this level include caseload administration without secretarial support, or clients needing revision of care plans. The older person group did score more highly in this area with 48.9% of these clients at level 3 or higher.

Child and family support (n=559) was one of the criteria used least in the tool, with level 2 most commonly selected (37.6%). The descriptor for that level suggests that minimal support and education are required regarding parenting/child care.

The health promotion needs (n=1162) were primarily assessed at level 1 (20.4%), level 2 (46.7%) and level 3 (19.4%). The frequency of selection at levels 4 and 5 was relatively low (7.2% and 6.4%). The descriptors for these levels would indicate that health promotion with the majority of clients is primarily opportunistic.
The environmental factors (n=1183) were most commonly assessed at level 1 (46.6%) and level 2 (31.3%). The descriptors here suggest that client homes are generally in good repair, as far as can be seen by the PHN, without any apparent major safety risks to clients. The tool allowed an extra 5 acuity points to be attributed to travel times for client visits in excess of 20 minutes to provide a fuller picture of the workload of the PHN. The analysis indicates that for the larger portion of clients (63.4%) travel time was within 20 minutes, leaving 36.5% of client assessments requiring the 5-point weighting for travel greater than 20 minutes.

5.5.3. Total score

Participants were asked to score patients across the various criteria to reach the total score (Fig. 5.5). The mean of the total score attributed to clients was 20.3 (S.D. 7.54). The range of acuity points was 1-50. The tool has pre-determined point increments, which correspond with a level of client need, scaled from 1 (low need) to 5 (high need) on each criterion. The highest score attributed to an individual client was 45 and the lowest was 2.

*Figure 5.5 Total score*
5.5.4. Client need score
In making the assessment from 1 to 5, the most frequently selected level of dependency was 3 (Fig.5.6.). All levels were selected and the mean of the needs level score was 2.7 (S.D. 92).

Figure 5.6 Levels of need

![Levels of need graph with bars for each need level from 1 to 5.]

5.6. Analysis of Client Need Classification

5.6.1. Analysis per client care group
The PHNs were asked to assign each client to a client care group each time the tool was completed. These group descriptions are used in the Galway Community Care Area by PHNs for documentation of patient visits. All five levels of need scores were selected within each care group with the exception of intellectual disability (scored from 2-4) and child protection (scored from 3-5). Level 3 was the most frequently selected in the older person care group. In child health, the most common need score was 2. The number of clients assessed at level 5, with high need, was relatively low across all groups (Fig.5.7).
5.6.2. Older persons
The older person care group was defined as all clients over 65 years of age. The older person group comprised 42.6% (n=575) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 21.7 (S.D. 7.28). A needs score of 3 was most commonly assigned to these clients (Fig 5.8.).
5.6.3. Child health
The child health care group includes all services to children from birth to primary school entry. School children are all those of primary school age until they reach 18 years. School children are also categorised separately in the work of the designated school nurse. The child health group comprised 29.4% (n=397) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 19.1 (S.D. 7.32). A needs score of 2 was most commonly assigned to these clients (Fig. 5.9.).

Figure. 5.9. Needs Level of Child Health Clients

5.6.4. Post-natal care
The post-natal group includes all new mothers for clinical and advisory post-natal care. Antenatal care is all pregnant women who are receiving service from the Public Health Nurse. The newborn child is considered separately in the child health category. The Galway Community Care Area has a local policy of visiting all new mothers daily up to 5 days post delivery. The post-natal group comprised 6.4% (n=84) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 19.1 (S.D. 7.32). A needs score of 2 was most commonly assigned to these clients (Fig. 5.10.).
Figure 5.10. Needs Level of Postnatal Clients

5.6.5. Physical disabilities
The physical disability care group is defined as all adults included on the physical disability register. This group comprised 5.9 % (n=80) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 21.7 (S.D. 8.12). A needs score of 3 was most commonly assigned to these clients (Fig. 5.11.).
5.6.6. Other care groups

The other care groups includes all persons between 16 and <65 who do not fit with all other care group
descriptions. The group is largely comprised of those in receipt of acute services for shorter periods and
included 10.7% (n=144) of the clients tested over the 2 weeks. The mean of the total acuity score of this
group was 19.6 (S.D. 7.45). A needs score of 3 was most commonly assigned to these clients (Fig. 5.12.).
5.6.7. Sensory disabilities
The sensory disability care group is defined as all persons on the sensory deficit register. The sensory disability group comprised 2.2 % (n=30) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 24 (S.D. 8.87). A needs score of 3 was most commonly assigned to these clients.

5.6.8. Intellectual disabilities
The intellectual disability group is all persons included on the learning disability register and comprised 1.3 % (n=17) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 23.5 (S.D. 6.90). A needs score of 3 was most commonly assigned to these clients.

5.6.9. Mental health
Mental health care group comprises all persons between the ages of 18 and <65 who are in receipt of psychiatric health services. This group may also be attended by Community Psychiatry Nursing service. The mental health care group comprised 1.1 % (n=15) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 23.5 (S.D. 6.90). A needs score of 3 was most commonly assigned to these clients.
5.6.10. Child protection
The child protection group comprised 0.5 % (n=7) of the clients tested over the 2 weeks. The mean of the total acuity score of this group was 27.0 (S.D. 6.32), the highest mean score of any care group. A needs score of 3 was most commonly assigned to these clients. The frequency of occurrence of this group over the two weeks was relatively small (n=7) but the need score was never less than 3 (n=5). The remaining clients in this group scored 4 and 5 respectively.

5.6.11. Indirect care of clients who did not have a Client Need Classification form completed
The results above are derived from the information documented in the client need classification tool relating to the direct and indirect time that PHNs spent with clients. The time spent by RGNs on these clients was also documented. The PHNs also spent a considerable amount of indirect time in relation to clients in hospital or in the special care baby unit. This workload involved discharge planning and liaising with a social worker, liaison with GPs or discussing issues with carers. One PHN documented that she spent an hour preparing equipment for a client in his home prior to discharge.

Some PHNs lost time due to poor information systems; e.g. one PHN wasted 30 minutes as she was sent to the wrong address. Other PHNs documented the amount of time spent on transferring records, faxes, making appointments and post. One PHN recorded that she spent 4 hours planning clinics for the next month, making appointments and contacting management.

5.7. Unmet Needs
The PHNs were asked to document unmet needs for each client in order to ascertain what input would be required, even though the particular services were not presently available. The most frequent issues noted were: Ineffective visit (i.e. client not at home) (29); wound dressings requiring further input (15); care from or liaison with other professional required (in particular, occupational therapist and social worker for the older persons) (20); terminal or hospice care required (7); and environmental factors and accommodation issues (5). Other issues included: the need for highly technical care (chemotherapy, morphine); incontinence assessment; and the care of disadvantaged groups such as asylum seekers and travelling people. It appeared that these unmet client needs resulted in an extra workload for the PHNs in terms of indirect time expended per client. For example, the following comments were documented, as the response required to meet these needs: Revisit (29), phone-calls to/liaison with other professionals/hospital (28), office work (14), administering supplies (6). Many of these tasks were time-consuming (e.g. "two-hour phone-call to hospital", "30 minutes handing out stock") and some could be carried out by a non-nurse (e.g. "drive to Tuam to get yellow bags").
5.8. The Total Time Spent With all the Client Care Groups

5.8.1. The total time spent by the PHN with all client care groups

During the two weeks of this study, PHNs spent the majority of their time in Direct Care (74% = 674.9 hours) and the remainder in the hidden work of Indirect Care (26% = 233.3 hours), for all Client Care Groups (Fig. 5.13).

*Figure 5.13. The distribution of the time (direct and indirect) that the PHN spends with all client care groups*

![Diagram showing the distribution of PHN time between direct and indirect care for all client care groups.]

However, indirect care accounted for 47.8% of the PHN time with the Child Protection Care group and 48.7% of the Sensory Disabilities group (Table 5.1).

*Table 5.1 The distribution of PHN Time between the different care groups*

<table>
<thead>
<tr>
<th>Client Care Group</th>
<th>PHN Direct Time in hours</th>
<th>Direct Time as % of Total</th>
<th>PHN Indirect Time in hours</th>
<th>Indirect Time as % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Natal Care Group</td>
<td>49.0</td>
<td>78</td>
<td>13.8</td>
<td>22</td>
</tr>
<tr>
<td>Child Health</td>
<td>156.6</td>
<td>79</td>
<td>41.6</td>
<td>21</td>
</tr>
<tr>
<td>Physical Disabilities</td>
<td>59.9</td>
<td>78.2</td>
<td>16.7</td>
<td>21.8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7.2</td>
<td>82.7</td>
<td>1.5</td>
<td>17.3</td>
</tr>
<tr>
<td>Other Care Groups</td>
<td>97.1</td>
<td>73.4</td>
<td>35.2</td>
<td>26.6</td>
</tr>
<tr>
<td>Older Persons</td>
<td>286.1</td>
<td>71.9</td>
<td>112.0</td>
<td>28.1</td>
</tr>
<tr>
<td>Intellectual Disabilities</td>
<td>8.2</td>
<td>78.8</td>
<td>2.2</td>
<td>21.2</td>
</tr>
<tr>
<td>Child Protection</td>
<td>4.9</td>
<td>52.2</td>
<td>4.5</td>
<td>47.8</td>
</tr>
<tr>
<td>Sensory Disabilities</td>
<td>6.0</td>
<td>51.3</td>
<td>5.7</td>
<td>48.7</td>
</tr>
</tbody>
</table>
PHNs spent the majority of their time, direct and indirect, caring for the elderly (44%) and children (22%) (Fig. 5.14.).

**Figure 5.14. Distribution of time (direct and indirect) that the PHN spends with different care groups**

The total time spent by the RGN with all client care groups

The Post Natal Care and the Child Protection Care Groups did not account for any of the RGN time, and the RGNs spent less than 2 hours with the Mental Health and Intellectual Disabilities groups. Fifty-four per cent (111.2 hours) of the RGN time is spent caring for the elderly while clients with sensory disabilities accounted for 18% (38 hours) of the RGN’s time (Fig. 5.15.).
Figure 5.15. Distribution of time (direct and indirect) that the RGN spends with different care groups

5.9. Distribution of Time Between the Different Care Groups

PHNs spent more time with the Child Health Care Group (156.6 hours) than with the other two care groups, Post Natal and Child Protection (Fig. 5.16.).

Figure 5.16. Total time (in hours) spent with Post Natal, Child Health & Child Protection
However, the mean direct time per client was smaller for Child Health (mean = 26.31 minutes, SD = 23.0), for the two weeks of this study than for Child Protection (mean = 32.78 minutes, SD = 25.99) and Post Natal (mean = 42.64 minutes, SD = 31.64). It is interesting to note that the Child Protection Care Group had the largest amount of mean Indirect time per client (mean = 30 minutes, SD = 21.21) of all the nine care groups. The smallest mean Indirect time per client was recorded for the Child Health group (mean = 6.99 minutes, SD = 10.35).

RGNs spent more time (38 hours) with the Sensory Disabilities care group than with the other two care groups (Mental Health and Intellectual Disabilities). However, the majority of this time was for one client, which accounted for 1560 minutes (26 hours) and had on average a 2-hour visit by an RGN daily (Fig. 5.17.). PHNs spent more total time with people with intellectual disabilities than with the other two care groups. The mean time for PHN Direct time per client was higher, however, for the Mental Health Care group (mean = 35.83 minutes, SD = 39.76) than for Intellectual Disabilities (mean = 28.82 minutes, SD = 41.51) and Sensory Disabilities (mean = 27.69 minutes, SD = 40.45).

During the two weeks of this study, the Elderly Care group (Direct = 286 hours, Indirect 112 hours) accounted for the largest amount of direct time (Fig. 5.18.). In contrast, the mean direct time per client during this two-week period is higher for the Physical Disabilities group (mean = 49.25 minutes, SD = 61.58), than the Other Care Groups (mean = 44.49 minutes, SD = 58.88). The lowest mean PHN direct time was for the Older Persons group (mean = 30.81 minutes, SD = 38.53).
5.10. The Relationship Between Needs Level and Time for all Client Care Groups

All PHNs recorded both the direct and indirect time spent with clients for the two weeks of the study. The time that the RGNs spent with clients was also recorded.

5.10.1. PHN direct time

The Levene Statistic was used to test for Homogeneity of Variances and this demonstrated unequal variances between the clients in the different needs levels groups (Levene statistic = 33.88, df = 4, 1217, p = < 0.001). Thus the Kruskall Wallis test (nonparametric test) was used to analyse the difference in time between clients who have different needs level. There is a significant difference in PHN Direct time ($\chi^2 = 59.47$ df = 4 p < 0.001) between the different client needs level groups (Fig. 5.19.).
Multiple comparisons, using ANOVA with unequal variance, was used to analyse the differences in mean time within the groups. Each group was compared with the other four groups’ mean PHN Direct time. Clients whose needs level was 1, 2 and 4 had a significantly different mean time (p<0.001) from clients in the other groups. Level 5 needs group had a smaller significant different mean time compared to the others (F= 7.35, df = 1, 46, p < 0.01). It is interesting to note that clients who scored 3 according to need, did not have a significant difference in mean PHN Direct time compared to the other groups (F= 2.81, df = 1, 180, p = 0.095) (Table 5.2).

Table 5.2. Mean PHN Direct and Indirect Time for all client care groups according to Needs Level

<table>
<thead>
<tr>
<th>Needs Level</th>
<th>PHN Direct Time</th>
<th>SD</th>
<th>PHN Indirect Time</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Mean time in minutes (SD))</td>
<td>Meantime in minutes (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>18.62</td>
<td>24.94</td>
<td>7.11</td>
<td>9.95</td>
</tr>
<tr>
<td>2</td>
<td>25.31</td>
<td>23.02</td>
<td>7.13</td>
<td>10.34</td>
</tr>
<tr>
<td>3</td>
<td>33.39</td>
<td>36.91</td>
<td>11.80</td>
<td>16.28</td>
</tr>
<tr>
<td>4</td>
<td>54.22</td>
<td>65.85</td>
<td>16.48</td>
<td>25.64</td>
</tr>
<tr>
<td>5</td>
<td>56.02</td>
<td>56.04</td>
<td>36.25</td>
<td>34.34</td>
</tr>
</tbody>
</table>

5.10.2. PHN indirect time

The Kruskal-Wallis Test demonstrated that the PHN Indirect time ($\chi^2 = 68.73$, df = 4, p< 0.001) for the five Needs Level groups was not equal. Multiple comparison analysis demonstrated that clients in Levels 1, 2, and 5 had a significant difference in mean PHN Indirect time than those in the other four groups (p <
0.001). However, Level 4 clients did not have a significant difference in PHN indirect time \( (F= 0.13, df = 1, 204, p = 0.71) \) In contrast to PHN Direct time, clients in Level 3 had a significant difference in mean PHN Indirect time \( (F=9.54, df = 1, 99, p < 0.005) \) (Table 5.2.).

### 5.10.3. RGN time

The Kruskal-Wallis test demonstrated that the RGN time was not equal for the 5 Needs Levels groups \( (\chi^2 = 21.617, df = 4, p < 0.001) \). However, due to the small sample size, further comparisons were not deemed appropriate.

### 5.10.4. PHN total time (direct and indirect time)

The mean total time for the clients in the different needs levels was not equal \( (\text{Kruskal- Wallis test } \chi^2 = 107.11, df = 4, p < 0.001) \). Only three groups, Needs Level 1, 2, and 5, had a statistically significant difference in mean time \( (p< 0.001) \) when a multiple comparison analysis was conducted (Table 5.3.).

### Table 5.3. Mean Total PHN time and Mean RGN Time for all Client Care Groups according to Needs Level

<table>
<thead>
<tr>
<th>Needs Level</th>
<th>PHN Direct and Indirect Time (Total Time)</th>
<th>RGN Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean time in minutes (Standard Deviation = SD)</td>
<td>Mean time in minutes (Standard Deviation = SD)</td>
</tr>
<tr>
<td>1</td>
<td>24.82 (27.03)</td>
<td>4.09 (16.31)</td>
</tr>
<tr>
<td>2</td>
<td>32.28 (26.2)</td>
<td>4.55 (13.07)</td>
</tr>
<tr>
<td>3</td>
<td>43.96 (41.91)</td>
<td>8.80 (20.32)</td>
</tr>
<tr>
<td>4</td>
<td>65.07 (79.80)</td>
<td>19.22 (85.41)</td>
</tr>
<tr>
<td>5</td>
<td>90.02 (68.39)</td>
<td>54.43 (235.06)</td>
</tr>
</tbody>
</table>

### 5.11. Correlation Between Total Need Score and Time

All clients were scored according to need in an ordinal scale (0-50). Spearman’s rank correlation coefficient was utilised to measure the degree of association between total needs score and time as the total needs score is an ordinal scale and all the time variables were not normally distributed (Petrie & Sabin, 2000; Pallant 2001). There is some positive correlation between the total needs score and the cumulative total of PHN time \( (r = .298, n = 1222, p < 0.01) \). The correlation is lower between total needs score and PHN Indirect time \( (r = .211, n = 1222, p < 0.01) \) than between PHN Direct time \( (r = .230, n = 1222, p < 0.01) \). There is a very small correlation between RGN time and the total needs score \( (r = .134, n = 1222, p < 0.01) \).
5.12. Relationship Between Needs Level and Time for the Different Care Groups

The relationship between needs level and time was analysed for each client care group.

5.12.1. Post Natal care group
No significant difference in mean time between the different groups was found when the Kruskal-Wallis test was utilised for both Direct PHN time ($\chi^2 = 3.80$, df = 4, $p = 0.433$) and Indirect PHN time ($\chi^2 = 5.93$, df = 4, $p = 0.2$) (Fig. 5. 20.).

*Figure 5.20. Post Natal Care Group*

5.12.2. Child Health care group
The Kruskal-Wallis Test was used to analyse the difference in mean time for the Child Health Group between the different Needs Level groups and there was a significant difference in mean Direct PHN time ($\chi^2 = 48.165$, df = 4, $p < 0.001$) and mean Indirect PHN time ($\chi^2 = 15.564$, df = 4, $p < 0.005$). The mean time for each Needs Level group was compared to the other four groups and only Needs Level 1 had a significant difference in mean Direct PHN time ($F = 26.15$, df = 1, 3.841, $p < 0.01$) (Fig. 5. 21.).
5.12.3. Physical Disabilities care group

The only significant difference in time was recorded for the PHN Indirect time (Kruskal-Wallis test ($\chi^2 = 16.56, \text{df} = 4, p < 0.005$) within the 5 Needs Level Groups. Thus, there was no significant difference in PHN Direct time and RGN time between the different groups. Level 2 Needs Group was the only group with a significant difference in mean PHN Indirect time when compared to the other four groups ($F = 14.35, \text{df} = 1, 8.5, p < 0.01$) (Fig. 5.22.).
5.12.4. Mental Health care group

There was no significant difference in PHN Direct and Indirect time and RGN time between the different Needs Level groups, for clients with Mental Illness (Fig. 5.23).

*Figure 5.23. Mental Health Care Group*

5.12.5. Other care groups

There was a significant difference in mean PHN Indirect time ($\chi^2 = 13.80$, df = 4, p < 0.01) and total PHN time ($\chi^2 = 13.61$, df = 4, p < 0.01) between the different Needs Level groups for the Other Care Client Care Group. Multiple Comparison analysis demonstrated that Level 1 Needs Group was the only group that had a significant difference in mean PHN Indirect time ($F = 17.1$, df = 4, p < 0.005) and total PHN time ($F = 10.28$, df = 4, p < 0.01) when compared to the other four groups (Fig. 5.24.).

*Figure 5.24. Other Care Groups*
5.12.6. Older Persons care group

The results from the Kruskal-Wallis test demonstrate a significant difference in time between the different Needs Level groups, for PHN Direct time ($\chi^2 = 28.55$, df = 4, $p= 0.000$), Indirect time ($\chi^2 = 37.00$, df = 4, $p= 0.000$) and total time ($\chi^2 = 49.76$, df = 4, $p= 0.000$). No significant difference was found between the different Needs Level groups for RGN time ($\chi^2 = 8.53$, df = 4, $p= 0.074$).

Each Needs Level group was compared to each other using multiple comparison. Needs Level Groups 1, 2, and 5 have a significantly different mean PHN Indirect time and total PHN time. Only Group 1 had a significant difference in RGN time ($F= 18.28$, df = 1, 85, $p < 0.001$) when compared to the other 4 groups. Needs Level 4 Group had a significant difference in mean time for PHN Direct time only ($F= 9.14$, df = 1, 121 $p= 0.003$). Level 3 Needs Group did not have a significantly different mean time in any of the categories (Fig. 5.25.).

![Figure 5.25 Older Persons](image)

5.12.7. Intellectual Disabilities care group

There was no significant difference in PHN Direct and Indirect time and RGN time between the different Needs Level groups for this care group (Fig 5.26.).
5.12.8. Child Protection care group

No Child Protection clients were scored Level 1 or Level 2. RGNs did not spend any time with this care group. There was no significant difference in mean PHN Direct or Indirect time between the different Needs Level groups (Fig. 5.27.).
5.12.9. Sensory Disabilities care group
No client in the Sensory Disabilities care group scored a Needs Level of 3. There was no significant difference in PHN Direct or Indirect time or RGN time between the different Needs Level groups (Fig. 5.28).

Figure 5.28 Sensory Disabilities

5.13. Hours Worked
During the two-week period of testing, the PHNs worked an average of 52.86 hours (S.D. 20.23), with a minimum recorded of 23 and a maximum of 95 hours. These results included within the period a Bank Holiday, study leave, annual leave, parental leave, sick leave, over-time, extra weekend work and job-sharing, so that the mean is not, and should not be taken to be, an accurate reflection of the usual full-time PHN workload. Fifteen PHNs took some type of annual, parental or sick leave during the fortnight with an average of 10 hours (S.D. 14.4). In addition, 2 PHNs had study leave of 2-3 days. Overtime hours were documented as an average of 4.58 hours (S.D. 3.95), with a minimum of 0 and a maximum of 15 hours for those who worked over the weekend. The majority of PHNs (n=16, 55%) did no overtime and 9 PHNs (31%) worked between 1 and 3 hours overtime in the two-week period, approximately 1 hour extra per week.

5.14. Distribution of Staff Time
During the two-week study period, respondents spent an average of 10 hours travelling (S.D. 8.6), 4 hours (S.D. 5.01) in non-case-load activity, 2.3 hours (S.D. 3.4) in clinics and 3 hours (S.D. 2.5) in staff meetings (Table 5.4). Travelling thus accounted for almost 20% of the PHNs' recorded time and non-case-load activity for a further 8%. Attending at clinics and staff meetings accounted for approximately 4% of total time each, leaving 64% of time remaining for the provision of nursing care. Only 2 PHNs spent any time (1-3.5 hours) on health promotion programmes (as distinct from including health promotion in with a visit), and only 1 spent time on community
development (3 hours). There was no PHN time specifically recorded for committee work during the course of the study.

Table 5.4. Distribution of staff time during the two-week test period

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of participants undertaking that activity</th>
<th>Mean hours N = 29</th>
<th>SD</th>
<th>Min hours</th>
<th>Max Hours</th>
<th>Mean Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time spent travelling</td>
<td>27</td>
<td>10.32</td>
<td>8.60</td>
<td>0</td>
<td>33</td>
<td>19.52</td>
</tr>
<tr>
<td>Time spent on non-case-load activity</td>
<td>29</td>
<td>4.11</td>
<td>5.01</td>
<td>0</td>
<td>23</td>
<td>7.78</td>
</tr>
<tr>
<td>Clinics</td>
<td>15</td>
<td>2.35</td>
<td>3.38</td>
<td>0</td>
<td>15</td>
<td>4.45</td>
</tr>
<tr>
<td>In-service education</td>
<td>14</td>
<td>2.05</td>
<td>3.19</td>
<td>0</td>
<td>16</td>
<td>3.88</td>
</tr>
<tr>
<td>Staff meetings</td>
<td>15</td>
<td>1.08</td>
<td>2.00</td>
<td>0</td>
<td>8</td>
<td>2.04</td>
</tr>
</tbody>
</table>

5.15. Admissions and Discharges

During the fortnight studied, 26 PHNs took on new clients, with a mean admission to caseload rate of 5.6 (S.D. 4.9), and rates varying from 1 to 21. Discharges from the caseload were lower, with a mean of 1.6 (S.D. 2.2) and rates varying from 0 to 8. This difference was statistically significant, using the Wilcoxon signed rank test ($Z=3.69$, d.f.=25, $p<0.001$), indicating that the PHNs' caseloads were increasing at a faster rate than they were decreasing.

5.16. Participants' Views of the Tool

5.16.1. Positive and negative comments

The majority of PHNs agreed or strongly agreed that the tool would help PHNs working in the community (n=21, 72%), was simple to understand (n=22, 76%) and easy to use (n=23, 79%). The participants were then asked to make comments about the tool. One PHN said in the pilot study that “it encouraged me to reflect on my role” whilst another PHN said that “it highlighted the multi-complexity of community nursing.”

The most common complaints were that the tool was too time-consuming (n=17, 59%), too detailed (n=5, 17%) and that it did not adequately assess the needs of some clients (n=4, 14%) (Table 5.5.).
Table 5.5. Summary of negative comments on the client need classification tool

<table>
<thead>
<tr>
<th>Negative comments</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time-consuming</td>
<td>17</td>
<td>58.62</td>
</tr>
<tr>
<td>Very detailed/too many categories</td>
<td>5</td>
<td>17.24</td>
</tr>
<tr>
<td>Negatively rates one section (child health x 2, elderly, teaching needs)</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>Difficult to understand/interpret</td>
<td>3</td>
<td>10.34</td>
</tr>
<tr>
<td>Lack of RGN involvement</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Travel</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Too few categories</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Does not address ethnicity issues</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Does not address leg ulcers, dressings</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Does not address surveillance work</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Not useful for long-term care</td>
<td>1</td>
<td>3.45</td>
</tr>
</tbody>
</table>

Positive comments were more numerous (115 positive compared with 65 negative ones), and included 'positively rates all aspects' (n=13, 45%), 'quantifies workload' (n=7, 24%) and 'time spent on indirect care was documented' (n=4, 14%) (Table 5.6).

Table 5.6 Summary of positive comments on the client need classification tool

<table>
<thead>
<tr>
<th>Positive comments</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positively rates all aspects</td>
<td>13</td>
<td>44.83</td>
</tr>
<tr>
<td>Positively rates one section</td>
<td>11</td>
<td>37.93</td>
</tr>
<tr>
<td>Quantifies workload</td>
<td>7</td>
<td>24.14</td>
</tr>
<tr>
<td>Time spent on indirect care documented</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>Health promotion clarified</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Travel documented</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Assessment issues</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Quick and easy to use</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Useful to document unmet needs</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Useful for monitoring short-term cases</td>
<td>1</td>
<td>3.45</td>
</tr>
</tbody>
</table>

5.16.2. Suitability of the tool for specific client groups

A majority of PHNs stated that the tool was suitable to predict the needs of clients in every category. The strongest positive rating for this was in the 'suitable to assess the needs of older persons' category where 27 PHNs (93%) thought that the tool was suitable compared with 2 (7%) who did not. The lowest positive rating was in the category of 'other care groups', where 18 PHNs thought the tool was suitable (62%) compared with 4 (14%) who did not (Table 5.7.). There was caution expressed by some participants that
the tool may not be suitable to assess clients from psychiatric and intellectual disability care groups comprehensively, where the PHN is not the only care giver; as one PHN comments “we may not be the key people working with them”.

**Table 5.7 Suitability of tool to assess the needs of each client care group**

<table>
<thead>
<tr>
<th>Client care group</th>
<th>Suitable to assess needs</th>
<th>Suitable to assess needs</th>
<th>Unsuitable to assess needs</th>
<th>Unsuitable to assess needs</th>
<th>Missing</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Older persons</td>
<td>27</td>
<td>93.10</td>
<td>2</td>
<td>6.90</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>26</td>
<td>89.65</td>
<td>2</td>
<td>6.90</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Post-natal</td>
<td>25</td>
<td>86.21</td>
<td>3</td>
<td>10.34</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>24</td>
<td>82.76</td>
<td>3</td>
<td>10.34</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Sensory disabilities</td>
<td>23</td>
<td>79.31</td>
<td>4</td>
<td>13.79</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Child health</td>
<td>22</td>
<td>75.86</td>
<td>7</td>
<td>24.14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>22</td>
<td>75.86</td>
<td>4</td>
<td>13.79</td>
<td>3</td>
<td>10.35</td>
</tr>
<tr>
<td>Child protection</td>
<td>19</td>
<td>65.52</td>
<td>3</td>
<td>10.34</td>
<td>7</td>
<td>24.14</td>
</tr>
<tr>
<td>Other care groups</td>
<td>18</td>
<td>62.07</td>
<td>4</td>
<td>13.79</td>
<td>7</td>
<td>24.14</td>
</tr>
</tbody>
</table>

**5.16.3. Time taken to complete the tool**

Respondents were asked to document how long it took them to complete the client needs assessment tool, and 19 of the PHNs did so. The average time taken to complete the tool for each client was 15 minutes (S.D. 8.82), with a minimum of 5 minutes and a maximum of 30 minutes (Fig.5.29). One PHN recorded that she spent the whole day completing the tool for one client. As this appeared to be completely at odds with her colleagues’ responses, this outlier was excluded and the mean was then computed on the remainder of the data.

*Figure 5.29. Time taken to complete the tool for each client*
5.16.4. Participants' suggested changes

Eighteen PHNs suggested changes to improve the tool, including: combining sections such as health promotion and teaching needs or environment and psychosocial needs, making a simpler form for the postnatal visits as they occur so frequently, using less headings/variables in each category, and including social welfare issues, torture, rape, HIV, terminal care, organising clinics.
Chapter Six

Discussion of Findings

6.1. PHN Role

6.1.1. Generalist versus specialist

The purpose of this study was to examine the role of the PHN and the workload that influences the parameters of that role. Many of the difficulties with the PHN role relate to the ongoing development of the community care services nationally and this difficulty in role clarity for the PHN has been reported in the literature (Chavasse 1995; Reutter and Ford 1996). The uncertainty around the parameters of the role was identified in this study as both strength and a weakness. The PHN is a generalist with responsibility to provide primary, secondary and tertiary care to a variety of groups (Hanafin 2002). The generalist aspects of the role may make it difficult for the nurse to focus on specific areas and yet increasing specialisation across all disciplines in nursing does render it difficult for a generalist to provide best practice care. The parameters of the role are influenced by the curative and preventive nature of the work (O’Sullivan 1995) but also in the caring for people of all ages. The approach to care and indeed the care priorities indicates that the PHN's focus is on the curative aspects. The study supports the notion that PHNs have a role within every facet of the community, and captures the enormity of the task facing the PHN in the field. This is illustrated in the narratives of many of the PHNs who participated, who suggested that the PHN role transcends the human lifespan on a continuum of care from cradle to grave, and in the diverseness of the client care groups assessed with the tool during the course of the study.

The "Jack-of-all-trades" was a central theme in this study as previously described by O’Sullivan (1995). This aspect of the job further complicates the interpretation of the PHN role. The inherent strength and uniqueness of the PHN service is that they have such an array of clinical skills, that they are capable of interfacing with all the diverse care groups. The down side of this is that the service can become a repository for all patients; as one participant comments ‘I think a number of other professions have viewed us as a catch all and we have allowed this to happen’ (p. 41). The constant increase in demand from the curative aspects of their work has limited the ability of the service to develop or indeed stand back from itself and some would suggest that the PHN role has remained largely unchanged since 1966 (Hanafin 1997). The PHN role is complicated further in that they have become the ‘band-aid’ of the community service, and patch up gaps in service or breakdowns in community care.
6.1.2. Role complexity

The PHN role attempts to provide holistic care in an ever-changing social, political, and cultural environment where the health needs of the resident and mobile populations place increased demands on an already poorly defined and under resourced community health service. The PHN has a mandate to visit homes of people who are well and this continuous contact with people with access to every home and family is unique to the PHN in community services. The range of work activities for the Irish PHN is broad and the recipients of the PHN service in the study reflected the broadness of the PHN’s responsibilities across all age groups. While the whole community is technically the recipient of the PHN service, in reality the recipients become those individuals in most need at a particular time. Sometimes this leads to PHNs having to make difficult choices among particular clients, as to who should receive care.

The desire of this group of PHNs to have a client focus to care is notable in the study; however, PHNs on the ground are sometimes not in a position to identify the community or family groups as the client, which limits the possibilities in regard to a preventative role. Although health promotion at a “micro” level was said to occur frequently, more formalised health promotion activities were rare, because of a combination of work overload, lack of confidence in public speaking and scarce resources. The traditional ‘tasks led’ approach is not conducive to promoting a client focus to care and may be reducing the scope of the PHN role.

The job description of the PHN does attempt to capture the diversity of the role. The essence and holistic features of the role are strongly influenced by the concept of establishing relationships that are based on trust with clients as highlighted in this study. Trust between service users and PHNs may well be enhanced by the tendency of PHNs to fill the gaps in the community care service, as noted above. There was a concern in the study about the development of the PHN role in uncertain times. The inherent strength of the public health nursing service in the future may lie in its ability to change to meet consumers’ expectations and changing client profiles. An overly prescriptive job description may be incompatible with such expectations.

Participants in the study reported a hidden role, which one person described as ‘invisible nursing’ (p. 41). Plew and Bryer (2002) have previously discussed the difficulties caused by the invisibility of community nursing. There appears to be a general lack of appreciation regarding the complexity of the role and what it actually involves. Decision-making, accountability, judgment, assessment of need and counselling of clients are unseen aspects of the role that are difficult to quantify. Further complications arise from the perceptions of some participants in the study, which are that managers and the community at large undervalue aspects of the PHN role. The activities that emerge from the secondary aspects of the role are the ones that are inevitably valued and, indeed, these are the aspects of the role that may have lent themselves more easily to measurement in previous studies.
6.1.3. Development of the PHN role

The strategic placement of the PHN role in the community was a recurrent feature in the literature (Chavasse 1995; Department of Health 1997; Hallett and Pateman 2000) and is significant in this study. The capacity of the PHN to see the ‘big picture’ due to their extensive knowledge and expertise of care in the community is a critical strength of the role (Reutter and Ford 1996; Hanafin 1997). The PHN is often the first professional the patient encounters in the community and they often look to the nurse to "pull it all together". Cloonan and Belyea (1993) describe this aspect of the role as case management, which is influenced greatly by the unseen elements in the work and is most frequently required by patients with complex care needs. This study highlights opportunities to develop the role further in the area of case management, as echoed in the work of O’Sullivan (1995) and Chan et al (2000).

There was realisation that the health service is changing and that the role will need to change concurrently with developments in community, such as the changing demographics in the Galway area, and also those that are happening in primary care nationally, such as the early discharge of clients from hospitals and the enhanced role for the PHN in caring for newly discharged mothers and babies. There was a consensus in the study that there was potential to develop and enhance the management aspects of the role with appropriate delegation of some care activities. However, such developments cannot happen in isolation and would have to be preceded by a comprehensive evaluation of the various roles and responsibilities of all personnel engaged in community health care provision. Education and training may also be required to prepare PHNs for this increased managerial responsibility and should include preparation for clinical audit.

There was a sense that PHNs are far removed from the decision making process regarding their role. Decisions that affect care should be taken as near to the point of service delivery as possible. Their sense of powerlessness may have implications for the future job satisfaction of this group. The changes in care delivery patterns in acute care services have seriously impacted on the role with little consultation with those at the ‘coalface’ regarding the implications for care in the community. The study highlights the tendency of PHNs to pickup on the work of others, with many participants reporting overwork. The fulfilling aspects of the role that emerged in the study was heartening in a time of apparent pessimism, but the potential for the work overload to impact on this is a concern. O’Sullivan’s (1995) study alluded to the view of one PHN superintendent, who reported that job satisfaction was poor and that service objectives were unclear. Jansen et al (1996) conclude that job satisfaction is positively affected by task clarity, skill variety and possibilities for development.

The study indicated a general acceptance that client needs in the community were changing, influenced by a wide range of political, social, demographic and professional issues and that the PHN role needs to change. Current developments do indicate that the PHN role will be required to adapt to its membership in primary care teams. The participants in this study welcomed such teamwork and the literature does suggest that there is the potential for increased teamwork and morale where this type of practice

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allocation is the norm (Tinsley 1998). However, there was evidence from the narratives of some participants as to their anxiety in relation to the exact role of the PHN in the primary care teams. Of course the anxiety alluded to in this study can only be aggravated by the limited input of the PHN service in the strategic planning of the primary care team. If PHNs do not attempt to clarify their own vision of the public health nursing service, their future role may be interpreted by others in community healthcare and may be imposed on them.

6.1.4. Health promotion

Health Promotion is central to the PHN role and the PHN is ideally placed for this responsibility as she can reach individuals and groups that may be largely inaccessible to the rest of the health service (Department of Health 1994, Department of Health and Children 1999a; 2000a; 2000b). Their preventative role does appear to be forfeited in preference to the curative aspects of care (O’Sullivan 1995; Western Health Board 2001a). With some exceptions, the study uncovered little evidence of PHN involvement in “formal health education and health promotion activities” as outlined in the job description (Department of Health and Children 2000a: 41), or as recommended by the Commission on Nursing (1998), with only one PHN documenting 3 hours on community development and two others reporting 1-3.5 hours on health promotion programmes. Staffing levels, inadequate resources, ill-equipped health centres, large caseloads and pressure of work are elements alluded to in the study that impinge on the ability of the PHN to fulfil the health promotion obligation of their work. In addition, one participant in the study perceives that health promotion is not valued and supported by ‘the powers that be’ (p. 45). The preventative aspects of the role are easily ignored because of the difficulty in auditing the contribution of any particular service providers in terms of health gain. The effectiveness of the PHN role in primary prevention is difficult to measure, as measures of such outcomes are often a result of the contribution of several initiatives across many professions. It would appear that the PHN has adapted to these limitations and evolved coping mechanisms to incorporate this preventative role whenever possible into the individual interactions with clients. This opportunist approach to health promotion does have a place in their work but there is an under utilisation of the PHN’s health promotion skills. A balance between the opportunistic and more formal health promotion initiatives is required. There was a suggestion by one PHN in the study that there may be an overlap in regard to this role with the health promotion department of the Western Health Board, and the work of PHN and the interface between the two may require further investigation.

6.2. Workload Issues

A number of issues were raised during the study regarding the workload of the PHN and its influence on the role of the PHN. The work overload experienced by PHNs is an international phenomenon due to increasing complexity in the range of health and social issues in community settings (Rapport and Maggs 1997; McDonald et al 1997; Evan 2002).
6.2.1. Workforce Profile
The age and demographics of the 27 participants in the workload measurement phase of the study (43%) is an interesting aspect of the data collected over the course of the study. The largest groups of participants in the study were aged between the 46-55 with a mean experience level as a PHN of 15 years, reflecting the national statistics on age profile of PHNs (Department of Health and Children 2002c). The PHNs in the Galway study are seasoned employees, and O'Sullivan (1995) also highlighted the maturity of this particular work force. Furthermore, the employees had on average worked in their present community care area for a mean of 9.6 years. These demographics would therefore suggest that Galway Community Care Area does not have a particular problem with retention, in contrast with some other nursing services nationally, an assumption that will be tested on the full population in the second phase of the study. The consistency of employment and the cumulative years of experience of those PHNs at the ‘coalface’ of delivery is one of the jewels in the crown of the community services.

The demographics, however, do highlight the potential problem of an aging workforce, as the largest group of participants was aged between 46 and 55. PParis statistics (2002) on the age profile of nurses employed in the Galway community area indicate that at least 62.97% of all PHNs employed in the service are over 40 years old. Some employees do not have a recorded date of birth so that the figures may even be greater. The Nursing and Midwifery Resource Final Report (Department of Health and Children 2002c) caution that there is potential for shortages in the numbers of PHNs due to ageing, unless numbers recruited and retained in the profession increase.

6.2.2. Client/PHN ratios
The ratio of PHN to population varies from 1:2,500 to 1:5,099 (Department of Health and Children Nursing Policy Division 2002) and there is a need to find a solution to the overwhelming demands on PHNs (Hanafin 2002). A major criticism of the large caseload of PHNs is that it limits their ability to provide primary as well as secondary aspects of care (O'Sullivan 1995; Chavasse 1998). The study does indicate that there are areas where the PHNs may be inappropriately utilised and are frequently engaged in activities that substitute the work of other members of the community care team who are unavailable or overstretched. A key difficulty in the provision of the PHN service is in the selection of priorities and the study would suggest that the PHNs respond to workload on a needs basis. One participant in the study reported “feeling swamped” (p. 43). Employees in the study appear focused on responding to needs as they arise and do not appear to be proactive regarding the primary aspects of the role. An example of care priority described in the study was those clients not receiving support from other services, whose care was then taken up by PHNs.

6.2.3. Referrals
A significant finding in the study was that PHNs’ caseloads were increasing at a greater rate then they were decreasing, similar to the findings of the Audit Commission (1999) in the United Kingdom, which found that district nurses were reluctant to discharge patients from their caseload. Open referrals are a distinguishing feature in the PHN service and this is very much in contrast to the practice of other
community care providers where the numbers of patients on a caseload is monitored and indeed limited. The study highlighted the logistics of the perceived absence of a formalised referral process, which may have implications for the successful auditing of the service. Respondents also perceived the open referral system as causing difficulties with planning care delivery and leading to client lists that grew continuously. The lack of desire for a formal system of referral may have arisen in the traditional approach to the PHN service in that it ‘takes all comers’. The service has traditionally always just adapted itself to meet the increasing demand without any particular increase in services. This very ability to adapt itself has, to some extent, contributed as an obstacle in the development of the entire role as the ever-increasing demand for curative service takes precedent.

6.2.4. Staff time

The distribution of staff time is another issue impacting on workload within the public health nursing service. Over the course of the study, PHNs spent 64% of work time on direct patient activity with the remaining time on travel and non-caseload activity. Over one third of clients required visits that took longer than 20 minutes travelling time, which adds appreciably to the PHN workload. Of the time spent on patient activity approximately 74% of the time was engaged with direct patient care with the remaining time spent on indirect patient care activities. The PHNs spent the majority of the time caring for the elderly (44%) and children (22%). The significant care commitment to the elderly is one area where further augmentation of the PHN service with more RGNs may free up some PHN time to concentrate on other aspects of the role. This level of productivity is noteworthy, as evidence by Marek (1996) in the USA indicates that home care nurses can spend up to 70% of their time on indirect care. During the two weeks of the study, non-caseload activity was only documented at 8% of all-time recorded. The time in question is relatively small but it does possibly highlight the limited amount of time that the PHN has for the broader aspects of the role that are not focused on individual clients. The study does highlight that the percentage of PHN time on indirect care is higher with the child protection group (47.8%) and with sensory disability group (48.7%). One other element emphasised in the findings [4.4.1] was the lack of clerical and secretarial support; this deficiency appears to apply across the board as area public health nurses also indicate that this is a major issue.

The study uncovered a range of unmet needs, which resulted in extra workload in terms of direct time expended per client. The frustration and dissatisfaction expressed by these PHNs echoes the negative sentiments of community nurses in relation to making up shortfalls in the community service, which have been previously documented (Timpka et al 1996). The service is still focused on the traditional Monday to Friday ‘9 to 5’ patterns of care delivery, with some planned essential services on weekends and public holidays. All in all, the service has not made sufficient significant moves to respond to changes in living patterns in modern society.
6.3. Intra-professional Activities

6.3.1. Communication between PHNs and other nurses

The main providers of nursing care in the community in the county of Galway are the Public Health Nurses; however, as this study describes, they have been supported of late by a limited number of RGNs who assist primarily with the provision of care for the elderly, and also by some specialist nurses who provide care for particular care groups such as those with an intellectual disability or people with mental health difficulties.

The relationship between the long established PHNs and the newly arrived RGNs within the community nursing service would appear to be still in a formative stage; however, as this study has noted, there are already signs of a traditional nursing hierarchy developing. Because the advent of RGNs in the Galway community nursing service is still in its infancy, the possibility of the formation of area teams where the PHN, RGN and Home Care Attendants/Home Helps might work together in a flattened structure should not be discounted. This type of structure, as suggested by the 1997 review of Public Health Nursing (Department of Health and Children 1997), might offer a model for co-operative care provision structures that do not look back to the former traditional nursing hierarchies. Indeed, such a structure might fit comfortably within the proposed inter-disciplinary teams that are put forward as the basic building block for the primary care proposals as set out in the Health Strategy (Department of Health and Children 2001a).

The second element of this consideration of intra-nursing team relationships is concerned with the relationship of the PHNs to the other nurses with whom they come into contact. This study found that the Public Health Nursing service interfaces with several different specialist nursing groups amongst which are intellectual disability and mental health nurses and also palliative care nurses. As this study makes clear, PHNs pride themselves on offering a cradle to grave service; this implies that end of life care may require the PHN to work with palliative care teams, where each service supports the other in the provision of a seamless service (Leahy-Warren 1998). In this situation, the seamless service is established by a fusion of the expertise of the palliative care team with the knowledge and empathic skills that the PHN has generated through the long-term relationship with the client.

This study found that just 1.1% of clients assessed were people with mental health needs; indeed, as O’Sullivan points out, "PHNs no longer have a major role in psychiatric nursing in the community" (O’Sullivan 1995:33). Similarly, just 1.3% of the clients tested were people with intellectual disabilities. As noted earlier in some areas of the country PHNs are employed specifically to work with people with this client group but that situation does not apply in Galway. In view of the growing emphasis on the provision of care in the person’s home and local community (Guidon 1990) it would seem that there is a
need for interprofessional and collaborative working between all nursing professionals caring for all clients in the community.

Until now the development of services for people with such special needs seem to be provided by Public Health Nurses where the specialist services are not sufficiently developed of resources to offer the care required. This results in the PHN becoming ‘the pick up person’. As Hanafi et al (2002) note, when the specialist nurse is not available then the client need is met by the PHN. Clearly some element of reorganisation and rationalisation of service provision and inter service communication is necessary, so that the community nursing team can provide for the specialist care needs of those who require such a service.

A final point in relation to intra-professional activities is to note that this particular group of PHNs did not appear to see the education of students as part of their role. Education of students was mentioned briefly, and unfavourably, in the qualitative section and was not recorded as taking up any of the PHNs’ time in the quantitative section.

6.3.2. Managerial issues

As this report has already noted, bullying is present in most areas of nursing in Ireland. While this study did not unearth specific indications of bullying, there was evidence of some PHNs being reluctant to commit their views to being recorded, particularly when discussing managerial issues. Certainly areas of mistrust between PHNs and their nursing managers were identified both in the semi-structured interviews with the PHNs and also in some of the discussions and reporting sessions that the team held with different groups of PHNs during the data gathering and reporting process. Most particularly, the process of monitoring the PHNs’ daily work was commented on in this study. This issue is also commented on in the report "A Service Without Walls" which describes some respondents noting that they were “being monitored for every minute of the day” (O’Sullivan 1995: 42). Indeed, that report emphasises the low self-esteem and sense of being controlled by others that some respondents in the Galway study also felt. In the context of this study the practitioner/manager relationships seemed to vary across different PHNs and their line managers, with a number of examples of good practice, but an overall impression was evident that these relationships did not operate as effectively as they might. Strategic planning for team building, the provision of support for nurses and the establishment of nursing relationships in the context of a flattened structure seem to be the goals for which the community nursing service should aim.

6.4. Inter-professional Activities

6.4.1. Primary health care team

The majority of PHNs see their future as being part of the primary care team in line with the Department of Health’s proposals (Department of Health and Children 2001a). Emergent from this study was a
suggestion for an optimal configuration of the community nursing team whereby a flattened nursing structure might enable a core team of PHNs and RGNs to work in tandem with other specialist nurses where a structured clear interface between the services existed so that everybody would know who was doing what. This then raises the issue of how that nursing team might fit within the proposed primary health care team that the Health Strategy suggests (Department of Health and Children 2001b).

A major issue that is identified in this study, indeed it constitutes a part of the whole of theme four, is the issue of communication within the multi-disciplinary team. Of the PHNs who were interviewed for the study, most who worked in urban areas were based in clinics along with other PHNs. Often GPs, RGNs and others would also be based in the same geographical location. Rural PHNs were in a different situation; many of them worked alone or in small clinics with only a GP present for part of the time. For most, there was a belief that the communication processes did not work effectively. Some felt that this applied particularly to child protection matters; others felt that there was ineffective communication regarding client progress between the acute and community sectors, and also within the community sector between team members. This is not a new scenario as the report “A Service Without Walls” made the point that there were no structures for collaboration with GPs or social workers (O’Sullivan 1995). Poor liaison with PHNs is noted by the Commission on Nursing (1998) and was evident in some of the responses by the nurses, some making the point that liaison with GPs largely depended on the interest that the GP had in communication with PHNs. Many PHNs felt that systems to refer clients to other health professionals worked in, at best, a rather patchy manner.

6.4.2. Communication

The review of Public Health Nursing states that “there is strong evidence to suggest that a desire for a closer working relationship with PHNs exists among GPs” (Department of Health 1997: 40). The submission of the Special Interest Group of Social Workers in Child Care cited by the Department of Health (1997: 37) notes that “there should be a dialogue between Social Workers and PHN groups ………in relation to boundaries, roles and functions and how they can work more effectively together.” This study notes that there is a strong argument for having the primary health care team all on one site. Indeed, so many disparate examples of communication difficulties and also of the time wasted in trying to communicate with other team members were evidenced, that the conclusion is that there is great benefit to be had by siting the team in the one place.

This view is tentatively put forward in the Service Without Walls report (O’Sullivan 1995) and more emphatically asserted in the Health strategy proposals (Department of Health and Children 2001). This situation did apply for one respondent in the survey who worked from the same health centre with a physiotherapist, occupational therapist, psychologist, school nurse, medical officers and social welfare officers. This respondent made the point that communication was so easy (and effective) in this setting and that it could be achieved on a formal or informal basis.
To sum up, locating of the community nursing team within the overall primary care team would seem to meet both the problems identified by the public health nurses and also the wishes of other professionals within the primary care service. In view of the fact that organising the community nursing team in both the same geographical location and within the one primary care team is a key objective of the Health strategy, it would appear that this then becomes a key recommendation.

6.5. Resource Issues

6.5.1. Work environment
The provision of material resources for the use of the public health nurse was quite variable in this study although a general pattern existed where insufficient resources were devoted to capital investment. A few PHNs operated out of new or nearly new clinics that boasted state of the art offices, interview rooms, clinic rooms and other facilities. However, many were working from inadequate buildings that were in need of renovation, while an unfortunate few operated out of buildings that were unlikely to continue standing for many more years due to their dilapidated state. The by-product of this was crowded facilities, rooms that were needed for more than one function and resultant poor service to clients. The remedy for this state is clearly identified by the Department of Health and Children (2001b) in the Health strategy where it notes that “The level of integration (of the team) and enhancement required will need to be supported through investment in physical infrastructure” (Department of Health and Children 2001b: 5). The provision of adequate, or even any, information technology support is noted as being a pressing need. It was of interest that the interviewers did not see even one computer in their visits to the 21 PHNs who were interviewed. Many PHNs were interested in obtaining computers and were excited at the possibilities for improving communications and for care planning that could be achieved with adequate IT facilities. This point is made by the Department of Health and Children (2001b: 5) who state that “Effective communication and pooling of information is essential to the delivery of an integrated service at primary care level…..The information and communications technology that is required to support that objective needs to be invested in.”

6.5.2. Supports for clients
The main wish of PHNs in this area was that supports for clients could be delivered rapidly, efficiently and without spending undue time in order to obtain them. Generally the provision of resources for clients was uneven; some PHNs had adequate resources near to hand or felt that they could be obtained reasonably easily, while many felt that it was very difficult to get hold of resources. Many noted the difficulty of obtaining even small requirements to carry out their work. One particular aspect of the rationing of resources was the length of time it took to get an OT visit for a client. The consequence of this was that obtaining the appropriate equipment might also be delayed until the visit had taken place. Many PHNs tried to make up for this by ordering the equipment, because it was needed urgently.
One other aspect of the work that is noted is that of advocacy for clients to obtain better housing facilities. This aspect of the work of the PHN is scarcely noted in the literature except in ‘Shaping the future,’ the report of the Homeless Agency (2001) that suggests that the homeless require enhanced health promotion; however, once again this appears to be an example of the PHN picking up the work of others because nobody else is there to do it.

This section has identified specific areas of logistical support that need to be addressed in the community nursing service in Galway. There is some anecdotal evidence to suggest that the situation in Galway is not representative of the country as a whole. In any event, it is clear that serious infrastructural deficits are present, which need to be addressed urgently.

### 6.6. Application of the Client Need Classification Tool

A key purpose of the study was the development of an appropriate caseload/workload measurement tool to aid in planning Galway Community nursing services. One of the main concerns of the researchers is the actual usefulness of the Community Client Need Classification System. A critical area of concern when embarking on the tool selection was that the tool was capable of assessing client need across all care groups encountered by the PHN.

#### 6.6.1. Workload/caseload measurement

One of the aims of this study was to produce a workload/caseload measurement system that was capable of capturing the unique role of the PHN in the Irish Republic. Workload assessment is an attempt to predict the nursing time and skills required to provide nursing care. The number and acuity of clients is a principal determinant of nursing workload (Walts and Kappadia 1996). The attempt to capture the nature of the work in any measurement tool is complicated by the range of services that may be delivered in any one patient interaction. Designing a system that would provide objective evidence of the patient workload/caseload need was a difficult task, as the care that the PHN delivers is so complex. This focus on measuring the workload/caseload accurately was critical; therefore there was dedicated effort to capture both the direct and indirect elements in community care. Past attempts to measure PHN workload in the Irish Republic focused on what the PHN is seen to do, which some may interpret as a reductionist approach to measuring the actual role. Measuring tasks can undervalue the art of assessment, which is central to the role of PHNs. The focus of the previous two national workload studies was centred around measuring the time on either categories of patients or time spent on various activities (Department of Health 1975; Burke 1986). The inherent aspects of decision-making, client and family support and advocacy were thus integrated into the tool to reflect the inherent nature of the PHN work more accurately.
This study was a significant improvement on past attempts. The resultant tool is concerned with measuring nursing dependency of the individual which may be defined as the client’s total need for nursing care including education, rehabilitation, and psychological care (Endacott and Chellel 1996). The Community Client Need Classification System succeeds in measuring the direct care aspects that pertain to the individual and indeed the indirect care such as organising services and communication with other staff. The larger role in assessing the health need of populations at large are less tangible and are difficult to measure. There is difficulty in explaining the variability of time spent with clients (Payne et al 1998). It is not possible to capture all of the PHN work activities through measuring individual need, as it is not entirely possible to capture and measure all those contributions that the role may have in terms of specific populations or indeed to the community at large.

6.6.2. Usefulness of tool

The tool captures the multidimensional aspects of the PHN role and affords insight into the complex nature of their work. The tool was used to assess clients from all care groups. The frequency of completion of the Community Client Need Classification Tool is an indication of the caseload priority care groups, i.e. child health and older person care groups. The child health and older persons care groups generated the largest number of assessments, echoing the findings of the Department of Health study in 1975, where the largest proportion of work time was spent on visits to the elderly and children. The number of client assessments generated with some care groups was relatively low over the course of the study, rendering it difficult to comment on the applicability of the tool to assess the total client need, where those clients receive only partial support from the PHN. This particularly related to clients with intellectual disability, mental health difficulties and sensory disability.

The Community Client Need Classification System enabled the PHN to review their workload. Participants highlighted the positives of the tool during the study as one reports, ‘it encouraged me to reflect on my role’ (page 88) and ‘highlighted the multi-complexity of community nursing’ (page 88).

Overall, the tool was evaluated favourably in terms of predicting and measuring the PHN work. The results would indicate that the tool afforded the PHN an opportunity to review the level of individual need with apparently good discrimination between clients. In fact, the total needs score across all care groups does reflect a normal distribution with very small numbers of clients being scored at higher levels of need.

The study did discriminate between lengths of time spent with clients of different need level and does indicate a positive linear relationship between PHN time and need. A positive correlation ($r=0.298$) is demonstrated between total PHN time and total needs score, although the correlation is lower between PHN indirect time and total needs score. This positive relationship was particularly evident in those care groups who received the larger amounts of PHN time, i.e. older persons, children and people in the other care group category. Analysis of variance indicates that the differences between mean time spent with
clients was significant across all need levels with the exception of level 3. This may be because respondents tended to select clients’ needs level at the median category 3 when they were in doubt as to the appropriate level of need and this aspect of the tool may require further consideration. The amount of time spent with clients of different care groups but with the same needs level was not constant, leading to the assumption that different client groups may require different time commitment.

The number of criteria used for assessment is greater than the six in the revised Easley- Storfjell tool (Anderson and Rokosky 2001). The extra criteria facilitated assessment of the unique elements of the Irish PHN role and were all utilised by the participants in the study. The study participants offered several insightful contributions on ways to improve the tool including combining some of the criteria for assessment and using less variables in each category. Some possibilities in this regard are the combination of sections such as health promotion and teaching needs or environment and psychosocial needs, which may contribute to increasing the reliability of the tool. Such development of the tool in the future would improve the application of the tool in practice.

The principal negative comment reported on the tool by the respondents was that it was time consuming to complete (59%). The mean time for completion for each client was 15 minutes. This may be seen as a significant time commitment for the PHN in practice and will need further consideration before wider implementation of the tool. Embedding the essential descriptors for each criterion into the main tool may reduce the frequency of need to consult the main descriptor document and could speed up the completion process. However, the number of new assessments of need would be considerably reduced if the tool were implemented over a longer period, which would also reduce the PHN time commitment. Increased familiarity and user comfort would contribute to this also.

6.7. Conclusion

The Department of Health envisaged that the PHN role in the future would be less clearly defined with greater flexibility in the approach to clients and with increased responsibility in the area of coordination (Department of Health and Children 1997). There is a requirement to develop community and primary care structures that are responsive to the needs of the people they serve (World Health Organisation 1999; Department of Health and Children 2001a; Western Health Board 2002a). Any restructuring of the acute or community health service is bound to have an effect on the role of the PHN not alone in terms of reporting structures, but also in terms of client ratios and allocation of services and resources. There is a need to understand the service at the point of delivery and this increased understanding of the nature of the work will assist in the future planning of the public health nursing service (Hanafin 2002). The Community Client Need Classification System assists PHNs in measuring the specific need of individual clients in their care and can contribute to an increased understanding of the diversity and complexity of PHN work.
Chapter Seven

Recommendations

7.1. Public Health Nurses

7.1.1. Case management
- Develop a case management system, which includes a referral system for effective and efficient workload and caseload management.
- Define criteria for referral to the PHN service
- Monitor admissions and discharges to caseloads.
- Establish criteria for admission and discharge from caseloads
- Establish criteria for active and inactive case loads
- Monitor the number of cases on the active list- (this needs to be defined, e.g. number of clients seen at least monthly by either a PHN or RGN)
- Decide on criteria for the numbers of clients on an active case list
- Define the client as being either the person recorded on the returns or the family.
- Administer the Community Client Need Classification System to each client on admission to a caseload.
- Review existing clients at a predetermined time as agreed by all members of the Public Health Nursing Service in Galway Community Care Area, using the Community Client Need Classification System.
- Develop a framework of case management that incorporates regular planned case discussions between members of the Primary Health Care Team and all other relevant stakeholders.

7.1.2. Role
- Define and clarify the role of the PHN within the proposed Primary Care Teams before such structures are implemented.

7.2. Management

7.2.1. Human resource management
- Provide access for all PHNs to IT and training.
- Develop a fully responsive health information management system for the Public Health Nursing Services, which is capable of integration with existing health information management systems in the Galway Community Care Area and Western Health Board.
- Provide secretarial and administrative support for all PHNs in the region.
- Develop a model of supportive supervision.
- Encourage the utilisation of the individual personal development plans, which are presently available in the Western Health Board.
- Develop an organisational climate that promotes team building, peer support, openness and transparency with regard to intra-professional and interprofessional relationships.
- Work to develop flattened organisational and managerial structures within the Public Health Nursing Service.
- Petition for and encourage the move towards one-site venues for Primary Care Teams.
- Audit the quality and review the health and safety issues of the work environments (health centres) of Public Health Nurses.
- Health Board investment in the buildings from which the public health nursing services are delivered should be increased as a matter of urgency.

7.2.2. Strategic planning

- Develop a five-year plan as a means by which to implement the above recommendations of this report in line with current and emerging local, national and international policies.
- The strategic plan needs to address a number of issues:
  - to recognise the curative and preventative aspects of the role of PHNs.
  - to recognise the needs of the public health nursing services and the clients it serves within the overall primary care team.
  - to recognise the skills of PHNs with particular client care groups.
  - to recognise the need for the PHN to become more involved in researching and developing community health services.
  - To recognise the need for PHNs to develop a Community Profile in partnership with members of the multi-disciplinary team.

7.3. Western Health Board Nursing and Midwifery Planning and Development Unit

7.3.1. Management

- Review the use of ratios of PHNs to population as a means to resource the PHN nursing service as previously recommended by the Department of Health (1997) and Hanafin et al (2002) in the context of emerging policies.
- Develop and implement Primary Health Care networks as recommended by the Primary Health Care Strategy (Department of Health and Children 2001a).
Implement a total quality system of delivering primary health care and public health nursing service in line with the recommendations of the Quality and Fairness: A Health System For You (Department of Health and Children 2001b).

Provide an adequate skill mix within the envisaged Primary Health Team.

Increase the involvement of PHNs in developing and co-ordinating services at a macro level, utilising the unique knowledge that PHNs have of community health needs.

Develop a Public Health Nursing Service which is person/client led as opposed to a service led system of care delivery.

### 7.3.2. Education and training

Develop a package of in-service training courses in a wide variety of areas of Public Health Nursing practice.

### 7.4. Further Research/Trinity College Dublin

Modify the Community Client Need Classification System in line with the suggested changes and conduct further research to examine and test the tool regarding its utility and reliability in practice settings.

Provide ongoing consultation and advice to the research site in order to ensure consistency in the application of the tool in practice settings.

Conduct further research with a larger sample of PHNs in other areas to examine the potential reliability and generalisability of the tool in other health care settings.

Conduct further research with other Health Care disciplines with regard to the utility of the tool as an inter-professional measure to classify client need.

Encourage further studies into areas of PHN work that were identified in this study to be problematic:

- Ineffective calls to clients, resulting in a sizeable proportion of unproductive time for PHNs.
- Current working practices that have changed due to the changing sociological profile of the population, e.g.:
  - Timing of clinics
  - Working hours
  - Non attenders to clinics
  - Unmet needs within the public health nursing service - e.g. patients awaiting referrals, equipment, translator, etc.
References


Public Health Department North Western Health Board (2001) Growing up in the North West: Profile of Child and Adolescent health in the North Western Health Board Sligo: North Western Health Board.


Western Health Board (2001a) Health and Wellbeing for Older People A strategy for 2001- 2006 Galway: Western Health Board.

Western Health Board (2001b) Western Health Board Child and Family Care Services Five Year Strategy 2001- 2005 Galway: Western Health Board.

Western Health Board (2002a) Tus Maith A Strategy for Primary Care in the Western Health Board 2002- 2005 Galway: Western Health Board.

Western Health Board (2002b) Western Health Board Service Plan 2002 Galway : Western Health Board.

Western Health Board (2002c) Promoting Health in the West Health Promotion Strategy 2003- 2008 Galway : Western Health Board.


Appendices

Appendix 8.01 – Job description of the PHN

Reports to: Assistant Director of Public Health Nursing.

Role: The Public Health Nurse will focus on a district or area meeting the curative and preventative nursing needs of the population within the area. The Public Health Nurse will be expected to provide a broad based integrated prevention, education and health promotion service and to act as co-coordinator in the delivery of a range of services in the community.

The Public Health Nurse in exercising his/her professional autonomy will be expected to maintain a high standard of nursing care, to share responsibility with the community nursing team for the management of nursing care and the patients' environment and to maintain a high standard of professional and ethical responsibility.

Main Duties and Responsibilities:

1. To deliver nursing care and provide professional advice and support to patients, carers and families, including Health Education and Health Promotion advice.
2. To provide support to persons with a disability and their carers on an ongoing basis.
3. To provide support to families following bereavement, family disharmony or break-up.
4. To liaise with hospitals on discharge planning and to perform home assessments prior to discharge from hospital or other institution.
5. To provide home nursing, including where appropriate, ante natal care in accordance with such arrangements as may be made by the Health Board from time to time.
6. To manage effectively requests for home nursing following discharge from hospital or other institution.
7. To promote and participate as required in the primary and booster immunisation programmes.
8. To visit homes following early discharge/birth notification and for on-going child, maternal and family health monitoring.
9. To liaise with and advise parents or guardians on all aspects of child health with particular emphasis on the benefits of breast-feeding.
10. To provide and participate in developmental screening/examination and pre-school health service.
11. To participate as required in the school health service and in subsequent follow up activities.
12. To work closely in partnership with colleagues in the area of child care and protection.
13. To provide regular preventive services for older people with a view to maintaining older people in dignity and independence at home in accordance with the wishes of the older person.
14. To provide safe, comprehensive nursing care to patients.
15. To actively participate with other relevant care professionals in planning patient care and to attend case conferences as required.
16. To establish care priorities based on patients' nursing and medical needs.
17. To promote a healthy environment for patients and clients.

18. To initiate and operate clinics which provide a nursing service to clients and to participate in medical clinics as required.

19(A). To identify and assess the need for the home help service.

19 (B). To identify and assess the need for and supervision of the home care attendant service.

20. To participate in formal health education and health promotion activities as required.

21. To provide practical work experience and guidance and act as course preceptors for Student Public Health Nurses or other student nurses during community placement as required.

22. To participate in continuing education.

23. To complete such records and supply such reports and other information as may be required from time to time.

24. To participate in infection disease control according to current Government and health board guidelines.

25. To initiate and participate in individual and team schemes to provide continuous quality improvement in the provision of nursing services.

26. To co-operate with GPs and practice nurses in the development and management of patient care.

27. To prepare and implement individual care plans as part of a multi-disciplinary team.

28. To provide health screening services as appropriate.

29. To undertake other relevant duties as may be determined from time to time by the C.B.O. or other designated officer.

## Appendix 8.02. - Role of the PHN in the Core Child Health Surveillance Programme

<table>
<thead>
<tr>
<th>Age at Examination</th>
<th>Screening</th>
<th>Topics for health education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 48 hours of</td>
<td>Guthrie test if not done by midwife. Note appearance</td>
<td>Breast Feeding and nutrition, baby care, Parental smoking, accident prevention, immunisation, Post-Natal depression, Recognition of illness and what to do.</td>
</tr>
<tr>
<td>discharge</td>
<td>Check for Congenital Dislocation of Hips (CDH)</td>
<td></td>
</tr>
<tr>
<td>3 months</td>
<td>Check appearance, weight and head circumference if indicated by parental concern or appearance. Check for CDH</td>
<td>Immunisation and weaning</td>
</tr>
<tr>
<td>7-9 months with AMO</td>
<td>As above, check for testicular descent, Hearing test, observe for squint</td>
<td>Accident prevention, transport in cars, dental and nutrition care. Developmental stimulation, sunburn, parental smoking</td>
</tr>
<tr>
<td>18- 24 months</td>
<td>Height and gait</td>
<td>As above also avoidance and management of behaviour problems</td>
</tr>
<tr>
<td>3.25- 3.5 years</td>
<td>Height and weight if indicated. Ask parents about vision, hearing, behaviour, language acquisition and development.</td>
<td>Accident prevention, preparation for school, nutrition and dental care</td>
</tr>
</tbody>
</table>

Adapted from Content and Timing of Core Child Health Surveillance Programme: In the Best Health for Children report (page 45) (Denyer Thorton & Pelly, 1999)
### Appendix 8.03.- Role of the School Nurse in the Core Child Health Surveillance Programme

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening</th>
<th>Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-6 years</td>
<td>Measure height and weight. Do hearing and vision test. Opportunity for general health check.</td>
<td>As per SPHE* programme</td>
</tr>
<tr>
<td>7-8 years</td>
<td>Check visual acuity. Opportunity for general health check</td>
<td>As per SPHE programme</td>
</tr>
<tr>
<td>11-12 years</td>
<td>Check visual acuity. Check colour vision. Opportunity for general health check</td>
<td>As per SPHE programme</td>
</tr>
</tbody>
</table>

Adapted from Content and Timing of Core Child Health Surveillance Programmen: In the Best health for Children report (page 46) (Denyer Thorton & Pelly, 1999)

* Social and Personal Health Education
Appendix 8.04. - Qualitative Interview Guide

1. Could you tell me about what the role of the PHN involves?
   Prompt: Can you describe your typical clinical responsibilities?
   Can you tell me about what other roles you have?

2. Can you identify what aspects of community care do not constitute your role?
   Prompt: what is not your role?

3. Can you tell me about the ideal configuration of the community nursing service?
   Prompt: How could the workload best be distributed between the community care team?
   How could it be distributed amongst the nursing team? Or the wider team?

4. What would facilitate your role?
   Prompt: Make it work more effectively.

5. Can you tell me about how you manage your caseload of clients / patients?
   Prompts: Planning / Administration / Recording.
   Time spent on reports etc….

6. What are the problems you experience in your job as a PHN?
   Prompt. Do you see threats to the role of the PHN?
   What supports might help deal with those problems?
   What is your ideal service?

7. Can you tell me about your role in health promotion?
   Prompts: Are you involved in health promotion with particular groups?
   Are you involved specifically in health promotion with children or the elderly?
   Are you involved in education?
   Are you involved in community development?

8. What does team working involve for you?
   Prompt: How does your role relate to others in the community care team?

9. What helps communication within the team?

10. What hinders communication within the team?

11. What developments do you foresee in the future regarding the role of the PHN?

12. Do you have any other points that you would like to make?
Appendix 8.05 – Instructions to study participants

Dear Colleague,

Many thanks for volunteering to participate in this study. Data Collection will take place from Monday 28th April to Sunday 11th May 2003. The forms that are enclosed should be used by PHNs on weekdays and weekends if required.

We are asking you to complete the [1] Client Need Classification System tool form (White form) on all clients-both new and existing clients during the 14 days of the study. A client is defined as an individual requiring a public health nursing service. We are asking you to classify the level of need each client requires. Accordingly we have enclosed a booklet the Guide to using the client need classification system [2] to guide you in classifying your clients according to low level of need and high level of need as discussed in the workshops.

For data analysis purposes each PHN will be allocated a code e.g. 624. Please code the clients with a six figure code number. Thus for the PHN who is coded 624 the first client whom she sees or provides indirect care for [eg phone call, report writing, ordering equipment] on the Monday 28th April will be coded 624 001. The second client will be 624002 etc… Each client will have an individual code for the duration of the study. If in your opinion, the client’s need changes during the two weeks, then a new client need classification form may be used to re-assess the client. Please ensure that the same code for the client is used on all documents in relation to the client. No consent is required from the client.

We are also asking you to complete a Summary of Client Contact Sheet [3]. This sheet sums up the time spent on each client each day. Thus in each row, you are asked to document the client number, the client care code, the client’s need level and the amount of time spent in Direct Care and Indirect Care with the Client. This tool also allows you to document unmet needs of the client.

We would also like you to complete the Activity Worksheet for PHNs [4]. This sheet asks you to document your commitments to health promotion, community development, and thus allows the calculation of time available for your caseload.

We welcome your opinion on these tools and we ask you to complete the Questionnaire to PHNs re the Client Need Classification tool [5] at the end of the 2 weeks. This is a satisfaction assessment and the purpose is to find out if the tool worked well for you.

To sum up, your pack should include the following six sections:

- Client Need Classification System tool [1] (To be completed for each client)
- A Guide to Using the Client Need Classification System Tool [2].
- A summary of Contact with Client’s Sheet [3]
- Activity Worksheet for PHNs [4]
- Questionnaire re Client need classification tool [5].

Thank you for agreeing to take part in the study. We hope that the results will be of benefit to all PHNs in county Galway and indeed in Ireland.

If you have any queries about this study, please contact us at the following number:

Reception of School of Nursing 01 6083073
Gobnait Byrne 01 6083105
Paul Horan 01 6083110

With best wishes,

Gobnait, Paul, Cecily, Colin, Caitriona and Anne-Marie
Appendix 8.06 - Form 1 Client Need Classification System

<table>
<thead>
<tr>
<th>Criteria</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Care Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psycho-Social Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child and Family Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel Time per visit [20 minutes]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subtotal Columns

<table>
<thead>
<tr>
<th>Acuity Point</th>
<th>Level</th>
<th>Total Score [To be recorded in Summary of Client Contact Sheet]</th>
<th>Needs Level Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 9 Pts</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 – 18 Pts</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 – 27 Pts</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 – 34 Pts</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 – 50 Pts</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL SCORE:

Please comment on additional client needs which this tool fails to score or categorise.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Appendix 8.07 – Questionnaire to PHNS re Client Need Classification System Tool

Dear Colleague,

We would be very grateful if you would complete the following questions. This information will help us with our PHN research project.

1. Did you use this tool for new referrals
   □ Yes □ No

2. No of new referrals
   ____________________

3. Did you find this tool useful in helping predict the amount of nursing input required
   □ Yes □ No

4. Did you use this tool for your existing clients
   □ Yes □ No

5. No. of existing clients reviewed using this tool
   ____________________

6. Would this tool be useful in predicting the needs of existing clients
   □ Yes □ No

7. Did you find this tool useful in measuring your workload?
   Yes □ No □
   Please give reasons for your answer.

   •
   •
   •
   •
8. Please list the aspects of the tool that you would rate positively.
   - 
   - 
   - 
   - 

9. Please list the aspects of the tool that you would rate negatively.
   - 
   - 
   - 

10. What changes would you make to the tool if any?
    - 
    - 
    - 

CLIENT CARE GROUPS

11. Is this tool suitable for predicting the needs of the following client groups?

Please tick ✔️ the appropriate box

<table>
<thead>
<tr>
<th>Care Groups</th>
<th>Yes</th>
<th>No</th>
<th>If No – Please state Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Natal Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(To include Preschool and School children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Protection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Persons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Care Groups (Please Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. How long did it take you to complete this tool for each client?

_________________________________________________________________________

13. “This tool would help PHNs working in the community.”
(Please tick one box)

   Strongly Agree ☐
   Agree ☐
   Undecided ☐
   Disagree ☐
   Strongly Disagree ☐

14. “This tool was simple to understand.”
(Please tick one box)

   Strongly Agree ☐
   Agree ☐
   Undecided ☐
   Disagree ☐
   Strongly Disagree ☐

15. “The tool was easy to use.”
(Please tick one box)

   Strongly Agree ☐
   Agree ☐
   Undecided ☐
   Disagree ☐
   Strongly Disagree ☐

16. Additional comments you might wish to make.
Continuation of any additional comments you might wish to make.

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

DEMOGRAPHIC DETAILS

18. Professional Qualifications

RGN  □  RM  □  PHN  □  Health Visitor  □

Other  □  (Please specify) ________________________________

____________________________________________________________________________

19. Please tick ☑ if you have the following qualifications:

Diploma  □
Degree  □
Masters  □
Other Course □  (Please specify) ________________________________

____________________________________________________________________________

____________________________________________________________________________

20. Are you presently doing a course at the moment?

Yes  □  No  □

If yes, please specify ________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

21. Number of years since completing PHN course: _________
22. Number of years working as a PHN:  

23. Age at last birthday
   
   < 25  
   25 – 30  
   31 – 35  
   36 – 40  
   < 41 – 45  
   46 – 50  
   51 – 55  
   56 – 60  
   61 – 65  
   > 65  

24. Number of years working as a PHN in this Community Area:  

25. Is your community area
   
   Rural  
   Urban  
   Island  

Many thanks for completing this questionnaire
Anne-Marie, Caitriona, Cecily, Colin, Gobnait and Paul
### Appendix 8.08 – A guide to using The Client Need Classification System: NURSING JUDGEMENT REQUIRED

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal need for ongoing assessment for symptom control.</td>
<td>Routine Nursing Assessment. May include Routine observation of vital bodily functions.</td>
<td>Client condition requires skilled assessment.</td>
<td>Physiologically, the client is predictably unstable, i.e. recently discharged.</td>
<td>Client requires skilled complex assessment and intervention to remain at home.</td>
</tr>
<tr>
<td>Routine observation of predictable physical and/or psychological condition.</td>
<td>Routine Developmental checks and screening. (E.g. Baby's weight)</td>
<td>Client's condition is variable at least once a fortnight.</td>
<td>Aggressive problem solving necessary to assist client / remaining at home.</td>
<td>Requires creatively co-ordinated plan to ensure optimal health functional level for client.</td>
</tr>
<tr>
<td>Requires limited skilled judgement., i.e. ongoing medication management.</td>
<td>Case management of diabetic client.</td>
<td>High potential of exacerbation.</td>
<td>Care is multidimensional.</td>
<td>Requires continuous care at home or may require transfer to residential care.</td>
</tr>
<tr>
<td>Use of fundamental nursing skills.</td>
<td></td>
<td>Client with active symptoms: 1 – 3 skilled nursing visits per week.</td>
<td>Client with acute / complex problems requiring more than three nursing visits per week.</td>
<td>First contact with family or client.</td>
</tr>
</tbody>
</table>
## Appendix 8.09 – A guide to using The Client Need Classification System: NURSING PROBLEMS

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few or uncomplicated problems.</td>
<td>Probable exacerbation without the need for skilled nursing intervention, i.e. case management.</td>
<td>One or more client problems of moderate complexity requiring one or more nursing interventions.</td>
<td>Two unstable medical diagnoses.</td>
<td>Requires 1 – 2 hours home visit.</td>
</tr>
<tr>
<td>Injections and Blood Glucose Monitoring.</td>
<td>Health deficit(s) identified.</td>
<td>Client exhibits at least one medical diagnosis in exacerbated state.</td>
<td>Infectious disease present, e.g. MRSA, TB or other.</td>
<td>Requires a daily visit from either a PHN or a RGN.</td>
</tr>
<tr>
<td>Client self-sufficient in existing environment.</td>
<td>Caregiver needed and available to manage presenting conditions.</td>
<td>Potential for inadequate hydration and nutrition (i.e. breast feeding).</td>
<td>Complex Assessment required.</td>
<td>More than 2 unstable medical diagnoses.</td>
</tr>
<tr>
<td>Client / client has regular source of medical care.</td>
<td>On-going case management and evaluation required.</td>
<td>Multiple interventions required during each visit. (May include teaching around three bodily systems, medications administration and nursing interventions / treatment.)</td>
<td>Multiple exacerbations in the last year.</td>
<td>Multiple exacerbations in the last year.</td>
</tr>
<tr>
<td>Family / Client know salient facts about disease / condition to take necessary actions in proper time.</td>
<td>Client and caregiver show impairment in one body system (i.e. respiratory, circulatory, digestive, reproductive or urinary).</td>
<td>Sleep / rest patterns interfere with family lifestyle (i.e. colicky baby). Adult / child wakes frequently during the night requiring care.</td>
<td>Problems require immediate interventions / acute problem solving.</td>
<td>Problems require immediate interventions / acute problem solving.</td>
</tr>
<tr>
<td>Family / Client understands the plan of care and are able to report significant deviations from same.</td>
<td>Client has reached highest level of functioning within resources and environment but may need some interventions to prevent condition from deteriorating.</td>
<td>Terminal diagnosis under six months; pain and symptoms controlled.</td>
<td>Client and / or caregiver exhibit impairments in two or more body systems and refuses all care.</td>
<td>Client and / or caregiver exhibit impairments in two or more body systems and refuses all care.</td>
</tr>
<tr>
<td>Minimal nursing assistance required.</td>
<td>High risk of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Infection</td>
<td>Terminal diagnosis under six months; pain and symptoms controlled.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Pressure sores</td>
<td>Pain greater than 5 on a 0 – 10 scale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Admission / re-admission to hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential non-attender of appointments.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 8.10 – A guide to using The Client Need Classification System: PHYSICAL CARE REQUIREMENTS

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple preventative physical or technical interventions. E.g. Suprapubic catheter care.</td>
<td>Use of skilled technical skills, i.e. first time in home gastrostomy tube change</td>
<td>Use of complex interventions requiring an understanding of scientific rationale</td>
<td>Issues that require immediate intervention and crisis management</td>
<td></td>
</tr>
<tr>
<td>Client / Family is self caring in the following:</td>
<td>Family and Client able to apply most general principles of hygiene.</td>
<td>Use of complex interventions requiring an understanding of scientific rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gastrostomy care</td>
<td>Family providing for physical care of client/client but only with encouragement and support.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Tracheostomy tube care</td>
<td>Use of home help support is likely.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Wound Care:</td>
<td>Use glucometer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- One visit per week,</td>
<td>Advice on Prevention (e.g. pressure sores)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections:</td>
<td>Wound Care:</td>
<td>Wound Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Weekly / monthly injections.</td>
<td>- Simple dressing changes requiring two visits per week.</td>
<td>- Infected tracheostomy site</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injections:</td>
<td>- Infected Umbilical cord</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Routine daily injections.</td>
<td>- Removal of clips / sutures</td>
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</tbody>
</table>
## Appendix 8.11 – A guide to using The Client Need Classification System: TEACHING NEEDS [Not including Parenting or Health Promotion]

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching in one area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Client able to demonstrate that they can carry out procedures safely and effectively with an understanding of the principles involved and with a confident, willing attitude.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeps all appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching in two areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Client demonstrate ability to carry out procedures and treatments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Client knows / accepts health condition / problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need some teaching / to maintain their current health status.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need reminders and encouragement to keep appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reinforcement of good infant feeding practices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching in three areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family lacks skills for care taking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Client is carrying out some but not all of the prescribed procedures or treatments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires moderate teaching input and referral to appropriate resources.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client has minimal ability to care for self, and family require a great deal of support / assistance in order to provide care.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inconsistent attendance of appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires prompting re. Attendance of appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching in four areas or teaching complex skills.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching to multiple caregivers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of compliance with previous teaching.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not keep appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching in five or more areas.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literacy difficulties.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of English and requires an Interpreter.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client / Caregiver has uncompensated sensory / cognitive deficit with no correction available (blind, deaf, mute, intellectual disabilities).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Client totally uninformed about health condition or health problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimal teaching done in hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications taken as prescribed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates very good knowledge of same.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications taken as prescribed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has some knowledge of medications.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications taken as prescribed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has no knowledge of medications.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five or more medications.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client / Family deviates from prescribed medication dosage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client refusing to take any medications.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 8.12 – A guide to using The Client Need Classification System: PSYCHO-SOCIAL NEEDS

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client is functioning without support, monitoring only required.</td>
<td>Minimal emotional and psychological support needed e.g. listening.</td>
<td>Moderate emotional and psychological support needed. E.g. listening / use of counseling skills.</td>
<td>Requires extensive support from PHN e.g. use of counseling skills and relationship building.</td>
<td>Multi-agency input required.</td>
</tr>
<tr>
<td>Family / Client understands / recognizes and accepts the need for health care.</td>
<td>Other persons in home impact caregiver time / ability to meet client's needs i.e. physical / mentally / emotionally challenged / small children.</td>
<td>Family life may be disorganized in many areas.</td>
<td>One or more household members abuse alcohol / drugs.</td>
<td>Family experience alienation from the community – lack of trust of outsiders.</td>
</tr>
<tr>
<td>Support network present</td>
<td>Client / Other household members demonstrate inappropriate and / or maladaptive behaviour.</td>
<td>Family has moved two or more times in past year. Problem relating to lifestyle: one or more family members use alcohol and / or drugs on a daily basis. Carer is working in isolation from the rest of the family. Carer needs a lot of support.</td>
<td>Socially isolated. Family unfamiliar with procedure for obtaining community services. Family has difficulty understanding the role of service providers. Client family frequently expressed anxiety, guilt, depressive symptoms or inability to cope with stress. Requires a Bereavement Visit.</td>
<td>Non-English speaking (interpreter).</td>
</tr>
<tr>
<td>No financial problems</td>
<td>Adequate Finances except for long term or disastrous types of conditions.</td>
<td>Able to manage with support.</td>
<td>Inadequate family finances. Has medical card.</td>
<td>Unemployed. No medical card. No concept of financial management.</td>
</tr>
</tbody>
</table>
### Appendix 8.13 – A guide to using The Client Need Classification System: CASE MANAGEMENT / CARE MANAGEMENT

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited involvement of one other healthcare professional or community resource.</td>
<td>Limited involvement of two or more healthcare professionals or community resources.</td>
<td>Two or more healthcare professionals involved with clients who are at risk of exacerbation.</td>
<td>Extensive co-ordination of client services utilization of three or more agency providers for comprehensive care</td>
<td>Extensive co-ordination of highly complex services</td>
</tr>
<tr>
<td>One other resource i.e meals on wheels.</td>
<td>Aware of necessary community resources.</td>
<td>Community resources in place but inappropriate utilisation by client / caregiver.</td>
<td>Requires urgent visits within 24 / 48 hours.</td>
<td>Requires crisis visit.</td>
</tr>
<tr>
<td>Family / Client use available resources and suitable facilities as needed.</td>
<td>Family / Client knows of and uses community resources but may need intervention to continue follow-through.</td>
<td>Two or more disciplines involved.</td>
<td>Liaison with other professional re. previous Referral Letter.</td>
<td>Requires regular case conferences. [Once a month]</td>
</tr>
<tr>
<td><strong>Caseload Administration with secretarial support:</strong></td>
<td><strong>Caseload Administration without secretarial support:</strong></td>
<td><strong>Case Management:</strong></td>
<td><strong>Case Management:</strong></td>
<td>Requires urgent referral letter.</td>
</tr>
<tr>
<td>• Filing</td>
<td>• Filing</td>
<td>• Arranging appointments</td>
<td>• Letter writing and postage</td>
<td>Client requires a supply of equipment on an ongoing basis.</td>
</tr>
<tr>
<td>• Arranging appointments</td>
<td>• Arranging appointments</td>
<td></td>
<td></td>
<td>Client arrives in clinic without appointment – requiring urgent assistance.</td>
</tr>
<tr>
<td>• Letter writing and postage</td>
<td>• Letter writing and postage</td>
<td></td>
<td></td>
<td>Client requires respite care / sheltered accommodation / foster care – within a week.</td>
</tr>
<tr>
<td><strong>Minimal recording</strong></td>
<td><strong>Detailed documentation of Client Care</strong></td>
<td><strong>Updating existing care plan with one issue</strong></td>
<td><strong>Updates updating on existing care plan with multiple new issues.</strong></td>
<td><strong>Developing care plans for new clients.</strong></td>
</tr>
</tbody>
</table>

- Requires urgent visits within 24 / 48 hours.
- Liaison with other professional re. previous Referral Letter.
- Client requires a supply of equipment on an ongoing basis.
- Client arrives in clinic without appointment – requiring urgent assistance.
- Client requires respite care / sheltered accommodation / foster care – within a week.
Appendix 8.14 – A guide to using The Client Need Classification System: CHILD AND FAMILY SUPPORT [PARENTING EDUCATION]

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting skills present and adequate.</td>
<td>Minimal support and education required regarding parenting skills / child care.</td>
<td>Some adequate parenting skills present but requires some education and support for medical and / or emotional and behavioural difficulties.</td>
<td>Some parenting skills present.</td>
<td>Lack of parenting skills – Require extensive education and support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Report needed.</td>
<td></td>
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<td></td>
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</tbody>
</table>
## Appendix 8.15 – A guide to using The Client Need Classification System: HEALTH PROMOTION

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client / Family has adequate knowledge of the following:</td>
<td>Needs some education or advocacy.</td>
<td>Needs extensive education.</td>
<td>The client has missed one or more appointments.</td>
<td>Requires multi-agency advocacy.</td>
</tr>
<tr>
<td>• Health lifestyles (Diet, exercise etc).</td>
<td>Opportunistic Health promotion. (It is an add-on to another activity with the client or family.)</td>
<td>Requires the PHN to act as client advocate e.g. to negotiate for services etc..</td>
<td>The client has a history of an accident in the home.</td>
<td>Health promotion is the primary reason for visiting the client / family.</td>
</tr>
<tr>
<td>• Prevention of accidents.</td>
<td></td>
<td>Needs to access established health promotion classes / programmes / support groups.</td>
<td>Requires the PHN to act as client advocate on a continuing basis.</td>
<td></td>
</tr>
<tr>
<td>• Importance of immunizations (childhood and flu vaccination)</td>
<td></td>
<td></td>
<td>Needs to access health promotion programmes / classes which are not available within the community care area and need to be developed.</td>
<td></td>
</tr>
<tr>
<td>• Childhood screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Breast and Cervical Cancer Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Men’s Health</td>
<td></td>
<td></td>
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<tr>
<td>• Women’s Health</td>
<td></td>
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</table>
Appendix 8.16 – A guide to using The Client Need Classification System: ENVIRONMENT

<table>
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<tr>
<th>Score 1</th>
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<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>House in good repair, no safety hazards identifiable.</td>
<td>House in good repair but safety hazards may be present that need evaluation. E.g.: steep stairs, cluttered living space, lacks needed safety devices.</td>
<td>House in fair condition, safety hazards exist but family could rectify if identified.</td>
<td>House has inadequate heating conditions, dampness – poor insulation and ventilation.</td>
<td>Client / Family are homeless or living in temporary sheltered accommodation.</td>
</tr>
<tr>
<td>Appears free of rodent and pest problems.</td>
<td>Overcrowding exists but house liveable</td>
<td>No evidence of fire alarms.</td>
<td>No transportation. Client is unable to access the clinic without assistance.</td>
<td></td>
</tr>
<tr>
<td>Transport to medical care available.</td>
<td>Elderly person living alone needs a personal alarm.</td>
<td>Client / Caregiver expresses concern over neighbourhood safety but willing to remain.</td>
<td>Requires urgent referral for re-housing or refurbishment issues.</td>
<td></td>
</tr>
<tr>
<td>Traveller living in good accommodation in a well-serviced halting site.</td>
<td>Traveller living in good accommodation in an unserviced halting site.</td>
<td>Traveller living in good accommodation in an unserviced halting site.</td>
<td>Traveller living in poor accommodation in an unserviced halting site.</td>
<td></td>
</tr>
<tr>
<td>The home contains all the safety devices for a toddler.</td>
<td>Some safety devices present. Some advice required on safety issues.</td>
<td>Need to order safety equipment for children. Education required on child safety.</td>
<td>Lack of sterilisation facilities for bottle-feeding. High risk of accidents. Needs urgent equipment and education.</td>
<td>The home is unsafe for toddlers, e.g. no safe play area, no fire guard, no stair guard etc...</td>
</tr>
</tbody>
</table>

Revision of the Revised Easley Storfjell Client Acuity Classification (Anderson and Rokosky 2001)
Appendix 8.17 – Pre-Test and Post-Test of Tool using Scenario

Dear Colleague,

We are asking you to complete the Client Need Classification Form for the client- Mary Ryan. We need all PHNs to complete this scenario twice to help check the validity and reliability of the tool.

Please complete the enclosed client need classification form on the first day of the study (28th April 2003), place in envelope and return to us with the rest of the data.

Many thanks

Gobnait, Paul, Cecily, Colin, Caitriona and Anne-Marie.

Mary Ryan

Mary Ryan is an infant child born on the 1st February 2003. Mary was born full term and is an only child. Mary’s parents are Jimmy aged 38 and Jean aged 36. Both of Mary’s parents are professionals and the family live in a bungalow in a well established suburban estate. The family home is well maintained and boasts all safety devices. Mary’s parents are both having difficulties coming to terms with the fact that Mary has Downs Syndrome. Mary does not attend crèche or nursery at present. None of Mary’s parents families, friends or relatives have children with disabilities. Mary’s mother Jean has not returned to work but is contemplating doing so. The family has no extended family in the local area.

You are going to visit the family to carry out Mary’s 3 month developmental check in the home as the developmental check clinic appointment was not kept. Jean reports that Mary is not feeding well (Mary is currently being bottle fed).
Appendix 8.18 – Activity Worksheet

Please complete this form for the two weeks (28/4/2003- 11/5/2003) of this study. This will help predict the time available for the management of your caseload and also document your commitments to community development and health promotion programmes.

<table>
<thead>
<tr>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Normal Hours worked (incl weekend)</td>
<td></td>
</tr>
<tr>
<td>Number of Overtime hours (Extra time)</td>
<td></td>
</tr>
<tr>
<td>Annual Leave and Other Leave</td>
<td></td>
</tr>
<tr>
<td>Professional Development</td>
<td></td>
</tr>
<tr>
<td>Study Leave</td>
<td></td>
</tr>
<tr>
<td>In- Service Education</td>
<td></td>
</tr>
<tr>
<td>Staff Meetings</td>
<td></td>
</tr>
<tr>
<td>Commitments other than Caseload</td>
<td></td>
</tr>
<tr>
<td>Health Promotion Programmes</td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td></td>
</tr>
<tr>
<td>Committee Work</td>
<td></td>
</tr>
<tr>
<td>Community Development</td>
<td></td>
</tr>
<tr>
<td>Total Time Spent Travelling during the two weeks</td>
<td></td>
</tr>
<tr>
<td>Total time spent on non-caseload activity- eg caretaking, ordering stationery, stock etc</td>
<td></td>
</tr>
<tr>
<td>No. of Admissions To Caseload</td>
<td></td>
</tr>
<tr>
<td>No. of Discharges from Caseload</td>
<td></td>
</tr>
</tbody>
</table>

**PHN Code:**