Adaptation of the clinical nurse role for improved safety in South Australian rural hospitals

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A new staffing resource was organised to efficiently address safety and quality improvements required within Country Health South Australia.

Introduction
Country Health South Australia Local Health Network (CHSALHN) covers 983,776 square kilometres, which is 99.8% of South Australia and the largest Local Health Network in Australia.

In 2011, approximately 490,635 people or 28.1% of the state population was living in country SA. This includes 15,210 Indigenous Australians, which is approximately 52% of the total Indigenous population of South Australia.

There are 65 public hospitals within CHSALHN, with services provided at 240 sites. 10.9% of patients identified themselves as being of Aboriginal or Torres Strait Islander descent.

Our workforce comprises of approximately 5,800 fulltime equivalent staff, of which approximately 2,500 fulltime equivalent are nurses and/or midwives. This represents a head count of 3,860 nurses and/or midwives. Across the 65 sites there are 60 Directors of Nursing and Midwifery. This Paper presents work undertaken by CHSALHN to optimise the benefits to the individual and organisation and make a difference to patients as a result of funding available for Registered Nurse reclassification to a Level 2 Clinical Nurse/Midwife position.

Background
The 2007 Nurse/Midwives (South Australian Public Sector) Enterprise Agreement1 introduced a new Career Structure for nurses and midwives. This provided an opportunity for Registered nurses who met agreed criteria including more than three years’ experience to apply for personal reclassification to Registered Nurse Level 2, Clinical Nurse/Midwife.

In 2009, funding was provided through South Australian Health Department (SA Health) for backfill for these Clinical Nurses/midwives, to undertake portfolio work.

The CHSALHN Directors of Nursing and Midwifery (DONMS) were responsible for the allocation of the portfolios. The funds provided to CHSALHN of $2,800,000 per financial year, allowed for Clinical Nurses with a portfolio responsibility, rostered time away from direct patient care.

Developing the program
In 2010, the CHSALHN Director of Nursing and Midwifery group identified Safety and Quality, as the priority for utilising this resource to improve and build on existing safety and quality systems and promote professional development opportunities for this registered nurse group.

Portfolio areas of:
- clinical handover
- falls prevention
- palliative care
- wound/stoma care
- infection control
were agreed by the CHSALHN Director of Nursing and Midwifery group.

A process to allocate funds was developed, based on a formula of full time equivalent (FTE) to each portfolio area, per hospital or cluster of geographically located hospitals. These portfolios were managed independently, at each hospital or small cluster of hospitals.

Nurses and Midwives, who met the criteria, were slow to apply for this personal reclassification; the process was reported to be onerous and difficult even when education and support was provided by DONMs and other senior staff to assist.

In early 2011, a review of the Clinical Nurse portfolio work across CHSALHN revealed inconsistencies in implementation, practice and processes. At least 10 hospitals did not have reclassified Clinical Nurses, while some had up to 10 Clinical Nurses allocated portfolio responsibilities. There was minimal evidence of changed and improved practice, or consistency across CHSALHN as a result of the program.

In July, 2011 a revised Clinical Nurse Portfolio model was developed and endorsed by the CHSALHN Director of Nursing and Midwifery group. This model recognised and incorporated the need for clinical governance and interdisciplinary engagement of clinicians to support and achieve better patient care. Clinical leadership, along with consistent application and support for development of the Clinical Nurse role was included in the revised model, as well as learning from the 2010 program.

Portfolio areas were changed, to reflect the CHSALHN priorities and the National Safety and Quality Health Services Standards. The Palliative Care and Wound/Stoma Care portfolios were replaced with Deteriorating Patient and Medication Safety portfolio areas. Table 1 shows the revised portfolio areas and rationale for prioritising the six areas. Stretching the limited funding across 65 hospitals, and limited numbers of reclassified Clinical Nurses, restricted the number of National Safety and Quality Standards that were included. The six selected areas all had high relevance for the diverse range of CHSALHN contexts and it was envisaged this would assist the reclassified clinical nurses to implement improvement initiatives. Clinical Handover was removed from the portfolio areas, as many of our hospitals were implementing the Team STEPPs program, which focuses on Clinical Handover, teamwork and communication.

A tiered model was introduced, with governance and clinical leadership embedded.

This included designated responsibilities for:

- the Director of Nursing and Midwifery CHSALHN as the lead for the Portfolio program
- a Director of Nursing and Midwifery, as nominated lead for each portfolio area
- lead clinician(s) with full time responsibility for the portfolio clinical area
- clinical nurses in each portfolio area across CHSALHN.

Clinical leadership was crucial in the design of the model with recognition that the diverse context culture and social dynamics of CHSALHN workplaces would impact on the effectiveness of the new clinical nurse portfolio role. Cook and Leathard (2004) identified creativity, highlighting, influencing, respect and supporting as important leadership attributes in clinical practice. The program aimed to encourage development and use of these attributes.

The Director of Nursing and Midwifery for CHSALHN is responsible for executive level strategic and operational nursing and midwifery leadership that contributes to the provision of high quality nursing and midwifery services, expert advice and sound patient care outcomes across CHSALHN. Providing leadership to the Portfolio program is an important part of this.
A hospital Director of Nursing & Midwifery Lead is responsible for supporting the Lead Clinician and Clinical nurses, to apply consistent systems and processes. When Clinical Nurses have difficulty implementing change at the local hospital level, or are not being rostered indirect time to undertake the portfolio work, the DONM lead will advocate and discuss with the DONM from that hospital. They also use their expertise to provide advice on implementation and governance requirements.

The Lead Clinicians are employed by at the corporate level of CHSALHN, to lead improvements in safety and quality, and the implementation of the National Safety and Quality Standards across all health services in CHSA. They are responsible for developing the system changes required including tools for implementation and auditing.

The Clinical Nurses assigned with a portfolio are provided with indirect time to undertake portfolio work, such as, education, implementation of a new procedure, auditing and reporting. The Clinical Nurse, is often allocated to the portfolio across several hospitals that are geographically aligned. Each Clinical Nurse has a communication strategy, usually telephone, teleconference or email, with each hospital, to ensure each hospital is engaged and informed.

Table 1  CHSALHN Portfolio areas

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Rationale</th>
<th>Lead clinician</th>
<th>DONM lead</th>
<th>Clinical portfolio nurse numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deteriorating patient</td>
<td>Coroners recommendations across SA Health</td>
<td>Cathie West and Sharyn Phillis Senior Registered Nurses</td>
<td>Alison Hoare</td>
<td>11</td>
</tr>
<tr>
<td>Medication safety</td>
<td>High number of medication incident in CHSALHN</td>
<td>Hannah Loller Pharmacist Trudy McIver Senior Registered Nurse</td>
<td>Pam Schubert Gill Churchett</td>
<td>11</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>High number of falls in CHSALHN</td>
<td>Meredith Stewart and Joyti Zwar Physiotherapists</td>
<td>Lynne Northcott</td>
<td>12</td>
</tr>
<tr>
<td>Infection control</td>
<td>High risk to patient outcomes</td>
<td>Jacqui McLean Registered Nurse Level 4</td>
<td>Desiree May</td>
<td>10</td>
</tr>
<tr>
<td>Blood safe</td>
<td>High wastage rates in CHSALHN, and minimal Policy</td>
<td>Merrilee Clarke Registered Nurse Level 3</td>
<td>Lindy Crawford</td>
<td>11</td>
</tr>
</tbody>
</table>

The total indirect time allocated is equivalent to the funding provided to CHSALHN for Clinical Nurse Portfolio management.

The revised model included recognition of the particular professional development needs for the reclassified Portfolio Clinical Nurse. This group was diverse with a wide range of prior experience. Like many rural nurses the majority had a strong broad clinical practice base (with limited experience leading projects across health units). The expectations of the portfolio role introduced concepts that were unfamiliar to many of the reclassified nurses.

In March 2012, a workshop with Clinical Nurses, Clinical Leads and DONM Leads was held, to bring together all those working in the portfolio areas from across CHSALHN. The workshop was supported by the CHSALHN Director of Nursing and Midwifery. Collaboration with the CHSALHN Acting Director of Safety and Quality and Clinical Development saw delivery of a successful workshop that built on the successful work in CHSALHN of Portfolios such as the Bloodsafe Portfolio. The opportunity for the Portfolio groups to meet and clarify individual and project expectations was a key achievement of this workshop that introduced tools and techniques including Clinical Practice Improvement concepts to assist the development of the Portfolio Clinical Nurses and the program.
Each Portfolio Lead Clinician and Portfolio DONM Lead hold regular teleconferences with their Clinical Nurses, for the purpose of education, advice, and implementation of safety and quality improvements, including auditing.

**Reporting**

Monthly meetings are chaired by the Director of Nursing and Midwifery for CHSALHN and involve all Clinical Leads, DONM Leads, and the Manager of Safety and Quality CHSALHN. Each Portfolio provides a monthly written report of their achievements and barriers. These reports are discussed with areas for improvement and recommendations reported to the CHSALHN Directors of Nursing/Midwifery Leadership group.

In June 2012, each Portfolio area reported on achievements, education conducted, audits and future initiatives planned.

This reporting will occur every June, consistent with the end of financial year, to review and enable continuous improvement of portfolio areas.

**Achievements to date**

**Deteriorating patient**
- Gap analysis at all CHSALHN hospitals
- Action plans developed for all CHSALHN Hospitals
- Clinical Observation Charts trialled and assessed
- Escalation Flow charts developed for each hospital
- Education program using “Train the Trainer” tools

**Medication safety**
- Medication Omission program “Better than a Blank” implemented, incorporating codes for correct documentation on National Inpatient Medication Charts commenced in July 2012
- Branding of medication management issues with “Medi Mouse” education sessions
- Gap analysis against EQuIP 1.5.1
- Developed education resources and visual aids

**Falls prevention**
- Contributed to Falls and Fall injury reporting template
- Implemented Falls Risk Assessment Form across all hospitals
- A range of audit tools have been used across CHSALHN based on EQuIP 1.5.4
- Majority of Clinical Nurses have completed the Falls Prevention Training
- Providing education across CHSALHN hospitals and aged care facilities
- Reduction in harm to patients and residents as a result of Falls

**Infection control**
- Improved processes for reporting and managing Multi-Resistant Organisms, and Outbreaks
• Implemented Hand Hygiene audit tool for all CHSALHN Hospitals, who are not required to report on the national database

• Clinical Nurses trained as Hand Hygiene assessors

• Clinical Nurse trained in Aseptic Touch Technique Program

• Gap analysis for EQuIP 1.5.3

Blood safe

• Red Blood Cell Audit 2010/11 completed at 53/65 sites—previous 2009/10 was completed at only 14 sites. Red Blood Cell Audit 2011/12 currently being completed at all 60 sites for further benchmarking

• 58/65 CHSALHN sites have been visited by both Clinical Nurses and Lead Clinician with educations sessions being conducted at these sites

• Returning of unused red blood cells has commenced at all 23 sites that hold emergency blood—this has led to a significant reduction in wastage

• Development and conducting of Blood Fridge Maintenance at sites that have a blood fridge

• Development and conducting of Blood Register Audits at all sites who transfuse blood

Barriers and areas for improvement

• Recruitment of Clinical Nurses into Portfolio areas has been difficult. There are approximately 226 of these Clinical Nurses in CHSALHN, yet only 55 engaged into a Portfolio. The Clinical Portfolio Nurses are not evenly geographically spread across hospitals

• DONMs in CHSALHN report that some Clinical Nurses are reluctant to work in the prescribed portfolio areas, because their clinical expertise or interest is not in these clinical areas

• Travel requirements to other hospitals are a barrier to some Clinical Nurses. Time spent travelling reduces time available for the Portfolio work, and can reduce time spent at home; in addition, many work part time

Overall achievements

• Improved communication between Lead Clinician, Portfolio Nurse and Hospital nursing/midwifery staff

• Improved communication across multi-disciplinary teams, particularly in the portfolios of Falls and Medication safety

• Hospital based decisions and inclusion within a evidence based standardised system

• Consistent education, information, processes and tools

• Benchmarking across hospitals

• “Buy-in” from local hospital staff

• Networking across hospitals

• Support network for Clinical Nurses

• Professional growth and career opportunities for Clinical Nurses
• Early identification of problems
• Ownership of the program/project
• Establishment of local experts and champions
• Improvements in safe, quality patient care and outcomes

Future directions
CHSALHN will continue to evaluate the systems and patient care outcomes to ensure there is evidence of improvements to patient care. This ongoing evaluation is particularly relevant for the current rapidly changing health care context as it will provide CHSALHN with opportunities to develop ‘working knowledge’ that can inform improvement initiatives Owen 2006.4

Before the end of June 2013, there is to be a review of the current portfolio areas with a view to including Pressure Prevention. There is support from the CHSALHN DONMs for this, to ensure consistency of evidence based practice.

Conclusion
This paper presents work undertaken by CHSALHN to optimise the benefits to the individual and organisation and make a difference to patients as a result of funding available for Registered Nurse reclassification to a Level 2 Clinical Nurse/Midwife position. Successful implementation, adaptation and utilisation of the Clinical Nurse role has assisted CHSALHN to support leadership in clinical practice and overcome some of the barriers of distance and diversity while embedding evidence based safety and quality priorities, that will improve patient outcomes.

Acknowledgments
The CHSALHN nursing and midwifery workforce for their commitment to improving patient care in the challenging rural and regional context:
• The Clinical Nurses
• Portfolio Clinical Leads
• Director of Nursing and Midwifery Leads
• Sandra Gilbert, Nurse Education Facilitator
• Stacey Holst, Executive Administration Officer

References
2 Australian Commission on Safety and Quality in Health Care (HCSQHC) (2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney