



# **FRAMEWORK FOR A QUALITY DISTRICT NURSING SERVICE IN NEW ZEALAND**

**A Tool For Future Service Planning**

**May 2008**

# **Framework for a Quality District Nursing Service in New Zealand: A tool for future service planning**

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**New Zealand Nurses Organisation**

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This paper and related district nursing information can be obtained from the College of Primary Health Care Nurses NZNO website. <http://www.nzno.org.nz>

## 1.0 Executive Summary

In response to indications that some District Health Boards (DHBs) were considering devolving their district nursing services to other providers, the NZ College of Primary Health Care Nurses of the New Zealand Nurses' Organisation (NZNO) sought members' views in 2006 regarding the best location of district nursing services. A paper, highlighting that the majority of members preferred to retain the status quo with DHB or current trust employment was sent to all Parliamentary members, Directors of Nursing and District Health Board General Managers. In 2007 the Minister of Health asked the section to outline the essential elements that district nursing services need to function effectively and deliver quality care.

District nurses provide a comprehensive range of quality, patient focussed, professional and advanced nursing services that are primarily home based. In general, district nurses provide intensive and short term episodes of care to address patients' increased health care needs in collaboration with the wider interdisciplinary team. District nurses provide a unique and vital role within the continuum of care and require organisational support to ensure that their ability to do so is strengthened and best positioned to meet emerging community needs. However, as highlighted by section members in 2007, it is vital that district nurses are included in discussions and decision making regarding future service delivery at a national, regional and local level, and that planning should allow for local solutions to be developed for local needs rather than a "one size fits all" approach. .

Essential elements for a quality district nursing service within the following categories provide a practical platform for building high quality, sustainable and future orientated district nursing services:

- Seamless transition across continuum of care
- Collaborative relationships
- Entry and exit to district nursing service
- Visibility and marketing of service
- Timely and equitable access to service
- Interdisciplinary approach
- Essential tools of work
- Products, supplies, equipment
- Workload measure
- Workforce development
- Professional support
- Clinical governance and nursing management
- Career pathway
- Employment
- Quality and risk management

*(See Appendix A for an outline of the elements within each category)*

In presenting these essentials elements, the section seeks to ensure that consistent, high quality, accessible, equitable, efficient, and effective home based district nursing care will continue to be provided in a variety of settings to all who require it throughout New Zealand (NZ). It is recommended that the framework provided be used as a guide to evaluate future work in planning for district nursing service placement and configuration.

## 2.0 Introduction

The aging population and a shift to community based care have combined to create a period of rapid growth in demand for home based nursing services. Many district nursing services are struggling to manage day to day work within the current resourcing available and the demand for care has driven many services to look closely at the work of the district nurse. Many services have been reviewed and refined in the past few years to maximise efficiencies. More recently, there have been indications from DHBs that they may elect to devolve their district nursing services to other providers. The Primary Health Care (PHC) Strategy Implementation 2001 indicates that district nursing services could be moved to high performing Primary Health Organisations (PHOs). There has been open consultation within one DHB to explore the contracting out of their district nursing service to an alternative provider, a move that has not been supported by district nurses, or from the community groups involved.

The NZ College of Primary Health Care Nurses of NZNO, as the professional representative body of district nurses within NZ, surveyed its members in 2006 to ask where they thought district nursing services should be located. Results demonstrated that the majority wanted to retain the status quo with DHB or current trust employment. Reasons articulated by section members were; changes to service location/configuration have a high potential to negatively impact on their ability to function as they currently do in order to meet their patient's health care needs, and uncertainty regarding what a change in employer would look like. A paper outlining members' views was sent to all Parliamentary members, Directors of Nursing and District Health Board General Managers. In July 2007 representatives from the section were invited to meet with Pete Hodgson, then Minister of Health and Mark Jones, Chief Advisor (Nursing) to the Minister to discuss the survey results. Consequently, the Minister requested the section outline the essential elements that district nursing services need to function effectively in order to deliver quality care.

## 3.0 Background

District nurses address health care needs that can not be met by a generalist medical or nursing service alone. They provide care for people who, without advanced nursing care, are at risk of further health deterioration, and for whom provision of that care in their normal living environment would not further compromise their health status. Collaborating with the wider health care team, district nurses deliver rapidly responsive, intensive, and advanced holistic nursing care that is primarily home based in order to:

- Prevent avoidable admission to, or enable early discharge from, hospital
- Minimise the impact of a personal health problem
- Support people with long term or chronic personal health problems or conditions
- Promote self care and independence
- Improve the health of Maori by delivering services to best meet Maori health need
- Improve the health of Pacific Island people by delivering services to best meet Pacific Island health need
- Provide terminal/palliative care in the community where such services are not covered by other service specifications funded by the Ministry of Health (MoH).

*(Specialist Community Nursing Service Specifications, Ministry of Health Objectives, 2001)*

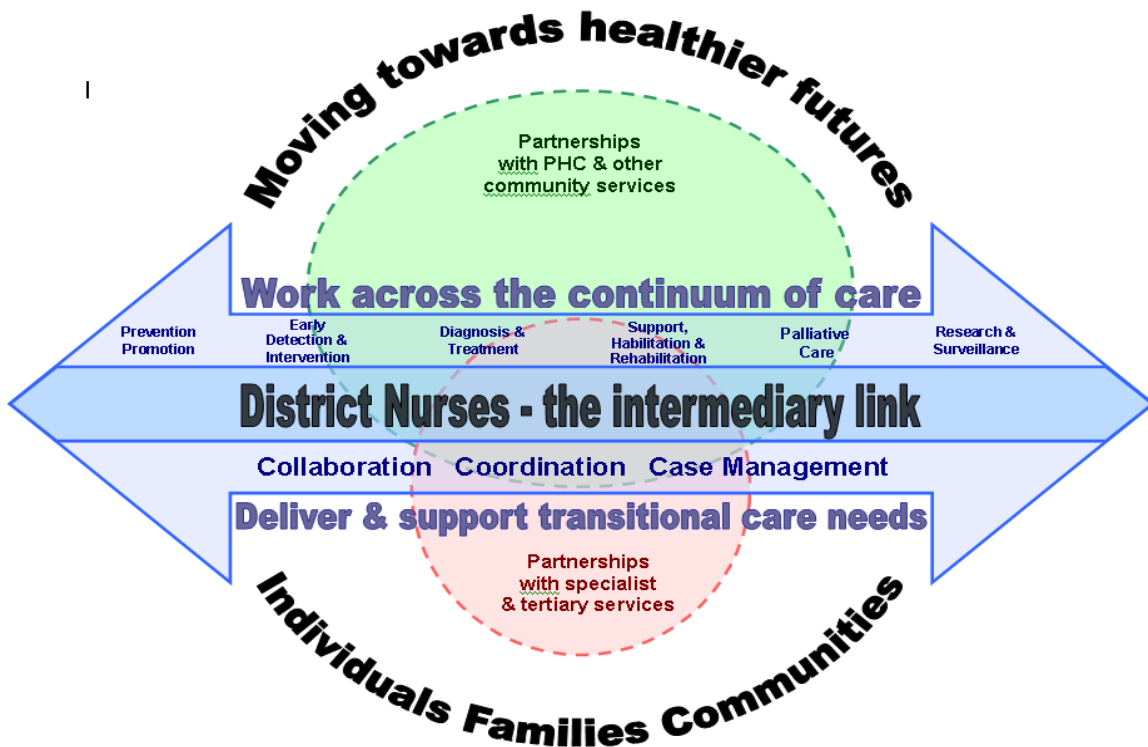
To achieve these MoH objectives; district nurses manage increasingly complex and technologically advanced care within the home, activities made more challenging due to the unpredictable and rapidly changing nature of patient health status and home environments that district nurses encounter on a daily basis. In addition, requests for district nursing care are demand driven and unpredictable, with no barriers that limit admissions when the service is at capacity. These factors pose a daily challenge to ensure sufficient but not excessive resources are available to meet referred patients' needs within contractually required timeframes (Referral response timeframes, MoH Specialist Community Nursing Service Specifications, 2001).

Delivering well co-ordinated, timely, efficient, effective and appropriate district nursing care within this context is a complex operation that requires careful management and oversight of the:

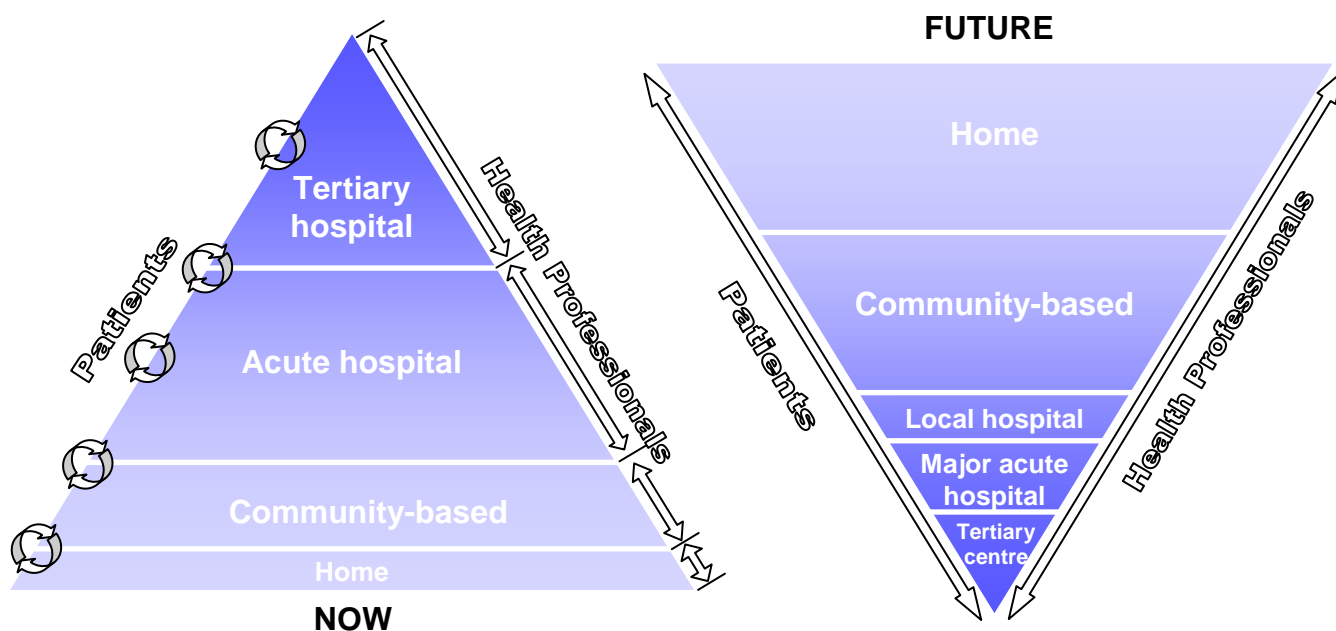
- Clinical practice and competence of the service's district nurses.
- Health status and health care needs of all current patients.
- Service's ability to first predict and then meet expected district nursing workload (a balancing operation that may need to be repeated several times over a 24 hour period and across a service delivery region).
- Quality and availability of information flow between district nurses and between the district nursing service and other health care providers.

Although district nurses incorporate a primary health care focus into their care, in general they do not provide first level of contact PHC, nor do they operate as an extension or capacity enhancement for primary care. Instead, district nursing services provide a unique and vital role within the continuum of care; complementing and assisting both primary and secondary services by operating as a rapidly responsive intermediary conduit that balances and strengthens the link between acute/specialist services and primary health care, bridging the gap between primary and secondary, between medical and nursing, and between high and low technology care. This is demonstrated in the model below.

The intermediary position that district nursing services occupy in the continuum is a key factor in their ability to promote faster recovery from illness by delivering and supporting transitional care needs, ultimately assisting to maximise quality of life and independent living. To do so, district nurses perform a multitude of activities and roles related to advocacy, information and education, self management, health promotion, community liaison, clinical tasks, navigating and linking with community resources, empowering people, care co-ordination and case management (Kralik and Telford; 2007). District nurses draw on a vast range of resources and services, often needing to navigate complex health systems to ensure their patient's needs are met, and therefore, have extensive knowledge of their community and services available, and have forged collaborative networks with these.



Currently, secondary services account for between 60 – 70 % of most NZ district nursing referral volumes, most likely an indication of the current role that acute hospital care plays in managing New Zealanders’ health. However, as indicated by the model below, a preferred future scenario is “connected communities”; in which a co-ordinated system of service provision that is centred on patients and their families enables a greater proportion of care to occur in the home and community. District nurses’ intermediary position can enable them to play a vital role in achieving this vision. However, as highlighted by section members in 2007, future planning must take care not to undermine or reduce their ability to do so. In particular, members advised that they must be included in discussions and decision making regarding future district nursing service delivery at a national, regional and local level, and that planning should allow for local solutions to be developed for local needs rather than a “one size fits all” approach. .



Central Regional District Health Boards Regional Clinical Services Plan, 2008

#### 4.0 Findings

Clearly district nursing services are a key part of the health sector, making a significant contribution to maintaining the health and wellbeing of New Zealanders. However, as the populations health care needs continue to change, and the drive for more community based care increases, its is vital that district nursing services are well positioned and strengthened in order to continue to deliver care that is rapidly responsive to emerging needs. For quality, sustainable and future orientated district nursing services, the following goals and principles need to be taken into account:

To Ensure New Zealanders Have					
Better health	Reduced inequalities	Better participation and independence	Trust and security in the health and disability support system		
New Zealand District Nursing Services Must					
Deliver high quality, safe and effective care	Ensure all entitled to health care in New Zealand have their needs met in a timely, equitable, accessible, and responsive manner		Select and utilise best practice guidelines, equipment, products, and resources to ensure care is appropriate, consistent, and effective, resulting in optimal outcomes for all		
To Achieve This District Nursing Services Must Be Guided By The Principles Of					
Equity	Effectiveness	Confidence	Value for Money	Affordability	Transparency

<b>To Implement These District Nursing Services Need Excellent Systems</b>		
Cross-sector collaboration and stake holder engagement	Structures and systems that really work	System capability

*(Adapted from Medicines New Zealand: Contributing to good health outcomes for all New Zealanders, 2007)*

## **4.1 Making it real**

The following principles, in combination, provide a framework outlining the essential elements that need to be present for district nursing services to achieve the above goals and principles:

- Wagner Chronic Care Model (National Health Committee, 2007).
- Factors that foster a professional practice environment (American Association of Colleges of Nursing White Paper: Hallmarks of a professional nursing practice environment, 2002).
- Positive Practice Environments - International Council of Nurses Information and Action Tool Kit; Quality Workplaces = Quality Patient Care, 2007.
- Elements of safe staffing (Safe Staffing/Healthy Workplaces Committee of Inquiry Report, 2006; American Nurses Association Utilization Guide for the Principles for Nurse Staffing, 2005).
- Investing in Health Update 2007 joint collaboration by NZNO and College of Nurses Aotearoa.

### **4.1.1 The Wagner Chronic Care Model**

The Wagner model offers a blueprint for safe, effective, timely, patient-centred, efficient and equitable care delivery. It identifies the following six key elements that services require to promote high quality management and health care delivery:

- Self management support.
- Delivery system design.
- Decision support.
- Clinical information system.
- Health care organisation.
- Mobilisation of community resources to meet patient need.

It is predicted that services with these elements will achieve productive interactions between activated patients (as well as their family and caregivers) and a prepared practice team, resulting in high quality, satisfying encounters and improved outcomes (Bodenheimer, Wagner, Grunbach, 2002). The Wagner model is not an abstract theory, but rather a concrete guide to improving practice, and therefore, it is recommended that changes to service design and delivery are checked against the criteria outlined in Appendix B.

### **4.1.2 A Professional Nursing Practice Environment**

The primary objective of a professional practice environment is to enable nurses and health care organisations to focus on patient safety and care quality and to always ask the question, "What is best for our patients?" (American Association of Colleges of Nursing, 2002). When people, resources and/or structures are lacking there is a conflict between nurses' professional responsibility and the provision of adequate patient care. If, for example, intense workloads only leave nurses time for tasks related to the physical needs, psycho-social and spiritual needs of patients may not be completely met nor holistic care achieved (International Council of Nurses, 2007). A significant number of studies demonstrate higher levels of quality care and improved patient outcomes within organisational environments that support professional nursing practice (Flynn, Carryer and Budge; 2005).

The American Association of Colleges of Nursing (AACN) White Paper (2002) advises that the hallmarks of a professional nursing practice environment are present in health care systems, hospitals, organisations, or practice environments that:



1. Manifest a philosophy of clinical care emphasising quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability.
2. Recognise contributions of nurses' knowledge and expertise to clinical care quality and patient outcomes.
3. Promote executive level nursing leadership.
4. Empower nurses' participation in clinical decision-making and organisation of clinical care systems.
5. Maintain clinical advancement programmes based on education, certification, and advanced preparation.
6. Demonstrate professional development support for nurses.
7. Create collaborative relationships among members of the health care provider team.
8. Utilise technological advances in clinical care and information.

The International Council of Nurses (ICN) advises that positive practice environments are those that are characterised by:

- Innovative policy frameworks focused on recruitment and retention.
- Strategies for continuing education and upgrading.
- Adequate employee compensation.
- Recognition programmes.
- Sufficient equipment and supplies.
- A safe working environment.

The ICN Nurse Work Environment Assessment Tool and the AACN Hallmarks of a professional nursing practice environment outlined in Appendix C provide guidance for managers, front-line nurses, professional associations, regulatory bodies, and all health stakeholders interested in improving the delivery of quality services.

#### **4.1.3 Elements of Safe Staffing**

The variable nature of healthcare demand and the relatively fixed nature of the nursing workforce often make it difficult to achieve a close match between workload and staffing. However, the need to achieve staffing that closely matches the needs of patients for care, 24 hours a day, seven days a week, and that maintains the health and well-being of nurses is a fundamental goal for all who manage nursing services, regardless of the setting (Safe Staffing/Healthy Workplaces Committee of Inquiry Report, 2006).

The ICN (2006) highlights that safe staffing has repeatedly been shown to contribute to better patient outcomes, which ultimately manifest in reduced health costs for individuals, families and communities and increased tax revenues as patients return to the active workforce. In addition, the ICN recommends that practices to achieve safe staffing should incorporate:

- The complexity and intensity of nursing activities.
- Varying levels of nurse preparation, competency and experience.
- Development of health care personnel.
- Support of nursing management at the operational and executive levels.
- Contextual and technological environment of the facility.
- Availability of support services.
- The provision of whistleblower protection.

The Safe Staffing/Healthy workplace Committee of Inquiry Report (2006) outlines the following elements of safe staffing:

1. The requirement for nursing care.
2. The cultural environment.
3. Creating and sustaining quality and safety.
4. Authority and leadership in nursing.
5. Acquiring and using knowledge and skills.

6. The wider team.
7. The physical environment, technology, equipment and work design.

To achieve safe staffing practice, the Committee of Inquiry recommends services implement the 10 step outlined in Appendix D. These steps, along with the ICN (2006) nurse staffing assessment tool outlined in Appendix D will assist services to:

1. Assure patient safety and satisfaction.
2. Support staff health and well-being.
3. Maximise organisational efficiency.

## **5.0 Conclusion and recommendations**

The need for an operational, quality monitoring, clinical governance and clinical leadership infrastructure that supports district nurses to deliver care efficiently and effectively is supported by the research presented. So too is the evidence that the learning culture of an organisation, and in particular, one that supports nursing innovation and access to professional development and recognition programmes, has a positive impact on quality of patient care. The table in appendix A provides examples of these principles. It is not an exhaustive list of essential factors, but provides a practical platform for building high quality, sustainable and future orientated district nursing services. It is recommended that planning of future district nursing service delivery/configuration incorporates the framework and principles outlined.

## **6.0 Appendices**

- Appendix A: Essential elements for a quality, sustainable and future orientated district nursing service.**
- Appendix B: Wagner Chronic Care Model Criteria for Service design and Delivery.**
- Appendix C: A Professional Nursing Practice Environment.**
- Appendix D: Elements of safe staffing.**

## **7.0 References:**

- American Association of Colleges of Nursing White Paper: Hallmarks of a professional nursing practice environment, 2002.
- American Nurses Association utilization guide for the principles for nurse staffing, 2005.
- Bodenheimer, T., Wagner, E., Grumbach, K. (2002). Improving primary care for patients with chronic illness. *Journal of the American Medical Association*. 288: 14, 1775 – 1779.
- Flynn L., Carryer J., Budge C. (2005). Organisational attributes valued by Hospital, Home Care, and District Nurses in the United States and New Zealand. *Journal of Nursing Scholarship*. 37:1, 1-6.
- International Council of Nurses Information and Action Tool Kit: Positive Practice Environments; Quality Workplaces = Quality Patient Care, 2007.
- International Council of Nurses Information and Action Tool Kit: Safe Staffing Saves Lives, 2006.
- Kralik, D. & Telford, T. (2007). What is important about district nursing for people with chronic illness? *In pursuit of excellence: research informed practice*. Royal District Nursing Service Research Unit, Issue 47.
- National Health Committee. (2007). *Meeting the needs of people with chronic conditions*. Wellington: Author.

New Zealand Nurses Organisation., College of Nurses Aotearoa New Zealand. (2007). *Investing in Health 2007: An update to the recommendations of Investing in Health: A framework for activating Primary Health Care Nursing (2003, Ministry of Health)*.

The New Zealand Nurses' Organisation NZ College of Primary Health Care Nurses(2007). *The Future of District Nursing in New Zealand - Where do we fit?* Discussion document: Author.

Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006.

## Appendix A: Essential elements for a quality, sustainable & future orientated district nursing service

CATEGORY	ESSENTIAL ELEMENTS
Seamless transition across continuum of care	<p>Collaborative arrangements between all health services provide adequate notice of referral of complex, high acuity and time intensive patients and to ensure sufficient resources are available prior to admission.</p> <p>Resources are allocated for district nursing liaison roles that foster “pulling patients back into the community” in a safe and effective manner.</p> <p>Resources are allocated for case management and to the care of current patients to ensure consistent standards of clinical practice as per MoH guidelines.</p> <p>Service delivery incorporates and recognises Te Tiriti o Waitangi.</p>
Collaborative relationships	<p>Care is delivered in partnership with patients. <b>NOTE:</b> for the purposes of this document, patient includes individual patients and their carers/family/whanau.</p> <p>The service fosters inter-sectorial and inter-disciplinary collaborative care that reduces fragmentation, in partnership with general practice teams.</p> <p>District nurses keep informed of all community resources available and refer to the most appropriate service to meet patient needs.</p>
Entry and exit to district nursing service	<p>Admission and discharge criteria, based on level of patient need, is utilised in an informed, consistent and appropriate manner.</p> <p>Access to shared electronic patient information management systems to safely initiate and manage care.</p> <p>Discharge process ensures safe handover of care requirements to other community organisations when the patient no longer requires district nursing level care.</p> <p>Co-ordinated and accessible referral management centre with nursing expertise for referrers to discuss potential referrals and access discharge planning support.</p> <p>Policies/guidelines ensure non-accepted referrals are managed consistently &amp; appropriately.</p>
Visibility and marketing of service	<p>Access to DHB and other health sector newsletters, webpages, and intranet.</p> <p>The district nursing service is visible throughout their DHB region e.g. liaison roles across the continuum, and all health care providers understand the district nursing role.</p> <p>All health care providers are aware of the entry/exit criteria and refer appropriately.</p> <p>The service is flexible, can adapt and respond to meet emerging community needs.</p>
Timely and equitable access to service	<p>Referrals can be responded to within MoH risk assessment time frames.</p> <p>Free access to district nursing services and equity of access within and across DHBs</p> <p>Arrangements that support care transferability across provider boundaries to meet transient population needs.</p> <p>Culturally responsive resources are available in a timely manner.</p>
Interdisciplinary approach	<p>Patients have access to other health care services in a timely and integrated manner.</p> <p>Timely access to a full range interdisciplinary expertise that supports district nurses in their provision of holistic care.</p> <p>Relevant patient assessment and care delivery information shared between involved clinicians and duplication of care and documentation is minimised.</p>
Essential tools of work	<p>Assessment, care planning and care evaluation tools to support patient focussed, outcome focussed and holistic nursing care.</p> <p>Inter / intra service communication pathways that ensure care is responsive to patient level of need.</p> <p>Cars, bags, supplies in accordance with best practice, cell phones, uniforms, personal protective equipment and resources. Patient /staff injury prevention training /equipment.</p> <p>Access to information technology (IT); computers, training, support, IT decision support and patient management software that meets nursing delivery needs.</p> <p>Adequate administration support and data storage that meets privacy requirements.</p>
Products, supplies, equipment	<p>Best practice products, supplies, and equipment are available and accessible at no cost of patient, as determined by district nursing clinical judgement.</p> <p>Efficient and effective supply ordering and provision processes in place.</p>

Workforce development	<p>Orientation and preceptorship programme supports nurse to make a safe and effective transition to district nursing area of practice.</p> <p>Resources to develop future district nursing workforce e.g. nurse entry to practice programme, return to nursing.</p> <p>Structured ongoing education to support advanced district nursing practice roles to meet future community care needs e.g. life long condition management, aging in place.</p>
Professional support	<p>Clinical supervision, coaching and mentoring is available.</p> <p>Debriefing/reflection is available after significant events.</p> <p>Access to electronic library to support research, maintain clinical knowledge base.</p> <p>Nurse leadership within the domains of clinical practice, management, research and education is evident at all levels throughout the organisation.</p> <p>Visible nursing leadership is accessible to all district nurses.</p> <p>Nurse leadership positions are dedicated resources.</p> <p>Resources for participation in regional and national professional development and networking opportunities.</p>
Clinical governance and nursing management	<p>Structures and processes provide district nurses with shared decision making and clinical autonomy. Opportunities to participate on organisational groups that influence future funding and care models to enable local solutions for local needs. For example the ability to establish district nurse led clinics.</p> <p>Research, innovation and continuous quality monitoring is valued and encouraged.</p>
Workload measure	<p>Best practice work load planning, allocation and monitoring systems are in place with fair and equitable distribution of work. Systems to identify and communicate when service has reached capacity for safe care delivery.</p> <p>Safe staffing escalation process that incorporates the recommendations of the DHB NZ / NZNO Safe staffing, Healthy Workplaces Unit.</p> <p>District nurses' workload and skill mix provides safe quality care by utilising allocation principles that take into account the patients' needs and the nurses' skills.</p>
Career pathway	<p>Access to an accredited professional development recognition programme with levels and payments.</p> <p>Learning organisation where education is encouraged to grow skills and improve quality of care. Access to clinical training agency funding for post graduate education and for professional development leave as per DHB multi-employer collective agreement (MECA). Access to nurse educator resources.</p> <p>Succession planning is visible and there are opportunities for district nurses to develop specialty focus/roles within the district nursing team.</p> <p>Partnership with learning institutions for research opportunities and clinical placements for nursing students.</p>
Employment	<p>Union delegates are resourced to support industrial and organisational concerns.</p> <p>Pay rates align with NZNO DHB MECA community /midwife scale.</p> <p>Access to support services such as occupational health services, human resource services, Employee Assistance Programme.</p>
Quality and risk management	<p>Services have contracts, policies, procedures and guidelines in place to ensure that all entitled to health care in NZ have their needs met in a timely, equitable, accessible, responsive, appropriate, consistent and effective manner.</p> <p>Systems support district nursing innovation and continuous quality improvement.</p> <p>Best practice care guidelines/pathways/protocols, infection control standards, hazard identification and management, safe handling, home visiting policies, standards of care, that meet the needs of nurses working alone in the community are in place, available, reviewed and updated regularly.</p> <p>Quality of care audits/benchmarking activities that focus on patient outcomes, nurse outcomes, and system outcomes are conducted regularly and suboptimal results are responded to.</p>

## Appendix B: Wagner Chronic Care Model Criteria for Service design and Delivery

1. **Self-management support:** The health care service empowers and prepares patients to manage their health and health care by:
  - Emphasising the patient's central role in managing their health and encouraging the collaborative decision making of the patient and family/whanau.
  - Utilising effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up, self management resources and tools.
  - Organising internal and community resources to provide ongoing self-management support to patients.
  - Preparing the patient and family/ whanau to manage their health through education and support regarding their health needs, medication need and correct use, and supporting lifestyle changes.
2. **Delivery system design:** The health care service assures the delivery of effective, efficient clinical care and self-management support by:
  - Defining roles and distributing tasks among team members.
  - Utilising planned interactions to support evidence-based care in order ensure effective, efficient quality clinical care.
  - Providing clinical case management services for complex patients.
  - Ensuring regular follow-up by the care team with proactive and planned visits.
  - Providing care in a manner that patients understand and that fits with their cultural background.
  - Responding to individual needs through providing a range of services and supports such as home visiting and clinic appointments.
3. **Decision support:** The health care service promotes clinical care that is consistent with scientific evidence and patient preferences by:
  - Embedding evidence-based guidelines into daily clinical practice.
  - Integrating specialist expertise and primary care and ensuring specialist expertise is available for consultation for nurses to enhance care planning.
  - Utilising proven provider education methods and providing a range of relevant educational opportunities for health professionals.
  - Sharing evidence-based guidelines and information with patients to encourage their participation.
4. **Clinical information system:** The health care service organises patient and population data to facilitate efficient and effective care by:
  - Providing timely reminders for providers and patients.
  - Identifying relevant subpopulations for proactive care.
  - Facilitating individual patient care planning.
  - Fostering timely information sharing with patients and providers in order to promote collaborative team work and coordinated care across providers.
  - Monitoring performance of the practice team and care system.
5. **Health care organisation:** The health care service creates a culture, organisation and mechanisms that promote safe, high quality care by:
  - Visibly supporting improvements at all levels of the organisation, beginning with the senior leader.
  - Promoting effective improvement strategies aimed at comprehensive system change.
  - Encouraging open and systematic handling of errors and quality problems to improve care.
  - Providing incentives based on quality of care.

- Developing agreements that facilitate care coordination within and across organisations.

6. **Community:** The health care service mobilises community resources to meet needs of patients by:

- Encouraging patients to participate in effective community programmes.
- Forming partnerships with community organisations to support and develop interventions that fill gaps in needed services.
- Advocating for policies to improve patient care.

## **Appendix C: A Professional Nursing Practice Environment**

The AACN White Paper (2002) advises that the hallmarks of a professional nursing practice environment are present in health care systems, hospitals, organisations, or practice environments that:

### **1. Manifest a philosophy of clinical care emphasising quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability, for example:**

- The organisation has a philosophy and mission statement that reflects these criteria.
- Nursing staff have meaningful input into policy development and operational management of issues related to clinical quality, safety, continuity of care, patient: staff ratios, and clinical outcomes evaluation.
- Nurse staffing patterns have an adequate number of qualified nurses to meet patients' needs, including consideration of the complexity of patient care.
- Nursing is represented on the organisation's staff committees that govern policy and operations.
- The organisation has a formal programme of quality assurance, and performance improvement that includes a focus on nursing practice, safety, continuity of care, and outcomes.
- Nursing staff assume responsibility and accountability for their own nursing practice.

### **2. Recognise contributions of nurses' knowledge and expertise to clinical care quality and patient outcomes, for example:**

- The organisation differentiates the practice roles of nurses based on educational preparation, certification, and advanced preparation.
- The organisation has a compensation and reward system that recognises role distinctions among staff nurses and other expert nurses, e.g. based on clinical expertise, reflective of nursing practice, education, or advanced credentialing.
- The organisation's performance improvement programme has criteria to evaluate whether nursing care practices are based on the most current research evidence.
- Professional and educational credentials of all disciplines, including nurses, are recognised by title on nametags and reports.
- Nurses and other disciplines participate in media events, public relations announcements, marketing of clinical services, and strategic planning.
- Nurses are encouraged to be mentors to less experienced colleagues and to share their enthusiasm about professional nursing within the organisation and the community.
- Advanced nursing roles, including clinical nurse specialists, nurse practitioners, scientists, educators, and other advanced practice roles, are utilised in the organisation to support and enhance nursing care.

### **3. Promote executive level nursing leadership, for example:**

- Clinical nursing leadership participates on the governing body.
- Clinical nursing leadership reports to highest level operations or corporate officer.
- Clinical nursing leadership has the authority and accountability for all nursing or patient care delivery, financial resources, and personnel.
- Clinical nursing leadership is supported by adequate managerial and support staff.

### **4. Empower nurses' participation in clinical decision-making and organisation of clinical care systems, for example:**

- Decentralised, unit-based programme or team organisational structure for decision making.
- Organisation or system-wide committee and communication structures include nurses. For example; nurses have input into the systems, equipment, and environment of care.
- Demonstrated leadership role for nurses in performance improvement of clinical care and the organisation of clinical care systems.



- Utilisation review system for nursing analysis and correction of clinical care errors and patient safety concerns.
- Staff nurses have the authority to develop and execute nursing care orders and actions and to control their practice. For example; nurses control decisions directly related to nursing practice and delivery of nursing care, such as staffing, nursing quality improvement, and peer review.

**5. Maintain clinical advancement programmes based on education, certification, and advanced preparation, for example:**

- Financial rewards available for clinical advancement and education.
- Opportunities for promotion and longevity related to education, clinical expertise and professional contributions.
- Peer review, patient, collegial, and managerial input available for performance evaluation on annual or routine basis.
- Individuals in nursing leadership/management positions have appropriate education and credentials aligned with their role and responsibilities.
- Recognition for meeting professional practice criteria. For example; public acknowledgement, salary increases, time release, additional education, and support to attend conferences.

**6. Demonstrate professional development support for nurses, for example:**

- Professional continuing education opportunities available and supported.
- Resource support for advanced education in nursing.
- Preceptorship, organised orientation programmes, or other educational programmes available and encouraged.
- Specialty certification and advanced credentials are encouraged, promoted, and recognised.
- Advanced practitioners, nurse researchers, and nurse educators are employed and utilised in leadership roles to support clinical nursing practice.
- Links are developed between health care institutions and baccalaureate/graduate schools of nursing to provide support for continuing education, collaborative research, and clinical educational affiliations.

**7. Create collaborative relationships among members of the health care provider team, for example:**

- Professional nurses, physicians, and other health care professionals practise collaboratively and participate in standing organisational committees, the governing structure, and institutional review processes.
- The practice setting is organized from a patient-centered perspective, rather than a discipline-centered perspective. For example; routine interdisciplinary care planning sessions are facilitated.
- Professional nurses have appropriate oversight and supervisory authority of other members of the nursing care team.
- Interdisciplinary team peer review process is used, especially in the review of patient care errors.

**8. Utilise technological advances in clinical care and information systems, for example:**

- Documentation is supported through appropriate application of technology to the patient care process. For example; nurses have electronic access within their practice setting to clinical nursing and health care knowledge and research results, including Web access.
- Appropriate equipment, supplies, and technology is available to optimise the efficient delivery of quality nursing care. For example; nurses have access to electronic and integrated electronic patient care documentation systems.
- Resource requirements are quantified and monitored to ensure appropriate resource allocation. For example; nursing practice is supported by up-to-date clinical care technology.

The ICN advises that positive practice environments are characterised by:

- Innovative policy frameworks focused on recruitment and retention.
- Strategies for continuing education and upgrading.
- Adequate employee compensation.
- Recognition programmes.
- Sufficient equipment and supplies.
- A safe working environment.

The ICN information and action tool kit: positive practice environments; quality workplaces = quality patient care (2007) provides the following positive nurse work environment assessment tool:

### **Organisations**

- Does the environment/organisation recognise nurses as professionals?
- Do nurses receive adequate compensation for their work?
- Are there opportunities for career advancement in nursing?
- Do the working conditions allow for optimal nurse recruitment and retention?
- Does the organisation have policies in place to guide work environments?
- Are there work environment/organisational policies that address occupational health hazards and promote safe working environments?
- Is policy enforcement monitored?
- Are policies reviewed regularly and revised as required?
- Is safe equipment available and well maintained?
- Are there effective grievance procedures?
- Are there “whistle blowing” procedures? Are there policies that protect the “whistle blower”?
- Is there a policy in place to give nurses control over their practice and scheduling?
- Is there a policy in place that establishes predictability and job specification?
- Are retention and recruitment policies in place?
- Are the turnover and vacancy rates excessive or negatively affecting patient outcomes?
- Are there programmes of recognition and reward?
- Are there policies about workplace violence?
- Do staff participate in the organisation’s decision-making?

### **Nurse**

- Do the nursing staff practise under an overarching code of ethics?
- Is there good communication between nurses and other health disciplines?
- Are there rewards/incentives for nurses who demonstrate strong communication skills with other nurses and between disciplines?
- Are there programmes that encourage personal health?
- Are there adequate physical and equipment supports that encourage safe practice?
- Are there policies in place that allow nurses to address workload issues?
- Are mentorship and coaching programmes readily available?
- Do nurses have access to continuing education programmes?

## **Appendix D: Elements of safe staffing**

### **The New Zealand Safe Staffing/Healthy Workplaces Committee of Inquiry Report (2006)**

This report identifies the elements necessary to achieve safe nursing staffing for an effective healthcare environment. These elements are interdependent: one cannot be prioritised over another without having a detrimental effect on safe staffing, and collectively they describe an appropriately resourced, well organised, healthy, care delivery environment in which patients achieve the planned outcomes. These elements and their key aspects are:

#### **1. The requirement for nursing care**

Meeting patients' requirements for nursing care is the first responsibility of nursing and requires the exercise of expert nursing judgement. Appropriate staffing will meet patients' care requirements, achieve good health outcomes for patients, and ensure that workplaces are healthy and satisfying for staff.

Identifying and delivering the appropriate staffing levels requires an effective nursing staffing system - one that is able to deliver the right number of nurses with the right competencies to provide the right care in the right place at the right time to every patient admitted to the service.

Effective staffing systems require the collection and use of information to inform the reliable forecasting and management of patients' requirements for nursing care, as well as effective auditing and assessment. This process must include expert nursing judgement. Measurement of effectiveness needs to include the assessment of staffing data against actual patient-generated workload and quality indicators, including patient satisfaction.

#### **2. The cultural environment**

A motivated, satisfied workforce is key to achieving organisational success. A positive workplace culture that fosters positive attitudes, principles-based strategies rather than prescriptive rules, and supports "ground-led, top-fed" approaches is necessary.

#### **3. Creating and sustaining quality and safety**

Fundamentally, healthcare organisations exist to deliver quality, safe healthcare to patients/clients. Quality and safety relate both to the patient/client and to the entire environment in which care takes place, including staff. Quality and safety are part of a continuum, with optimum outcomes at one end and doing no harm at the other.

It is vital that quality and safety activities are considered 'work as usual' and factored into budgets and non-clinical time. Organisations that achieve the highest levels of quality and safety make these elements pervasive, visible, and valued across the entire organisation. This is achieved through commitment to evolving and reframing current systems, and to positioning quality and safety at the highest levels of organisational attention. Without this approach, other competing priorities will inevitably continue to be given precedence.

#### **4. Authority and leadership in nursing**

Nurses understand the business of providing care 24 hours a day, seven days a week, and how organisations need to work in order to deliver quality patient outcomes. To support appropriate and timely decisions that improve patient and nurse satisfaction, and improve service productivity and organisational functioning, nurses nearest to the point of care need the authority and support to make decisions, and to design and manage safe, supportive systems that make appropriate use of the full range of nursing personnel, thus allowing optimum use of scarce health resources.

## **5. Acquiring and using knowledge and skills**

Acquiring and using the knowledge and skills to support nursing practice is part of nursing work, and requires protected time and dedicated resources. The workplace is the principal place of learning and education, and future efforts should maximise opportunities for acquiring knowledge and skill at the point of care. Managers and their teams need to develop the competencies to support more flexible ways of working, and good team functioning.

External/tertiary learning opportunities are key to advancing practice and the overall body of knowledge of nursing. Co-ordination and collaboration are required between health and education providers to ensure that practice drives education, so that nurses are “fit for the purpose”.

## **6. The wider team**

Good patient outcomes are built from the contributions of the wider team. The nursing staffing model must explicitly take into account the mix, skill sets and availability of the wider team. Nurses provide the continuity and consistency in the system, and this aspect of their work requires time and recognition within the staffing model.

Defining what has to be done by nurses and what could or should be done by others has the potential to free up nurses to do their work. Role extension needs to be supported by appropriate training, supervision and authority. To achieve the best outcomes, the wider team needs opportunities to work and plan together in order to ensure a better fit between the various components of care. This, in turn, will lead to better outcomes for patients.

## **7. The physical environment, technology, equipment and work design**

The nature and quality of the physical environment, technology, equipment and work design have a profound impact on nursing workloads, and therefore on the safety and effectiveness of healthcare delivery. Well designed and well resourced environments to support maximum efficiency are vital.

Involving nurses in key decisions about their physical environment, technology, equipment and work design will lead to environments that support nurses to work more effectively. The expected benefits of new technology may not occur if the technology is not designed to fit with the rest of the work environment. Employee participation in this area is vital for the success of workplace health and safety, which is supported by legislation and national standards.

### **The New Zealand Safe Staffing/Healthy Workplaces Committee of Inquiry Report (2006): 10 steps for implementing safe staffing measures.**

#### **Step 1 Forecasting patients**

Services need to be able to obtain the best possible forecast of the patient population their service will be required to care for. Minimum forecasting data should include:

- The number of patients expected
- Anticipated length of stay in the service, and the general nature of their need for care.

Forecasts should be developed both at a whole-service level, and at an area/base/unit level, and provide the basis for planning staffing to meet care delivery requirements. Therefore, forecasting should be completed prior to planning staff resources and allocating budgets.

#### **Step 2 Smoothing the planned workload**

Services require workload management systems/processes that provide capacity to smooth their workloads, or at the very least to adjust staff resource allocation in response to peaks of acute demand and variations from expected workload. For example systems that enable rapid identification of peak and unexpected workloads that prompt reallocation of staff resources in a timely manner. It is

recommended that services have integrated workload forecasting and smoothing systems in order to ensure capacity to consistently meet the need for care.

### **Step 3 Estimating patient-generated staffing**

The generation of a staffing plan utilising forecasted workload data, and expert nursing judgment should be completed at service and unit/base/area level, and should be the responsibility of the nurse in charge of these areas. Staffing plans should identify the numbers, types and skill mix of nurses required on an hour-by-hour basis.

### **Step 4 Estimating non-patient-generated staffing**

Staffing plans must also enable the work of creating and sustaining quality and safety, and for acquiring skills and knowledge. Estimating the staffing allowance to be made for the work of creating and sustaining quality and safety, and for acquiring skills and knowledge, should be the responsibility of the nurse in charge of the area/base/unit, in conjunction with the nurse in charge of the overall service. Informed expert judgment is required to complete this step.

### **Step 5 Estimating the effect of other moderating factors**

Factors associated with the cultural environment, leadership and authority, the wider team, and the physical environment, technology, equipment and work design have the potential to influence the effectiveness of the nursing staff providing care delivery. For example, a positive cultural environment will enhance the service's capacity to cope with unexpected events and workloads that temporarily exceed usual limits. This may allow a leaner staffing plan than would otherwise be the case. Closely related to this is the way in which leadership and authority are delegated within a service. If nurses in the clinical workplace have limited authority to make decisions that are important to patient outcomes, patients will tend to spend longer in the service than would be the case if such decisions were made and acted on more promptly. Any reduction in patient complications and length of stay provides the opportunity for relatively fewer staff to be required for the same patient group.

The design of the work environment and the availability and suitability of equipment and technology can also markedly increase or reduce staffing effectiveness and workload, as can the availability of multidisciplinary team members. In their absence, work normally undertaken by other MDT members must either be done by nurses, or delayed until MDT resource/members are available. However, it cannot be assumed that if other staff groups are not available, nurses can simply build the work normally undertaken by these groups into their own workloads. Additional nursing work and training is often required to enable this.

The sum effects of the factors outlined above are not readily quantifiable, but they must be taken into account when planning staffing. Informed expert judgment should be used to estimate the impact of these factors on the staffing plan.

### **Step 6 Provision for leave**

Safe staffing requires a well informed and realistic estimate of the amount of time that staff will be unavailable due to annual leave, sick leave, parental leave, or special leave to be built into the total staffing plan. Estimates should take into account historical patterns of staff leave requirements, and current workplace conditions/characteristics. Careful planning is required to ensure good provision for leave, as stressed workforces lead to the compounding effect of increased rates of sick leave made worse by an inability to replace nurses who are off work because they are unwell.

### **Step 7 Fine-tuning and budgeting**

The systematic planning process above should be completed well in advance of implementation, to allow the effective management and integration of the patient and staffing management systems. Before the staffing plan is finalised, it should be tested against patient forecasts. If testing shows

that, at any point, expected workload will exceed staff capacity, steps should be taken to minimize or resolve capacity issues. Failure to do so is likely to result in undesirable outcomes, such as failures in standards of care, incident/accidents, and staff distress.

Budgets must fit staffing requirements, instead of staffing being made to fit budget requirements. Where the forecast workload requirements exceed the available budget, steps must be taken either to increase the budget allocation, or to reduce the level or quality of services offered, or to modify parts of the system to optimise efficiency and resource utilisation. Failure to do so undermines the goal of safe and effective healthcare delivery.

### **Step 8 On the day**

Appropriate workload allocation by the nurse in charge, incorporating professional standards of direction and delegation, should occur throughout the shift to ensure that planned care is delivered in a timely and appropriate manner. The delegating nurse uses professional judgment and available information to match the right nurse to deliver the right care with the right competencies to the right patients. Systems should enable and support proactive patient reallocation or nurse reallocation. The nurse should be supported by the broader organisation to manage the competing priorities in the workflow. This may include workload allocation to members of the wider team.

### **Step 9 Incident responsiveness**

Staffing planning must include the development of a detailed and workable escalation plan, to manage those occasions when workload surges beyond the capacity of available staff to cope. The system must ensure that, where any nurse identifies that the limits of safe practice are at risk of being breached; their professional judgment is acted upon, with an immediate and appropriate response to resolve the situation. The plan needs to include indicators to provide an early warning system and de-escalation measures, with relevant authority attached to each step.

### **Step 10 Review**

Regular review of forecasted and actual worked is vital, as this is the main driver of the staffing plan and systems should enable this to be done monthly, weekly, daily and hourly in order to identify variance as early as possible. It is essential that where it becomes clear that the number of patients and/or level of need in any given area exceed that area's capacity, steps are taken as soon as possible to maintain the operational effectiveness of the staffing plan. Failure to review or failure to act on identified changes in planning assumptions will reduce the effectiveness of the above steps for achieving safe staffing.

## **The ICN information and action tool kit: safe staffing saves life's tool kit (2006)**

This tool kit provides the following nurse staffing assessment tool:

### **Employers Work Environment/Organisation**

- Does the work environment/organisation provide adequate equipment for staff to provide safe and sufficient patient care?
- Does the work environment/organisation have an appropriate physical location that enables staff to carry out their work in a functional manner?
- Are there work environment/organisation policies that address safe staffing? Is their enforcement monitored? Are the policies reviewed regularly and revised as required?
- Are grievance procedures in place?
- Is there clear and influential nursing leadership at the highest levels of decision making playing a full and proactive role in corporate and strategic planning?
- Do nurses receive adequate compensation for their work? Do the working conditions allow for optimal nurse recruitment and retention?

### **Nurse**

- Does the nursing staff contain a mix of adequate personnel?
- Is patient complexity considered when determining nurses' workload?
- Are regular nurse workload evaluations conducted including an assessment of the impact of such duties as education and supervisory duties?
- Are nurses involved in staffing decisions?
- Do nurses monitor their personal health?

## **The AACN utilisation guide for the principles for nurse staffing (2005)**

This guide identifies the following principles for safe nurse staffing:

### **Patient Care Unit Related**

1. Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient complexity and need. The following critical factors must be considered in the determination of appropriate staffing:
  - Number of patients
  - Levels of intensity of the patients for whom care is being provided
  - Contextual issues including architecture and geography of the environment and available technology
  - Level of preparation and experience of those providing care.
2. Unit functions necessary to support delivery of quality patient care must also be considered in determining staffing levels:
  - Unit governance
  - Involvement in quality measurement activities
  - Development of critical pathways
  - Evaluation of practice outcomes.

### **Staff Related**

3. The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area.

4. Registered nurses (RNs) must have nursing management support and representation at both the operational level and the executive level.
5. Clinical support from experienced RNs should be readily available to those RNs with less proficiency.

#### **Institution/Organisation Related**

6. Organisational policy should reflect an organisational climate that values registered nurses and other employees as strategic assets and exhibit a true commitment to filling budgeted positions in a timely manner.
7. All institutions should have documented competencies for nursing staff (including supplemental and traveling staff), for those activities that they have been authorised to perform. When floating between units occurs, there should be a systematic plan in place to ensure competency.
8. Organisational policies should recognise the myriad needs of both patients and nursing staff and provide the following:
  - Effective and efficient support services (e.g. transport, clerical, housekeeping, equipment, laboratory) to reduce time away from patient care and the need for the nurse to engage in “re-work”.
  - Access to timely, accurate, relevant information provided by communication technology that links clinical, administrative and outcomes data.
  - Sufficient orientation and preparation including nurse preceptors and nurse experts to ensure competency.
  - Preparation specific to technology used in providing patient care.
  - Necessary time to collaborate with and supervise other staff.
  - Support in ethical decision-making.
  - Sufficient opportunity for care coordination and arranging for continuity of care and patient or family education.
  - Adequate time for coordination and supervision of nursing support personnel by RNs.
  - Processes to facilitate transitions during work redesign, mergers and other major changes in work life.
  - The right for staff to report unsafe conditions or inappropriate staffing without personal consequence.
  - A logical method by which to forecast patient level of need, predict workload, determine and roster staffing levels and skill mix.